

COMMUNITY ENGAGEMENT PROJECT

The NIMHE Mental Health Programme

REPORT OF THE COMMUNITY LED RESEARCH PROJECT FOCUSING ON
MENTAL HEALTH SERVICE NEEDS

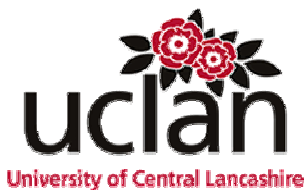
CARRIED OUT BY THE PENWITH COMMUNITY DEVELOPMENT TRUST

“To investigate potential barriers to accessing mental health services within the Black and minority ethnic community in Cornwall”

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Funded by the NIMHE Managed and supported by
The Centre for Ethnicity and Health, University of Central Lancashire.



PROJECT TEAM

The following are the members of the project team:

Ania Ojrzynska, 26, Polish. Working for Penwith Community Development Trust, in a voluntary sector and also as a volunteer for this project. Passion for languages, diverse cultures, people, music, playing guitar, tennis, hiking, cooking, travelling, belly dancing, reading and playing pool. Has been involved in different voluntary roles for many years. Believes that if you want to make a change in the world and make it a better place you start with yourself.

Adam Strowger – 27. He has been employed by Penwith Community Development Trust over the last 3 years. Adam's role in this project was researcher/team leader and this involved being the first point of contact for the team. He has an interest in research because of his educational background in Social Sciences and research. Away from work Adam enjoys playing and watching football, running, swimming, travelling, cooking, skiing and politics.

Dean Harvey – Dean was a volunteer on this community engagement project. Played a key role on the project by delivering a focus group.

Dilys Down, Chinese, married with two sons. Moved to England and settled down in Cornwall in 1989. Employed by the Penwith Community Development Trust as Strategic Development Manager. Her roles in this project included the co-ordination of the research study and provided project management support for the volunteers/research team. She has been working in the Voluntary and Community Sector for 7 years. Her areas of expertise include strategic planning, project management, funding, training, research and evaluation. Through this community engagement programme, she has learned a great deal on mental health and working with people from a wide range of BME backgrounds. She is keen to share her learning and experience with other voluntary and community organisations/groups.

ACKNOWLEDGEMENTS

The BME Mental Health Research Team of the Penwith Community Development Trust would like to thank the University of Central Lancashire for providing us with this unique opportunity to recruit local BME individuals to participate in this community research study.

We would also like to thank everyone who has made contributions in this research project, in particular all the respondents who participated in this project, Joanna Hicks of the University of Central Lancashire, our dedicated volunteers/team members and our steering group, which includes the following members who provided advice and support for this project:

- Sandra Benjamin – Chair of CPT Mental Health Trust
- Dr. Philip Brigham – Cornwall & Isles of Scilly Primary Care Trust
- Eileen Bortey – Chair of Council Racial Equality in Cornwall
- Victor Downer – Equality & Diversity Advisor of Cornwall & Isles of Scilly PCT and Chair of Unity Cornwall
- Louise Knox – Chief Executive of Pentreath Ltd
- Paul Green – Social Inclusion Officer of Cornwall Rural Community Council
- Jason Lehman – Social Inclusion Officer of Cornwall Rural Community Council
- Tryphaena Doyle – Mental Health Commissioner Cornwall & Isles of Scilly PCT
- Joanna Hicks – Support Worker of University of Central Lancashire
- Mark Patterson – Race Equality Lead of Care Services Improvement Partnership

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1. EXECUTIVE SUMMARY

Penwith Community Development Trust (PCDT) successfully applied for funding to develop a mental health research project for Black and minority ethnic communities. This project is part of the National Institute for Mental Health in England (NIMHE) Community Engagement Programme funded by the Department of Health through the NIMHE. The programme is managed and supported by NIMHE and the University of Central Lancashire. PCDT was one of the 29 groups selected across England to conduct this research project during 2006/7.

This project aims to engage the Black and minority ethnic people from the local community to participate in the research work. The findings of this research project will contribute to the following three key aims of the Delivering Race Equality in Mental Health Care Five Year Action Plan, which is part of wider programmes on inequalities and social exclusion within the Department of Health and across government:

- Equality of Access
- Equality of Experience
- Equality of Outcomes

This project also aims to explore the following themes within the Delivering Race Equality in Mental Health Care document in order to improve the understanding for both service providers and service users from the BME communities on the area of mental health:

- Less fear of mental health care and services among BME communities and BME service users
- Increased satisfaction with services
- A more active role for BME communities and BME service users in the training of professionals, in development of mental health policy, and in the planning and provision of services
- A workforce and organisation capable of delivering appropriate and responsive mental services to BME communities

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

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

- Contributing to workforce development, and specifically the recruitment of 500 Community Development Workers.

