COMMUNITY ENGAGEMENT PROJECT

NIHME MENTAL HEALTH PROGRAMME

REPORT OF THE COMMUNITY LED RESEARCH PROJECT FOCUSSING ON ACCESS TO MENTAL HEALTH SERVICES AND TREATMENT FOR THE ARABIC SPEAKING COMMUNITIES IN BRIGHTON AND HOVE AND WHETHER THEY ARE CULTURALLY APPROPRIATE.

BY THE BRUNSWICK COMMUNITY DEVELOPMENT PROJECT
COMMUNITY IN BRIGHTON & HOVE

SADIQ ASKARAVI, LENA KHAYAL, SUSAN MORRISON, CHARLES BOUSTANY

DATE - MARCH - 2007

FUNDED BY THE DEPARTMENT OF HEALTH,
MANAGED AND SUPPORTED BY
THE CENTRE FOR ETHNICITY AND HEALTH,
UNIVERSITY OF CENTRAL LANCASHIRE

PROJECT TEAM

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

Sadiq Askaravi………….
I come from Iran. In Iran I passed my diploma in economics in 1999. I came to the UK as an asylum seeker in 2004. I started study in English language and IT at Bhasvic College in Brighton. I work part time in a local Lebanese restaurant. I run the take a way section where we sell dishes. I'm working part time at the Brunswick community development project where I'm learning new skill as a researcher. I intend to use their skills to consult with the Arabic speaking community on the issue of Mental Health.

Lena Khayal………….
My name is Lena Khayal, I studied business administration in Jordan in 1991 and then worked in a bank.
I came from Jordan to England in 1995 to improve my English, I' am mother with two children aged 9 and 7 years of aged, since I married I have undertaken a number of courses which include: children psychology, literacy level 1 & 2, I have chosen to do this research course because it give me a chance to speak Arabic and meet new people.

Susan Morrison………….
In 1996 I started an access course in Women studies. On completion of this one-year course I successfully applied to Brighton University and completed a BA Hones degree in Humanities in 2000. I then volunteered with the Black and Minority Ethnic Partnership helping them with their research in finding out the needs and priorities of Black and Minority Ethnic people living in Brighton and Hove. Since then I have worked at Brunswick Community Development Project, initially as a volunteer co-ordinator for Arabic speaking and Chinese communities. At present I work as a community support worker again for the same communities but also provide administration support for all the groups. I have been resident in Brighton since I was five years of age and being involved in this project has given me an insight into how mental health issues has been dealt with in the last ten years in Brighton.

Charles Boustany……………
In my capacity as lead researcher it was my responsibility to secure funding, plan and co-ordinate the project, recruit and induct the researchers. Previous to my involvement with this research consultation I was aware of the local mental health issues but had little knowledge about mental health issues nationally. I coordinated local needs analysis and research using participatory methods as I always aim to help local people gain more confidence, knowledge and expertise therefore retaining those skills within the local area and /or community. I am now more confident in taking on community based research work dealing with a group of people I had not worked with in the past. But mostly I have gained so much working with a fantastic and enthusiastic team.

ACKNOWLEDGEMENTS

Firstly a big THANK YOU to all 30 participants, and 2 case study participants who took the time to answer the questionnaires.

We would also like to thank all those who contributed and supported the research.

THANKS T0

MANJIT BOLA	TUTOR UCLan
SARAH DYDE	Equalities Officer South Downs Health NHS Trust
DR RICHARD FORD	Executive Director Sussex Partnership NHS Trust
EILEEN JACKSON	PROJECT ADMINISTRATOR UCLan
POPPY JAMAN	Regional Race Equality and mental health well being lead
ANTHONY KOLLIE	Support Worker UCLAN
ANDY PORTER	Lead Commissioner Mental Health
TONY SHARP	Assistant Executive Director Sussex Partnership NHS Trust
ALIA SYED	Senior Support worker UCLAN
HAZEL WHALLEY	Research & Development Facilitator Health & Social Care Governance Support Team Sussex Partnership NHS Trust

CONTENTS

PROJECT TEAM	PAGE 2
ACKNOWLEDGEMENTS	PAGE 3
EXECUTIVE SUMMARY	PAGE 5
INTRODUCTION	PAGE 8
METHODOLOGY	PAGE 14
RESULTS	PAGE 18
QUANTITATIVE DATA	PAGE 18
QUALITATIVE DATA	PAGE 26
DISCUSSION	PAGE 30
RECOMMENDATIONS	PAGE 33
APPENDICES	PAGE 35

EXECUTIVE SUMMARY

The Brunswick Community Development project (BCDP) group was one of 40 Community groups who took part in NIMHE Mental Health Community engagement programme in 2006 through the University of Central Lancashire (UCLAN) to carry out research focusing on Access to Mental Health Services and treatment. BCDP's project focussed on mental health services for the Arabic Speaking Communities in Brighton and Hove and whether they are culturally appropriate.

Brunswick ward is one of the 25% most disadvantaged wards in the UK and Regency one of the 15% most deprived. The area is the most densely populated area of the city of Brighton and Hove, which brings with it many issues for local people, including environmental, housing, transport and anti-social behaviour issues. There are also a high proportion of residents from a variety of ethnic backgrounds; especially Chinese (the UK's 3rd largest Chinese population) and Arabic speakers from several different countries (including Muslim Ones), and the challenges faced by the ward become clear.

For the last few years we have been involved in ameliorating the quality of life for local residents who have continuously complained about street drinkers, drug dealing, prostitution, refugees and asylum seekers and associated problems. During this time one consistent theme was emerging; That mental health problems cut across all of these issues We now feel it is important to capture the other side of these issues so we can bring about a sense of social cohesion.

The focus of our work was to carry out research focusing on Access to Mental Health Services and treatment for the Arabic speaking Communities in Brighton and Hove and whether they are culturally appropriate. We selected this option to meet the objectives of the five-year vision for Delivering Race Equality in mental health care.

Three researchers with experience of mental health issues were recruited from the local community to conduct the research. They were supported by a series of workshops delivered by Uclan, together with a lead researcher and a Support Worker who visited the group on a regular basis.

The teamwork entailed preparation of all the paperwork, which included a project plan; individual questionnaires consent form and ethic policy. The team decided on purposive sampling and the community was accessed by the researcher's strong links using semi-structured questionnaires, one to one interviews and two case studies. They also collected and collated all data, translated, analysed and wrote the report.

A multi agency steering group was formed whose aim was to provide support and guidance to the Mental Health research team.

FINDINGS

30 respondents were interviewed and 2 case studies completed successfully.

Stress, Depression and Anxiety were the words used to explain their understanding of mental wellbeing. Again battling with depression was the majority response given to “How do you feel mentally?” In fact only three people said that they were really happy.

The attitude of the staff across mental health services who were helpful polite and who supported them by talking and listening were what was good about mental health services in general. What was unsatisfactory was the time it took to get an appointment. One person firmly said that there was ***“No Clear admission and discharge procedure”***

As the majority of those questioned had not been aware of what mental health services were available it was difficult for them to say what could be improved. But those that did quoted

- Better communication between client and service provider
- Staffing levels that were too low
- Funding available to employ specialised staff to the service.

The respondents to “If you were treated what advice and support were you given?” said that they were given accommodation, money, medication, exercise and other self help therapies.

When asked whether they were given enough time to talk about the help they needed.

- Six people said yes
- Two people said sometimes the time was not sufficient
- One person said a definite no.

Though the majority said yes they were treated in a culturally appropriate manner they could only say “they treated me as a human being” and “they were helpful and kind. The ones who disagreed said there should be more interpreters and gender sensitiveness.

In answer to what would be a culturally appropriate service and treatment they confirmed that it was important you had a choice of either a female or male doctor. And access to an Arabic speaking doctor or interpreter.

There was a lot more feedback to the question about the best methods of providing information to the Arabic community, the majority stating an information leaflet in Arabic left at the mosque of local church. Others thought culturally trained staff should visit the Arabic Club and the Arabic Women’s club to promote mental health issues

Again many people saw the benefits of a social club with weekly meeting where they could organise activities, trips and parties as a means of improving the quality of life for the Arabic community. Parenting advice on issues such as

education, culture, health and alternative therapies were also sought. Others talked about more conversation English classes and job opportunities.

Lastly people talked about more openness on the part of the Arabic community asking for"**Interface involving all sections of the community to discuss Mental Health, domestic violence and other issues that affect the community**

Based on our findings and discussion our recommendations are as follows:

1. More Mental Health Practitioners to go into the Arabic community to explain what mental illness is about. To dispel the myths and the stigma about the illness.

2. Mental Health professionals to engage with the Arabic speaking community about planning and delivering appropriate Mental Health services.

3. For clients to receive a culturally appropriate service that takes into account language, gender, religious and cultural differences.