The focus of our work was to “investigate potential barriers to accessing mental health services within the Black and minority ethnic community in Cornwall”. The research methodology included sampling, postal questionnaire survey, face-to-face interviewing and focus group.

Volunteers were recruited as community researchers through the Penwith Volunteer Bureau and the West Cornwall Healthy Living Centre Forum from the local community to form a research team to carry out this research study. A team leader was also employed 2 days per week for 10 months to support the volunteers/team members. The research team was also supported by the project support worker from the University who visited the project on a regular basis, the staff of PCDT and a steering group consisting of the representatives from a wide range of statutory and voluntary agencies. The University also provided a 7-day training programme for the volunteers/team members in order to build their capacity and train them to conduct the research work.

The Findings:

Service provider questionnaire

- 93 questionnaires were sent to service providers in Cornwall and 26 returned (28% response rate). 54% were from the voluntary sector, 34% were statutory organisations and 8% were from community groups.
- 35% of service providers offered specific services for members of the BME community, 53% did not, 4% did not know and 8% did not answer. Specific services provided by the respondents included interpreters, information in different languages, multi faith services and dietary needs. Reasons for not providing specific services to members of the BME community included: had not been an issue (71%), low numbers (57%), lack of resources (29%) and lack of funding (21%).
- 57% of respondents suggested that there was a defined BME community in Cornwall (the BME communities they were aware of including Eastern European, Chinese and Travelling community), 4% said there was not, 35% did not know and 4% did not answer the question.
- 61% of the respondents monitored whether BME communities access their service through registration/record, referral and appearance/accent, 23% did not, 12% did not know and 4% did not answer the question.
- 19% of service providers had a designated staff member for race equality, 50% did not, 23% did not know and 8% did not answer.
- 42% of respondent organisations provided diversity training for staff. 31% of organisations made diversity training compulsory for staff. 38% of respondents made equal opportunities training compulsory for staff.

- Particular factors or circumstances that need to be considered by service providers when engaging with BME individuals included: language, culture, training, partnership working and religion. 5 respondents stated that nothing needed to be considered when engaging with BME individuals.
- Service providers were asked what would stop BME individuals from accessing their services. The most popular responses included: language barriers, nothing, cultural reasons, lack of information available, lack of BME staff and stigma.
- The most common barriers service providers face when trying to improve services for BME individuals included: financial resources, language and lack of awareness of BME problems.
- Service providers were asked what 3 things they would like to change about the way their organisation delivers mental health services to BME individuals. Responses included: promotional material in other languages, more advertising, would not change anything, monitor performance, reduce stigma and more funding.

Face-to-face Interviews with 31 members of the BME community

- 87% of respondents were registered with a GP and 13% were not. 16% of respondents had experienced problems registering with or contacting a GP.
- 13% thought the standard of Cornwall's mental health services was poor, 10% suggested it was good, 3% thought it was satisfactory and 74% had not experienced Cornwall's mental health services
- The most likely symptoms of a mental health problem identified by respondents were hearing voices (84%), flashbacks (77%), anxiety (74%), not wanting to go out and see other people (71%), and sleeping problems (61%).
- 77% of respondents would seek help if they were experiencing anxiety and their preferred help included support from family and friends (45%), counselling (29%) and talking therapies (19%)
- 71% of respondents would seek help for hearing voices and their preferred help included support from family and friends (26%), counselling (16%), medication (10%).
- 71% of respondents would seek help for flashbacks and their preferred help for flashbacks included counselling (29%), support from family and friends (26%), and talking therapies (16%),
- 71% of respondents would seek help for not wanting to go out and see other people and their preferred help included support from family and friends (29%), counselling (26%) and advice and guidance (10%)