4. For clients to receive a culturally appropriate treatment that values counselling treatment as well as medication.

5. For more information about the Mental Health Services translated into Arabic.

6. Funding to be sought to provide cultural training for staff.

7. More parenting advice is needed on issues such as education, culture, religion, alternative health therapies, health and safety and general health tips

8. More awareness of the community needs and wants in order to provide the right service. Involving the church, mosque and mullah in discussion.

9. Interface involving all sections of the community to discuss Mental Health, Domestic violence and other issues that affect the community

INTRODUCTION

The Centre For Ethnicity and Health's Model of Community Engagement

Background

We often hear the following words or phrases:

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

Sometimes they are used inter-changeably to mean the same thing. Sometimes the same word or phrase is used by different people in the same meeting to mean different things. The Centre for Ethnicity and Health has a very specific notion of Community Engagement, and this paper is an attempt to describe it. The Centre's Model of Community Engagement evolved over a number of years as a result of its involvement in a number of projects. Perhaps the most important milestone however came in November 2000, when the Department of Health awarded a contract to what was then the Ethnicity and Health Unit at the University of Central Lancashire to administer and support a new grants initiative. The initiative aimed to get local Black and minority ethnic community groups across England to conduct their own needs assessments, in relation to drugs education, prevention, and treatment services.

The Department of Health had two key things in mind when it commissioned the work; first, 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, and to an extent even more important, was the process by which this was to be done. If all the Department of Health had wanted was a needs assessment and a 'glossy report', they could have directly commissioned a number of researchers who could have gone into local Black and minority ethnic communities, talked to them about their needs, written up a report, and produced yet another set of reports that potentially do not have any long term impact. This scheme was different however. The Department of Health was clear that it did not want researchers to go into the community, to do the work, and then 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; what they would have is 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 six-month 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 & 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. It was out of this project that the Centre for Ethnicity and Health's model of community engagement was born.

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

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

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

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

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

The Key Ingredients

According to the Centre for Ethnicity and Health model, a Community Engagement project must have the community at its very heart. In order to achieve this, it is essential to work through a **host community organisation.** This may be an existing community group, but it might also be necessary to set a real or virtual group up where one does not exist already. The key thing is that this host community organisation should have good links to the target community[1] (whoever this is) such that it is able to recruit a number of people

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

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

A Host Community Organisation	With Good Links To The Target Community	To Provide Basic Infra-structure For The Project (Recruit And Co-ordinate Project Team; Provide Office Space, Phones And Computers; Look After The Finances)	To Recruit A Number Of People From The Target Community To Do The Work
A Task	Time Limited Meaningful Manageable	A Piece Of Research Into Key Needs/Gaps/Issues For The Community	Learning And Development Of Key Individuals; Access Hard To Reach Groups; Raise Awareness and Debate; Community Ownership
Support	Financial (Typically Up To £20,000)	Training And Workshops; On-Going Support And Guidance; Personal Tutor	Statutory Partnerships; Steering Groups; Sustainability

The second key ingredient is the **task** that the community is to be engaged in. According to the Centre for Ethnicity and Health model, this must be something that is meaningful, time limited and manageable. Nearly all of the community engagement projects that we have run have involved communities in undertaking a piece of research or a consultation exercise within their own communities. Sometimes we have been met with an initial resistance to doing 'yet another piece of research', but this misses the point. As in the initial programme that we ran on behalf of the Department of Health, *the process (i.e. of getting ordinary people involved in doing the work) is as important,* if not more important, than the report that they produce at the end of the day. The task or activity is something around which lots of other things will happen over the lifetime of the project. Individuals will learn and new partnerships will be formed. Besides, it is important not to lose sight of the fact that it will be *the fist time that these individuals have undertaken a research project*.

The final ingredient, according to the Centre for Ethnicity and Health's model, is the provision of appropriate **support** and guidance. We do not expect community groups to become involved for nothing. Typically we would make in the region of £15-20,000 available to the host organisation. We would expect that the bulk of this money would be used to pay people from the target

community as community researchers[2]. We then allocate a named member of staff from our Community Engagement Team as a project support worker. This person will visit the project at for at least half a day once a fortnight. It is their role to support and guide the host organisation and the researchers through the project. We also provide 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 pull together a steering group for the project[3]. The steering group is an essential element of the project: without one, it is difficult to see who the community are engaging with and it is unlikely that anything out of the project will be sustained in the longer term. The group will be doing a needs assessment or a consultation exercise, but for what purpose? It is the role of the steering group to ensure that the work that the group undertakes sits with local priorities and strategies, and that there is a mechanism for picking up the findings and recommendations that the group may make. It is also their role to help to pick up the key individuals who are developed through the project process to help them to take their 'next steps'.

The Community Engagement Team

The Community Engagement Team comprises of 25 members of staff. They work across a range of Community Engagement areas of specialism, within a tight regional framework.

<table>
<tr><td colspan="4">National Programme Directors</td></tr>
<tr><td>Northern Team</td><td>Midlands Team</td><td>Southern Team</td><td rowspan="2">Senior Programme Advisors</td></tr>
<tr><td>Senior Support Worker</td><td>Senior Support Worker</td><td>Senior Support Worker</td></tr>
<tr><td rowspan="3">Support Workers
X 3</td><td rowspan="3">Support Workers
X 3</td><td rowspan="3">Support Workers
X 6</td><td>Drug Interventions Programme</td></tr>
<tr><td>Regeneration</td></tr>
<tr><td>Mental Health</td></tr>
<tr><td colspan="4">Teaching And Learning Team</td></tr>
<tr><td colspan="4">Administration Team</td></tr>
</table>

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

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

Communications Officer

Programme Outcomes

Each group involved in any of our Community Engagement Programmes is required to submit a report detailing the needs, issues or concerns of the community that it consulted with. The qualitative themes that emerge from the reports are often very powerful, particularly when taken together with other reports produced by groups involved in the same programme. Such information is key to commissioning and planning services for diverse and 'hard to reach' communities. Often new partnerships between statutory sector and hard to reach communities are formed as a direct result of community engagement projects.

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

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

The Focus of This Particular Report

The Brunswick Community Development project (BCDP) group was one of 40 Community groups who took part in NIMHE Mental Health Community engagement programme in 2006 through the University of Central Lancashire (UCLAN) to carry out research focusing on Access to Mental Health Services and treatment. BCDP's project focussed on mental health services for the Arabic Speaking Communities in Brighton and Hove and whether they are culturally appropriate.

The specific objectives of this programme were:

- To ensure that local groups gain a better understanding of the mental health issues for their communities;
- To establish information networks across participating projects, in order to encourage information to be shared and gaps in services to be identified;
- To provide capacity building for local community group to ensure not only the completion of the work, but also an enhanced ability to articulate identified needs to service planners and providers;

- To ensure local planners and providers are involved in the process in order to enable the development of services that are sensitive to and meet identified needs.

Background information about the demographics

Brunswick ward is one of the 25% most disadvantaged wards in the UK and Regency one of the 15% most deprived. (Based on the indices of deprivation 2000)

The area is the most densely populated area of the city of Brighton and Hove, which brings with it many issues for local people, including environmental, housing, transport and anti-social behaviour issues.

Many local residents are living in bed-sits and cramped inadequate accommodation. Street homelessness and hidden homelessness are at high levels as are problems of street drinking and anti-social behaviour.

Add to this the high proportion of residents from a variety of ethnic backgrounds; especially Chinese (the UK's 3rd largest Chinese population) and Arabic speakers from several different countries (including Muslim Ones), and the challenges faced by the ward become clear.

The Neighbourhood Action Plan (2004) for the Brunswick and Regency area has highlighted the following issues:

- Feeling unsafe within the neighbourhood
- Lack of participation in decision-making processes that affect people's lives
- A highly visible population of street drinkers
- Drug dealing and Its associated problems.

For the last few years we have been involved in ameliorating the quality of life for local residents who have continuously complained about street drinkers, drug dealing, prostitution, refugees and asylum seekers and associated problems. During this time one consistent theme was emerging; That mental health problems cut across all of these issues We now feel it is important to capture the other side of these issues so we can bring about a sense of social cohesion.

Aims and objectives of the particular piece of work

The focus of our work was:

- **To carry out research focusing on Access to Mental Health Services and treatment for the Arabic speaking Communities in Brighton and Hove.**

- **And whether they are culturally appropriate.**

Focusing on this will help meet the following objectives of the five-year vision for Delivering Race Equality in mental health care.

1- **Less fear of Mental Health services among Black and minority ethnic communities and service users**

2- **A more balanced range of effective therapies, such as peer support services and psychotherapeutic and counselling treatment, as well as pharmacological interventions that are culturally appropriate and effective**

3- **A more active role for black and minority ethnic communities and black and minority ethnic service uses in training of professionals in the development of mental health policy, and in the planning and provision of services**

METHODOLOGY

RECRUITMENT AND TRAINING OF THE RESEARCH TEAM

Initially we were looking for 4 Community Researchers that fitted the following criteria:

- That lived or worked in Brighton and Hove
- Was a member of the Arabic Speaking community
- Someone that suffered from Mental Health problems
  or knew of someone that had been affected by Mental Health Issues

- Their availability to work 10 Hours a week on Tuesday and Wednesday over a 9 months period
- Willingness and availability to attend set training days
- Knowledge of and Access to the Arabic speaking community
- Good communications skills in Arabic and English
- Team working
- What was their motivation

An advert was widely circulated to service providers with a follow up call to ascertain if there had been any interest shown.
A lot of word of mouth within the neighbourhood
Advert was posted on an internal e-group for the community and voluntary sector in the City

Eventually Three researchers were recruited through word of mouth 2 Women and 1 man supported by a Lead researcher and 1 support worker

Working closely together in a team with regular support from the co-ordinator and support worker, Researchers attended 5 workshops (2 on Mental Health issues and 3 on Research methods) provided by the University of Central Lancashire. The lead researcher was their line manager and support was made available through NIMHE

MENTAL HEALTH AWARENESS TRAINING

The aim of the 2 Mental Health workshops was to develop the knowledge and the skills needed to carry out research in local communities.
By the end of the training participants will be able to:

- Demonstrate an understanding of the function of Mental Health Services
- Demonstrate an understanding of the relationship between national policy and local practice
- Demonstrate an understanding of the role of lay and user experiences in Mental Health service development

Workshop 1 – Attitudes to Mental Health
Discussion on Stigma and Discrimination
Racism and Mental Illness
Advantage of User Involvement
Definition of Mental Illness

Workshop 2 –
Legislation
Delivering Race Equality
12 Point Race Equality Action Plan

COMMUNITY BASED RESEARCH

The aim of the 3 research workshops was to develop the knowledge and the skills needed to carry out research in local communities.
By the end of the training participants will be able to:

- Contribute to planning a community – based research project
- Recognise the advantages and disadvantages of different research methods
- Analyse and explain data
- Present and write a report

WORKSHOPS 1 & 2 – CONTENTS

1. Introduction to social research
2. Planning your research project
3. Deciding on your research focus
4. Approaches to data collection
5. Constructing a research instrument
6. Interviewing skills
7. Finding research participants
8. Ethical issues and research

WORKSHOPS 3 – CONTENTS

9. Presenting data and explaining results
10. Revisiting your research proposal
11. Writing and disseminating the findings
12. Reflecting on what you have learned

QUALIFICATION

Anyone who attends these workshops has the opportunity to enrol for a university qualification.

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

WHAT THE WORK ENTAILED

Prepared all forms described below;

- Ethic Policy
- Information sheet
- Consent form
- Individual Questionnaire
- Interviewed 30 people
- Conducted 2 case studies
- Collated all this information and analysed it
- Attended 5 workshops

- Liaised with Support worker
- Contributed to the ethic policy, questionnaires, information sheet, consent forms work ethos
- Contributed to the list of service providers and invite letters for the steering group
- Contributed to the report writing

SELECTION OF THE SAMPLE

The team decided on what is titled as Purposive Sampling. This best describe those people that have useful information about Mental Health services Communities were accessed by the researchers through their strong links with their local communities where they asked the Arabic speaking community to take part in the research. The researchers informed people about the project its purposes, aims and objectives.

Steering Group

A multi agency steering group was formed which included membership from people who were involved in Mental Health Services .The aim was to provide support and guidance to the mental health Research Team and to look at any issues that arose in order to provide solutions. Poppy Jaman Race Equality lead and Anthony Kollie our support worker from the University of Central Lancashire, further supported this.

The group who met 4 times provided support, guidance and resources to assist the researchers with the development of the project and with sustaining outcomes from the report.

DATA COLLECTION TECHNIQUES USED.

- We used semi -structured questionnaires
- One to One Interviews
- Case studies

We found these to be the most appropriate for:

- The target population
- The time and resources available to us at the time
- The researchers own knowledge and experience of the target population.

These were first translated into Arabic and piloted with individual participants. This gave us the chance to test if they work both as valid questions and as a flowing structure without the loss of meaning through translation. Going through the many drafts before the final product gave the researchers confidence.
30 interviews 2 Case studies were successfully carried out. All who participated were given clear information about the project, a consent/information sheet based on our Ethics policy.

The team agreed a project plan, designed, translated and piloted the questionnaires, prepared and facilitated the steering groups meetings. They also conducted interviews, collected and collated all data, Translated these back into English, analysed these and wrote the report.

LIMITATIONS OF THE APPROACH, IF ANY, AND OBSTACLES ENCOUNTERED IN THE COURSE OF DATA COLLECTION

- Some of the respondents did not want us to complete the questionnaire but preferred to complete themselves, which meant we had to revisit them again to collect the questionnaire. It caused additional time and resources to ensure they were happy with the process

- Others only wanted us to meet in their homes The difficulty with this was that of disturbance from the children, phones, friends popping in which made the interview last longer than an hour and rather more difficult to conduct, mindful of confidentiality and frame of mind having already been given the assurances that they have made allowances to meet with us without being disturbed But life isn't that easy.

- Some did not like the questions They felt they were very personal and intrusive as they did not match their culture and traditions

- We found it difficult organising our time as respondents were difficult to pin down and had only limited time in which to see us in. This meant working to suit their time and place in addition to our normal duties

- As an English speaker I was asked to translate specific words so that they can understand them better

METHODS USED FOR DATA ANALYSIS

Quantitative data; was first collated and entered into excel and analysed
It was then sorted manually by question number.
It was then totalled and processed into the final report

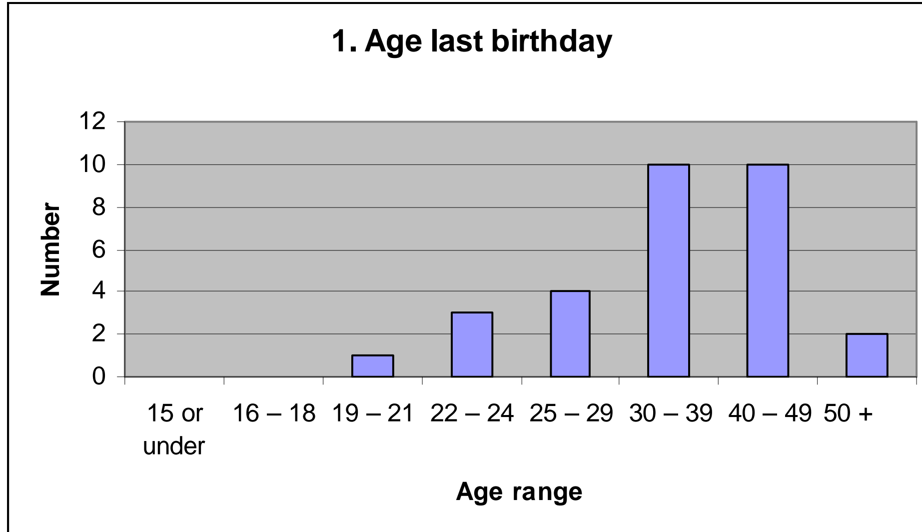
Qualitative data; First these were translated
And after having sorted responses into appropriate headings
We started to sort them into themes or categories depending on the findings.
We then summarised these into different themes telling a story where appropriate by using quotes.

RESULTS

QUANTITATIVE DATA

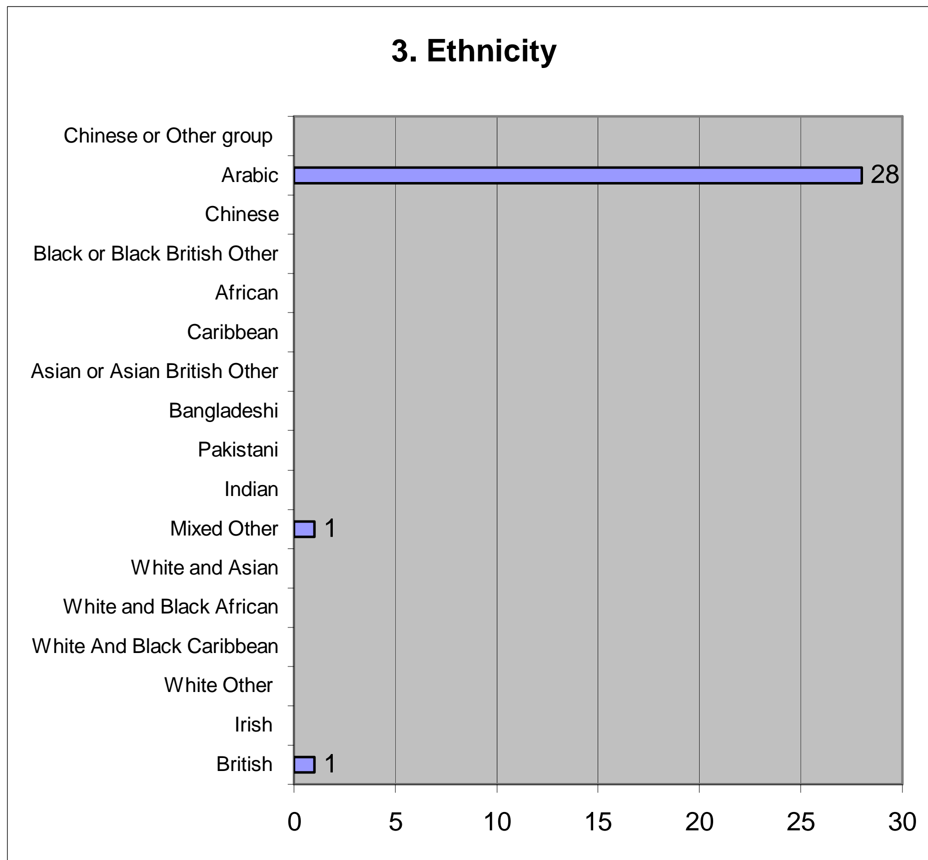
Section 1: Core Questions

1.1 Age group
n = 30



1.2 Gender n = 30	
Males,	16
Females	14
Trans-gendered	0

1.3 Ethnicity
n = 30



- **Mixed Other = Arabic French**

1.4 Length of residence in UK **n = 30**	
Less than 1 year	**0**
1 – 5 years	**8**
6 – 10 years	**11**
11 years or more	**11**

1.5 Citizenship **n = 30**	
British Citizen	**17**
Refugee	**4**
Asylum Seeker	**4**
Other	**4**
No Response	**1**

Languages	
1.6 First language spoken and written	
Arabic	28
French	1
English	1
1.7 Language Fluency	
Arabic	27
English	2
Farsi	1

1.8 Religion **n = 30**	
None	1
Christian	6
Buddhist	0
Hindu	0
Jewish	0
Muslim	23
Sikh	0
Other	0

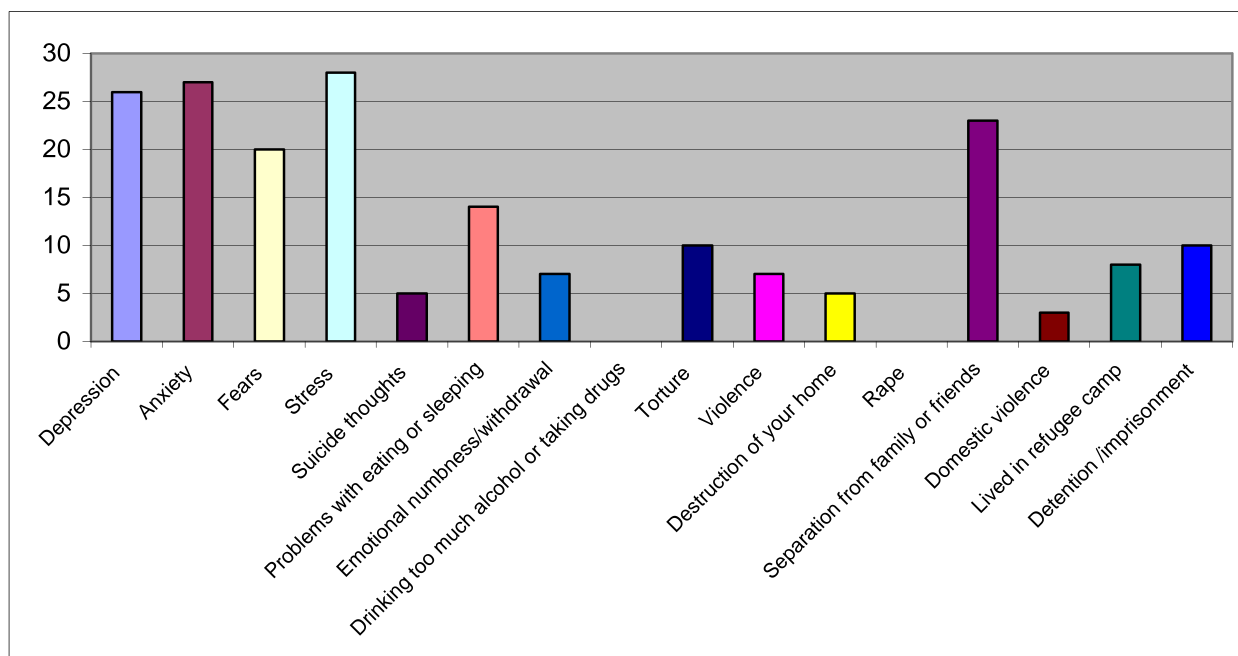
1.8 Sexuality **n = 30**	
Lesbian or gay woman	**0**
Homosexual or gay man	**0**
Heterosexual or straight	**29**
Bisexual	**0**
Do not wish to answer	**1**
Other (Please explain)	**0**

1.9 Disability **n = 30**	
23 people said they have no disability **5** people they have a disability. (Partially blind, Polio, Mentally) **2** people did not wish to answer	

Question 4; Have you experienced any of the following? (Please tick [✓])

Depression	Emotional numbness/withdrawal
Anxiety	Drinking too much alcohol or taking drugs
Fears	Torture
Stress	Violence
Suicide thoughts	Destruction of your home
Problems with eating or sleeping	Rape
Separation from family or friends	Lived in refugee camp
Domestic violence	Detention /imprisonment

Numbers of respondents in this section will not match the total number of participants because respondents could select more than one answer



Question 5 - Have you heard of or used any of these Mental Health services in Brighton & Hove? **IF NO Please go to question //**		
SERVICES	**Heard of (Yes/No)**	**Used (Yes/No)**
Aldrington Day Hospital	**6**	**2**
Alzheimer's Society	**8**	**1**
Community Mental Health Team	**10**	**3**
Mencap services	**4**	**1**
Mind in Brighton and Hove	**4**	**1**
Path way to health	**2**	**0**
Threshold women's mental health project	**0**	**0**
Allen Centre	**0**	**0**
Buckingham Rd Community MH Centre	**4**	**1**
Millview Hospital, Neville Avenue	**18**	**10**
East Brighton Community MH Centre	**4**	**2**
Hearing Voices	**1**	**0**
Ireland Lodge Resource Centre	**2**	**1**
Mental Health line	**5**	**1**
The Samaritans	**4**	**0**
Others please specify ………………		

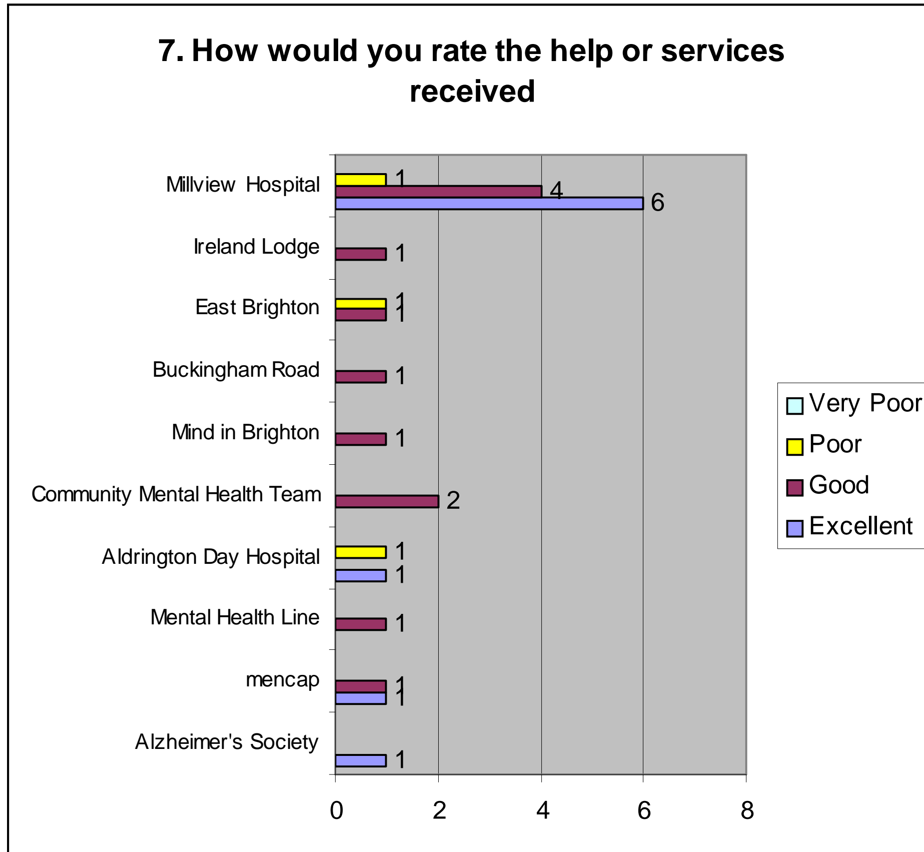
Question 6- Where did you hear of these services?

GP – (Doctor)	**14**	Citizen Advice Bureau	**2**	Community Organisation	**4**
Brighton & Hove City Council	**4**	Church	**0**	Mosque	**0**
Friends	**9**	Hospital	**6**	Counselling services	**2**
Interpreter	**2**				

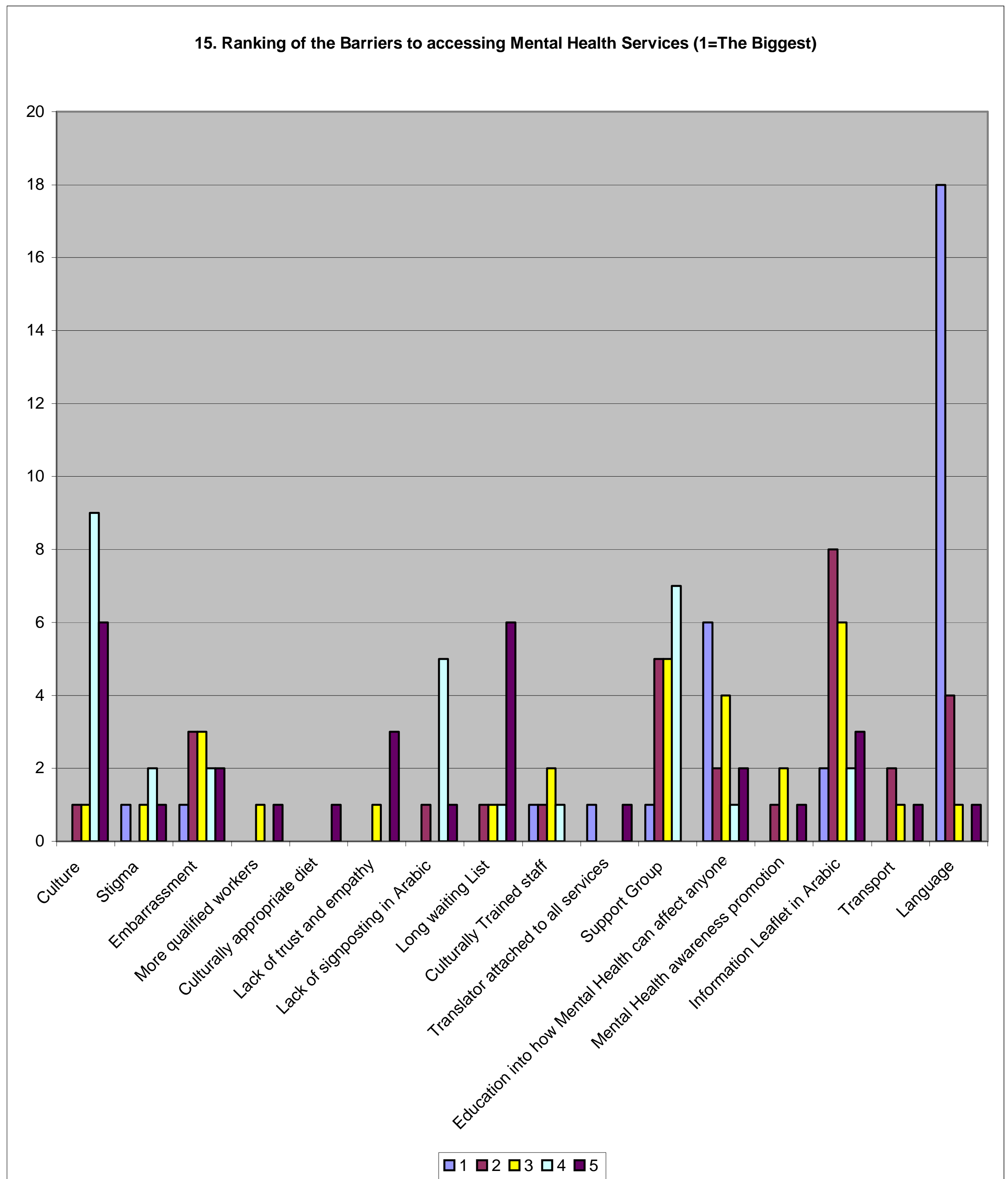
Others please specify ………………..

Yellow pages,
Argus,
Newspapers,
Medical journal
Documentary,
Movies (true story),
Signpost.
Alzheimer's society,
Leaflet from friends centre,
Millview hospital is near to my daughter school and I visited friend there.

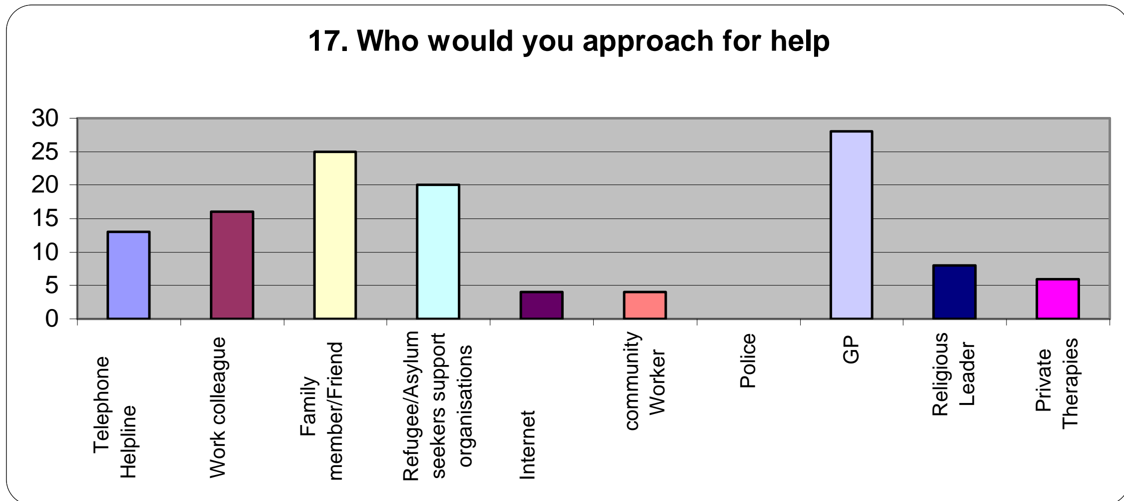
Question 7 - How would you rate the help or services received? On a scale 1 to 4 - (1 very poor, 2 poor, 3 good, 4 excellent).



Question 15 - What do you feel are the barriers if any, to accessing Mental Health services? (Rank the top 5 Barriers – 1= The Biggest)



Question 17 - If someone in The Arabic community had Mental well being Issues, who do you think they would approach for advice/help? (Rank the top 5 most approachable) 1 = most approachable)



QUALITATIVE DATA

> ***In Arabic Culture physical disability is seen as shameful in the family. Parents blame themselves and they try to hide the person away. Mental disability is 100 times worse and again they feel that it is their fault. They feel very vulnerable and do not know the answers when people ask the nature of the illness. They see it as a stigma, if it's a girl they fear she will never marry and if it's a boy they fear that the family line will not continue so it affects generations. I feel that parents need to be taught more about mental illness. Also if a parent has a child with a disability they should go out in the community and speak about their experiences to help others and take the fear away "***
>
> ***Female respondent***

2. What is your understanding of mental wellbeing?
The top three answers to this question were Stress (12 people) Depression (8 people) and Anxiety (7 people.) Three people also talked about loneliness affecting their wellbeing " ***I was depressed when I first came to England because I was alone and far away from my family".*** Another three people described mental wellbeing as to do with the state of mind whether it be the lack of balance or understanding and whether one has the capacity and the knowledge to deal with a problem or situation.

3. How do you feel mentally? (Direct translation)
Six people said that they were battling with depression. Factors that were causing this depression were ***"pressures of life"*** loneliness and worries about the future ***"I came as a refugee and I waited five years until I got my document. In that time I was stressed and depressed"***
Three people said that their moods changed sometimes up then down, good and bad *"At peace and fearful at the same time"*
Only three people said that they were happy of which one gentleman said ***"I feel stable and happy because I married to an Arabic lady"*** Another lady said she was ***"generally happy but worried and anxious about portrayal of Islam and Arabs in the Media".***

8. If satisfactory what was good about the services?
Only eight people answered this question as the majority had not heard or used any of the Mental Health services discussed. Five people commented on the staff and said they were helpful polite and kind. Three people praised the psychiatrist on supporting them by talking and listening to them.
Two people remarked about the cleanliness of the hospital that they attended.

9. If unsatisfactory what did you not like about it?
Three people complained about the time it took to get an appointment. One person firmly said that there was ***"No Clear admission and discharge procedure"***

Case Study ONE A lonely woman with extreme depression
I loved my husband and our marriage was born out of love. He then got to know a few people one of which introduced him to drugs and Alcohol From that day on my depression started When he got drunk he hit me and hit my children. On one occasion he hit my young daughter on her left ear, which resulted in her eardrum being perforated. I took her to the doctor who insisted on knowing what happened to my daughter. I told him exactly what happened to her. From that day on my life changed completely. I left home and with the help of social services and other agencies such as the Women's Refuge Centre who offered me and my children assistance and accommodation. My children suffer from extreme fear especially from those who they come into contact with, as they believe that everyone is like their father. *"Now I want to be as any other mother giving of my love and affection to my children and I hope to help them overcome the fear they feel towards any other persons"*

10. What could be improved?
Eight people answered this question. Two people cited communication between client and service provider could be improved. Two people complained about staffing levels being too low. Three people replied but said they had no idea what could be improved. One person said more funding should be allocated to employ more specialised staff.

11. If you were treated what advice and support were you given? (Please explain what was offered and whether it helped you or not?)
Four people said that they were offered accommodation, money and medication. Concerning advice they were given suggestions on what they could do at home to help themselves. This included exercise, finding courses, making new friends and enjoying time out with them and ***"committing to something I am interested in"***

12. Did you feel that you were given enough time to talk about the help you needed?
Six people said yes they were given enough time to talk about the help they needed.
Two people said sometimes the time allocated was not sufficient and not always at the time when they needed to see a doctor.
One person said no but that was because he felt the doctor did not listen to him. When he asked to change his doctor he found that the new doctor was more helpful.

13. Were you treated in a culturally appropriate manner? If YES - What was good about the services? If NO - What Happened?
Six people said yes, two of which said ***"They treated me as a human being"*** and ***"They were helpful and kind"***
One person commented, ***"In general I was treated OK but in my experience working as a interpreter I often feel if I was not there, not so many questions would be asked. So it is good that when you call an organisation they will ask if you need a translator"***
One person did not worry about the culture as long as the treatment is there.
One person felt embarrassed when a female was in charge.
One person said no he was not treated in a culturally appropriate manner. He felt the problem was because he could not speak the language and felt there was some racism involved.

14. What would be a culturally appropriate service & treatment to you? Services – Treatment
Two people had no idea what would be a culturally appropriate service
Two people said it was important that you had a choice of whether you were seen by a doctor of the opposite sex.
One person said that there should be access to an Arabic speaking doctor or translator if you could not speak the language.
One person wanted medication that did not contain alcohol.
One person said that offering accommodation and money support was appropriate.

One person though not commenting on a culturally appropriate service said,
" the service he received was not very good but the treatment was good."

One person who had to visit her sick husband in London would have welcomed some support

> ***"I think it would be a good idea that there should be a social worker attached to the hospital to help the carer with any problems they are experiencing and where they can get help. I was not aware of any of these mental health services".***

16. In your opinion, what are the best methods to provide information about Mental Health services to the Arabic Community?

Eleven people said the best method was an information leaflet written in Arabic

Five people suggested information should be available at the Mosque and Churches. ***" Coptics don't miss a meeting whether it's a community or spiritual. Its similar in the mosque"***

Five people said using culturally trained staff to explain about mental health services.

Five people talked about promoting Mental Health issues at local community groups such as the Arabic Club and the Arabic Women's Club.

One person said; provide information about Mental Health services on the TV and in newspapers.

18. Can you suggest ways of improving the quality of life for your community?

Six people saw the benefit of a social club with weekly meetings where they could organise activities, trips and parties. ***"I think it will be nice to meet someone who can speak the same language or is the same culture"***

Four people talked about the value of communication. ***"We need more English classes to learn conservation English"***

Three people talked about more opportunities for the community to be employed.

Three people said that they needed more parenting advice on issues such as education, culture, religion, alternative health therapies, health and safety and general health tips.

Two people talked about more openness on the part of the Arabic community and services. Being aware of the community needs and wants in order to provide the right service. Involving the church, mosque and mullah in discussion. ***"Interface involving all sections of the community to discuss Mental Health, Domestic violence and other issues that effect the community"***

One person felt interaction with the host community could be difficult. ***" I feel the Arabic community and English community need to get to know each other more, customs, traditions a sharing day where we both come together and exchange information about cooking etc"***

Case study 2
A male respondent who entered the UK seeking asylum.

The reason for escaping my country was due to repressive and harsh regime

After staying in this country for a long time away from my family, friends and country I felt anxious and depressed longing for my family and friends back home. I suffered for a long time not only with my depression but also the feeling of loneliness without any help.

One day one of my friends advised me to visit a psychiatrist. So I felt at ease knowing there is someone out there who can help me and hopefully offer me help and support. However my hopes quickly evaporated when I had to wait for a long time to get an appointment with the psychiatrist.

After meeting with the doctor and telling him about my mental wellbeing and how I have been feeling and still feel. I felt that my expectations were not met as:

- My mental condition did not feel important enough to him.
- I was not given enough time to talk about my condition
- The staff generally were not kind to me

"Following this bad experience I am minded not to see anyone who does not wish to help me".

DISCUSSION

Due to the lack of knowledge around the definition of mental health we found that many of the people we contacted were reluctant to speak and engage with our researchers out of fear. This was the main problem we faced when trying to set up interviews with possible respondents. Eventually 30 people participated by answering the questionnaire of which 16 were male and 14 were female. There were no transgender participants. The age range consisted of 2 who were 50plus, 10 were 40-49yrs, 10 were 30-39yrs, 4 were 25-29years 3 were 22-24yrs and 1 person was 19-21yrs.

As we had purposely targeted the Arabic speaking community The ethnicity breakdown of the core questions were predictable which were 28 respondents who were Arabs 1 respondent was mixed race i.e. Arabic/French and 1 respondent was British. When we asked what was their status 17 said they were British, 4 said they were refugee 4 said they were Asylum seekers 4 said other and one had no response.
When asked about languages, first language spoken and written was 28 people said Arabic 1 person said French and 1 person said English. When asked what language are you fluent in 27 people said Arabic 2 said English and 1 person said Farsi.
The Sexuality question informed us that 29 were Heterosexual or straight and 1 did not wish to answer.

From our visits with the respondents we also noted that many did not want to engage with or give any personal information. This was the major barrier between the researchers and the intended participants that also limited the number of people taking part. However the findings highlighted a large proportion of people who suffered from Depression Anxiety and Fear. Further more 23 had experienced separation from their friends and family. 14 suffered problems with eating and sleeping 10 had endured torture 10 detention/imprisonment 8 had lived in refugee camps 7 had suffered violence 7 Emotional numbness/withdrawal.5 had experienced suicide thoughts and 5 had witnessed destruction of their home. Some people also refused to engage with the researchers due to their embarrassment that they had visited Doctors or establishments connected with mental health issues.
Out of those that did participate many had not heard about any of the services and therefore had not used them either. The main barrier to this was due to language, as they could not read the leaflets, which were in English, and their main concern was to have the information leaflets translated into Arabic. Luckily some had used some of these services and were happy to engage with the researchers.
Participants were asked if they had heard or used any of the Mental Health services listed. 18 had heard of Millview but only 10 had used the service. 10 had heard of Community Health Team but only 3 had used the service. 8 had heard

of the Alzheimer's Society but only 1 person had used it. 6 had heard of Aldrington Day Hospital but 2 had used. 5 had heard of Mental Health line but 1 had used. 4 people had heard of Mencap, Mind and Buckingham Rd Community MH Centre but only 1 person had used each one. 4 people had heard of East Brighton Community MH Centre but 2 people had used, 4 people had heard of Samaritans but nobody had used. 2 people had heard Ireland lodge Resource centre but 1 used. 2 people had heard of Pathway to Health but none had used. 1 person knew about hearing voices but never used. None of the people interviewed had heard of Threshold women's mental health project and the Allen Centre so consequently not used either.

Participants were asked where did they hear of these services. 14 people said from the doctor. 9 from friends 6 from hospital 4 each from Brighton &Hove City Council and Community organisations, 2 each from Interpreters, CAB, counselling services. Others mentioned Yellow Pages, Argus, Newspapers, Medical journal, Documentaries Movies (true story) Signpost outside Alzheimer's Society, a leaflet from the Friends Centre and visiting Millview hospital to see a friend.
When asked how would you rate the help or services received? On a scale 1-4 Scale 1-4 (1 very poor, 2 poor, 3,good and 4 excellent).
6 people said Millview was excellent, 1 person said Aldrington Day hospital and another praised the Alzheimer's Society.
4 people said the service at Millview was good another 2 said the Community Mental Health Team. East Brighton, Buckingham Rd, Mind, Mental Health line and Mencap had 1 person each saying the service was good
Millview, East Brighton and Aldrington Day Hospital were also rated as having a poor service. None of the respondent said any of the service received was very poor.
A percentage of participants stated that they preferred to be seen or to be dealt with by Arabic speaking professionals. Some wanted the opportunity to have weekly meeting with their children included, so that families could come together and share issues.

The biggest barrier to accessing Mental Health services was language followed by Education into how mental health can affect anyone. The Third barrier was information leaflet that were not translated into Arabic. The Fourth barrier was not having a support group. Fifth barrier was Embarrassment.

The last question If someone in the Arabic community had Mental Wellbeing issues. Who do you think they would approach for advice and help?
28 people said GP 25 People said friend and family member 20 said Refuge/Asylum seeking support organisation. 16 work colleague 13 Telephone helpline 8 would consult religious leader 6 private therapist 4 people would look to the internet or community worker for advice. None of the people consulted would go to the police.

From the researchers point of view we found the translation from English to Arabic and then from Arabic to English quite difficult. Moreover the problems we

faced were amplified, as we also had to translate from Arabic to Arabic due to the Arabic language containing several dialects, intonation and difference in meaning.

As researchers we were able to expand on our skills, which included learning to respect each other.
Organisation of individual and group timekeeping
Improving our English both speaking and writing especially sentence composition,

We also gained a lot more confidence in using the computer, which included emailing, typing and layout setting. It was a new experience to prepare a project plan, design, translate and pilot a questionnaire before using it to obtain information.
There was time spent in tracking and mapping the relevant Mental Health services in Brighton and Hove. As a group we spent time practising interview techniques.

We also benefited from attending workshops, training, participating in debates/ discussion and raising points of view.

We learned how to translate and capture the correct meaning from Arabic to English

Individually we have improved our listening speaking and writing skills and patience and developed new skills in photocopying, imputing data, data analysis and report writing.

We learned how to be determined and resolute in our work and lastly we have benefited greatly from those around us who have a lot of experience

.

RECOMMENDATIONS

Based on our findings and discussion

1. More Mental Health Practitioners to go into the Arabic community to explain what mental illness is about. To dispel the myths and the stigma about the illness.

2. Mental Health professionals to engage with the Arabic speaking community about planning and delivering appropriate Mental Health services.

3. For clients to receive a culturally appropriate service that takes into account language, gender, religious and cultural differences.

4. For client to receive a culturally appropriate treatment that values counselling treatment as well as medication.

5. For more information about the Mental Health Services translated into Arabic.

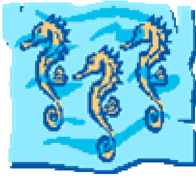
6. Funding to be thought to provide cultural training for staff.

7. More parenting advice is needed on issues such as education, culture, religion, alternative health therapies, health and safety and general health tips

8. More awareness of the community needs and wants in order to provide the right service. Involving the church, mosque and mullah in discussion.

9. Interface involving all sections of the community to discuss Mental Health, Domestic violence and other issues that affect the community

APPENDICES



Brunswick Community Development Project
Arabic Speaking Community Engagement
Mental Wellbeing Project

Core Questions:

1.1	**Age last birthday:**	15 or under	☐
		16 – 18	☐
		19 – 21	☐
		22 – 24	☐
		25 – 29	☐
		30 – 39	☐
		40 – 49	☐
		50 +	☐
1.2	**Gender:**	Male	☐
		Female	☐
		Transgendered or transsexual	☐
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) ☐

Arabic ………………..

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 <u>first</u> language?

Spoken:
……………………………………………………………………………………

Written:
……………………………………………………………………………………

1.7 Which languages are you fluent in?

Spoken:
……………………………………………………………………………………

Written:

………………………………………………………………………..…………………

1.8 What is your religion:

- None ☐
- Christianity ☐
- Buddhist ☐
- Hindu ☐
- Jewish ☐
- Muslim ☐
- Sikh ☐
- 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 ☐

2. What is your understanding of mental wellbeing?

Prompt! Explain what is mental wellbeing?
The goal is to educate as well as to find out
Using words from **Q4** e.g. from stress at exams to committing suicide

3. How do you feel mentally (direct translation)

4. Have you experienced any of the following? (please tick [✓])

Depression [ ]	Emotional numbness/withdrawal [ ]	Separation from family or friends [ ]
Anxiety [ ]	Drinking too much alcohol or taking drugs [ ]	Domestic violence [ ]
Fears [ ]	Torture [ ]	Lived in refugee camp [ ]
Stress [ ]	Violence [ ]	Detention /imprisonment [ ]
Suicide thoughts [ ]	Destruction of your home [ ]	
Problems with eating or sleeping [ ]	Rape [ ]	

Others [ ] please specify ………………………………………………………

5. Have you heard of or used any of these Mental Health services in Brighton & Hove? **IF NO Please go to question 15**		
SERVICES	**Heard of (Yes/No)**	**Used (Yes/No)**
Aldrington Day Hospital		
Alzheimer's Society		
Community Mental Health Team		
Mencap services		
Mind in Brighton and Hove		
Path way to health		
Threshold women's mental health project		
Allen Centre		
Buckingham Rd Community MH Centre		
Millview Hospital, Neville Avenue		
East Brighton Community MH Centre		
Hearing Voices		
Ireland Lodge Resource Centre		
Mental Health line		
The Samaritans		
Others [ ] please specify …………………………………………………………		

6. Where did you hear of these services?

GP – (Doctor)	Citizen Advice Bureau	Community Organisation
Brighton & Hove City Council	Church	Mosque
Friends	Hospital	Counselling services
Interpreter		

Others [ ] please specify …………………………………………………………

7. How would you rate the help or services received? On a scale 1 to 4 - (1 very poor, 2 poor, 3 good,
4 excellent).

Alzheimer's Society
1 – 2 – 3 – 4

Path way to health
1 – 2 – 3 – 4

Threshold women's mental health project
1 – 2 – 3 – 4

Community Mental Health Team
1 – 2 – 3 – 4

Mencap services
1 – 2 – 3 – 4

Mind in Brighton and Hove
1 – 2 – 3 – 4

Allen Centre
Community MH Centre
1 – 2 – 3 – 4

Buckingham Rd

1 – 2 – 3 – 4

Mental Health line
MH Centre
1 – 2 – 3 – 4

East Brighton Community

1 – 2 – 3 – 4

Aldrington Day Hospital
1 – 2 – 3 – 4

Hearing Voices
1 – 2 – 3 – 4

Ireland Lodge Resource Centre
Avenue
1 – 2 – 3 – 4

Millview Hospital, Neville

1 – 2 – 3 – 4

The Samaritans

1 – 2 – 3 – 4

Other Please specify

1 – 2 – 3 – 4

8. If satisfactory what was good about the services?

9. If Unsatisfactory what did you not like about it?

10. What could be improved?

11. If you were treated what advice and support were you given

(Please explain what was offered and whether it helped you or not?)

12. Did you feel that you were given enough time to talk about the help you needed?

13. Were you treated in a culturally appropriate manner?

a) If YES - What was good about the service?

b) If NO – What Happened?

14. What would be a culturally appropriate service & treatment TO YOU?

Service

Treatment

15. What do you feel are the barriers if any, to accessing Mental Health services? (Rank the top 5 barriers – 1 = being greatest barrier)

Language	**A translator/Interpreter attached to all local services**	**More qualified workers**
Transport	Culturally trained staff	Embarrassment
Information leaflets in Arabic and English	Long waiting list	Stigma
Mental Health awareness promotions	Lack of signposting in Arabic	Culture
Education into how Mental Health can affect anyone	Lack of trust and empathy	
Support group	Culturally appropriate diet	

Other (please state)…………………………………………………………………

16. In your opinion, what are the best methods to provide information about Mental Health services to the Arabic Community? (Prompt)

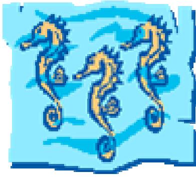
17. If someone in The Arabic community had Mental well being Issues, who do you think they would approach for advice/help? (Rank the top 5 most approachable)
1 = most approachable)

Telephone Helpline Which One?	**Community worker** Who?
Work colleague	**Police**
Family member/Friend	**GP**
Refugee/Asylum seekers support organisations Which One?	**Religious leader** Which One?
Internet Which Site	**Private therapies** Which One

Other (Please state)
……………………………………………………………………………………..

18. Can you suggest ways of improving the quality of life for your community?

☺ THANK YOU FOR YOUR TIME! ☺



Brunswick Community Development Project
Arabic Speaking Community Engagement
Mental Health Project

Information sheet

- We are Lena, Safaa, Sadiq and Susan; researchers from the Brunswick Community Development Project in Hove East Sussex

- We are working in partnership with the Race Equality Lead (REL) and the University of Central Lancashire (UCLan) to do Mental Health research with the Arabic speaking community in Brighton and Hove. The focus of our research is ***"Access to mental health services and treatment for the Arabic speaking communities in Brighton and Hove and whether they are culturally appropriate"***

- Our aim is to give participants the opportunity to influence local professionals and policy makers in improving and/or providing additional services.

This will result in the following outcomes:
To look specifically at the Delivering Race Equality two priorities for the National 12 points Action Plan.

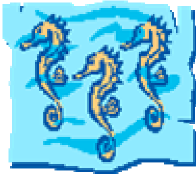
- A more balanced range of effective therapies such as peer support services, psychotherapeutic and counselling treatments as well pharmacological interventions that are culturally appropriate and effective
- A workforce and organisation capable of delivering appropriate and responsive mental health services to BME communities.

- We aim to do this by interviewing people with active or previous mental health issues from the Arabic speaking community. We will carry out one to one interviews using semi structured questionnaire and case studies, to get an overall view of awareness of services available, how appropriate they are and how they meet the needs of the community.

- Any information given will be treated with the utmost respect and confidentiality. However we are obligated to disclose any serious offences involving children and serious self-harm to themselves or to others.

- It should also be stressed that participants consent to take part can be withdrawn at any stage of the interview.

- Results of the study will be compiled into a report to be presented to UCLan by February 2007; in return it will be compiled into a national report and presented to the REL and other national and local organisations.
- If you require a copy of the final report or any other information please contact the manager on 01273 325039



Brunswick Community Development Project
Arabic Speaking Community Engagement
Mental Health Project

CONSENT FORM

This study is being carried out by the Brunswick Community Development Project (BCDP) in Brighton and Hove.

We are carrying out research focusing on **"Access to mental health services and treatment for the Arabic Speaking Communities in Brighton and Hove and whether they are culturally appropriate"**.

Our aim is to give participants the opportunity to influence local professionals and policy makers in improving and/or providing additional services. This will result in the following outcomes:

To look specifically at the Delivering Race Equality two priorities for the National 12 points Action Plan.

- A more balanced range of effective therapies such as peer support services, psychotherapeutic and counselling treatments as well pharmacological interventions that are culturally appropriate and effective

I can assure you that everything you tell the research team is confidential and no information which can identify you will be passed on to anyone outside the team. The only exception to this would be if you disclosed information about a serious and immediate risk of harm to yourself or someone else, including child abuse, in which case we would take the necessary steps to prevent the harm and this may include talking to other agencies.

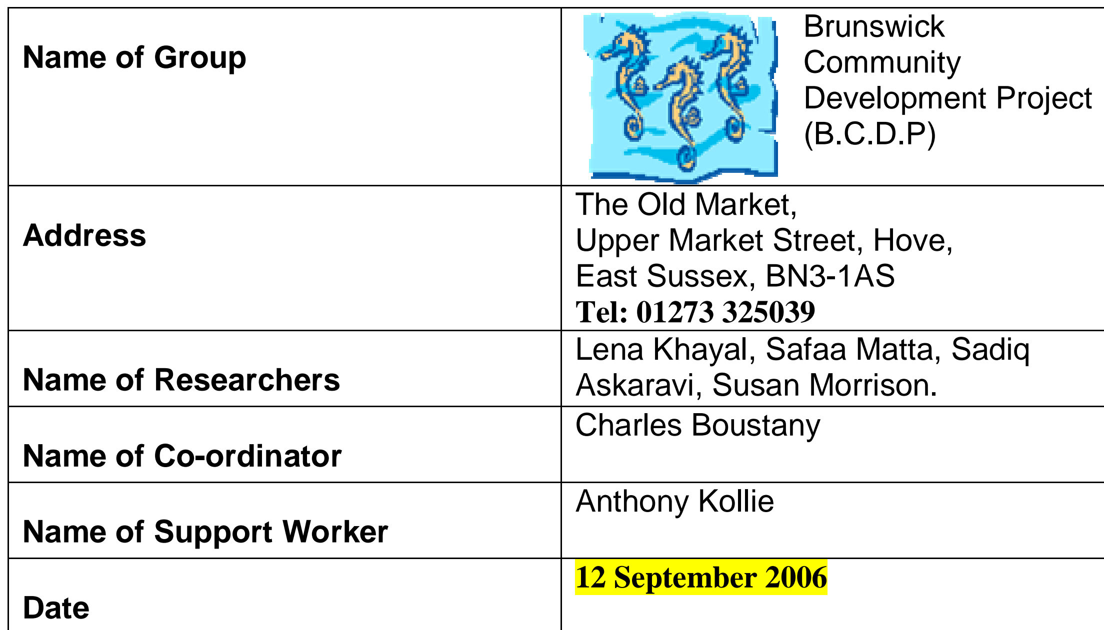
You don't have to answer any of the questions if you don't want to, but answer where you can.

The interview will take approximately 40 minutes to complete.

If at any time you wish to stop the interview or have a break you are free to do so.

Do you have any questions about the study or interview? YES [ ]   NO [ ]

Are you willing to participate and be interviewed? YES [ ]   NO [ ]

Name of Group	 Brunswick Community Development Project (B.C.D.P)
Address	The Old Market, Upper Market Street, Hove, East Sussex, BN3-1AS **Tel: 01273 325039**
Name of Researchers	Lena Khayal, Safaa Matta, Sadiq Askaravi, Susan Morrison.
Name of Co-ordinator	Charles Boustany
Name of Support Worker	Anthony Kollie
Date	**12 September 2006**

Section 2:

What kind of work does the group intend to do as part of this project?	The group intends to carry out research focusing on *“Access to mental health services and treatment for the Arabic Speaking Communities in Brighton and Hove and whether they are culturally appropriate”.*
How do they intend to do this?	The group anticipates interviewing approximately 30 people using semi-structures questionnaires and developing 2 case studies.
Who will the participants be?	Arabic Speaking people living in Brighton and Hove with active or previous Mental Health issues.
Who will they get to do the work?	Researchers named above who have been recruited from the local community will undertake all research.
How will those doing the work be supported and supervised?	1- Researchers have attended research and mental health workshops organised by UCLan **2- UCLan has assigned a support worker to the team who will help the group implement research according to UCLan ethical procedures** 3- The team will be line managed by a co-ordinator based in the project 4- Work will be overseen by the Steering Group.

How will they ensure that participants in the project have given consent?	**1- A letter informing each participant has been prepared followed by a consent form which each interested participant will read before taking part in the interview.** 2- Participants will be asked whether they are happy to proceed with the interview based on the information that they have been given. Each participant will be reminded that he/she is free to withdraw from the interview at any time.
How will the project ensure confidentiality?	1-Names will not be recorded on the questionnaires. Interviews will be conducted in privacy at B.C.D.P offices or other suitable areas agreed with the participant. 2-Completed questionnaires will be stored in a locked filing cabinet in an office at B.C.D.P. Only staff working on the project will have access to them. 3-Data from the questionnaires will be analysed and presented in the final report (and any interim reports) in such a way to ensure that any information given by participants will be completely confidential with no names recorded anywhere.
How will data generated by the project be handled and stored?	Completed questionnaires and notes from interviews will be stored in a locked filing cabinet in an office within B.C.D.P. Only staff working on the project will have access to them. All interview notes/questionnaires will be destroyed by shredding once the final report has been written and submitted.
What risks are there? How will risks be identified and managed?	**1-A number of ways exist to identify possible risks: individual workers may identify them on their own; they may be identified as part of weekly team meetings; they may be identified**

	during discussion with the support worker; they may be identified at steering group meetings. **2-Where any risk is identified it will be the responsibility of the Project co-ordinator with the advice and consent of the steering group to ensure that measures are taken to manage the risk appropriately. The UCLan support worker, the Steering group and BCDP's own line management structure within the organisation will support them in doing this.** So far the following risks have been identified- **Managing anger/violence/distress** 1- We will make each participant comfortable and assure them that they have the option to continue or not. 2- However, it is possible that one of the participants may become agitated during an interview due to the nature of the sensitive discussions around mental illness. Accordingly, we have provided our researchers with training on how to deal with aggression and anger. 3-Researchers will be interviewing in pairs with mobile phones to check in and out with co-ordinator at B.C.D.P. 4-The researchers have all received training in interview techniques-including body language and non-verbal communication. Researchers have been instructed not to continue with anyone who is agitated. **Managing disclosure of criminal activity-** It is important that participant's confidentiality is maintained, and disclosures of criminal activity will be passed on to the relevant authorities in the case of a threat of harm to

	other, or child abuse. This will be explained to participants at the beginning of the interview as part of the information sheet that is read out to obtain consent.
Please confirm the make-up of the steering group	CSIP, UCLan, BCDP, PCT, REL Southdown Health
How often will the steering group meet?	The group will hold meetings every two months, however members are available to provide advice/ assistance to the research team whenever needed
Is the steering group clear that it has a responsibility for helping manage the ethical issues that may arise as a result of running this project?	Yes. Draft copy of this Proforma will be provided to each member of the Steering Group for approval before it is implemented.

Section 3: To be completed By UCLan internal ethics committee

Date received:	
Received by:	
Decision:	