- 58% would seek help for sleeping problems and their preferred help included counselling (13%), medication (10%) and complementary therapies (6%).
- The most popular help preferred by respondents for possible mental health symptoms were support from family and friends and counselling.
- 62% of those interviewed had suffered from depression, 32% stated that they had not suffered from depression and 6% did not answer the question.
- Mental health services that respondents had heard of included: NHS mental health services (61%), mental health community development workers (29%), Mind (29%), Pentreath (19%), Rethink (13%) and NIHME (10%).
- 68% of respondents were not aware that the government was making changes to improve mental health services for people from BME backgrounds.
- A number of factors would stop respondents accessing mental health services including: language barrier (39%), embarrassment (29%), don't know where to go (26%), fear of being locked up (23%) and cultural beliefs (16%). 26% of respondents said that nothing would stop them from accessing mental health services in Cornwall.
- 97% of respondents would tell someone if they thought they were suffering from a mental health problem. 71% of respondents would tell their family, 68% would tell their GP and 42% would tell their friends.
- 74% of respondents would go to their GP to find out about mental health services and 58% would look at websites.
- 10% of respondents felt that mental health services were well publicised, 55% did not and 35% did not know.
- Respondents believed that a number of factors could affect the mental health of person from a BME background including racism (84%), lack of employment opportunities (77%), loneliness (77%), language barriers (77%), discrimination (74%) and verbal abuse (61%).

Focus group conducted with 6 members of the BME community

- The group found it difficult to capture the concept of mental health and no firm definition came forward. There was an agreement that mental health is a difficult subject.
- A number of possible barriers preventing members of the BME community accessing mental health services were highlighted in the focus group including: fear, stigma, lack of information, language barriers, shame, poverty, very low numbers of staff from BME communities and upbringing.

- Participants were dubious about the quality of mental health services in the UK and it was suggested that mental health institutions are more interested in sectioning patients for the sake of funding and meeting targets.
- Respondents came up with a number of ideas about what they would like to see in a mental health hospital if they were in charge of building it and money was no object. Responses included: translation services, multicultural staff, education, counselling, good complaints procedure, respect for people's religious beliefs, after care, healthy food, help before you become ill and a get well centre.
- Participants liked the idea of alternative therapies and talking therapies as treatments for mental health. Medication was less popular, but if it had to be used participants would like to see suitable drugs prescribed for specific ethnic groups.
- Participants believed that employing more BME staff could be a solution to overcoming language barriers.

Recommendations:

The following recommendations were suggested and to be implemented within the next 18 months. These recommendations will be able to contribute to the key aims of the Delivering Race Equality in Mental Health Care Five Year Action Plan, which is part of wider programmes on inequalities and social exclusion within the Department of Health and across government.

- Service providers should improve their knowledge about the local population. Service providers should not assume that if they have no BME clients then there is no need for services to reflect BME individuals' needs. This knowledge can be improved by greater community engagement from service providers through forums and focus groups in the local community. Also all staff working in mental health services including GPs, health professionals and front line staff should undertake Diversity Training as compulsory and induction training.
- Service providers should improve their understanding of other countries health care systems. NHS should work with other BME organisations to provide better information in appropriate languages for other BME groups in order to enable them to understand the health care system in the UK and know where to get help if they have a mental health problem.
- Produce a mental health website including information with language translation about what is mental health and all the services that are available. This website could be produced and updated on a regular basis by the NHS and linked with other mental health service providers' websites.
- The way mental health services are publicised needs to be improved, and improvements could be made by producing leaflets and other promotional material in different languages and producing websites in different languages.

- More alternative treatments and services available such as supporting networks for friends and family, counselling, advice and guidance, talking and alternative therapies
- Further research on Migrant Workers (Eastern European) and mental health is needed in order to investigate their mental health needs.

2. INTRODUCTION

Penwith Community Development Trust (PCDT) successfully applied for funding to develop a mental health research project for Black and minority ethnic communities. This project is part of the National Institute for Mental Health in England (NIMHE) Community Engagement Programme funded by the Department of Health through NIMHE. This programme is managed and supported by NIMHE and the University of Central Lancashire.

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

2.1.1 Background to the community engagement model

We often hear the following words or phrases:

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

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

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

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

undertaking the work. In this way, at the end of the process, there would be a number of individuals left behind in the community who would have gained from undertaking this work. They would have learned about drugs, and learned about the needs of their communities, and they would be able to continue to articulate those needs to their local service providers, and their local Drug Action Teams (DATs). It was out of this project that the Centre for Ethnicity and Health's model of community engagement was born.

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

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

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

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

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

2.1.2 The key ingredients of the model

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

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

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

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

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

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

The steering group is an essential element of the project: it helps the community researchers to identify the community they are engaging with, and can also facilitate the

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

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

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.

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

2.1.3 The community engagement team

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

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

2.1.4 Programme outcomes

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

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

- The Community Engagement Programme had made very significant contributions to increasing awareness of substance misuse and understanding of the substance misuse needs of the participating communities. It also raised awareness of the corresponding specialist services available and of the wider policy and strategy context.
- The Community Engagement Programme had enabled many new networks and professional relationships to be formed and that DATs appreciated the links they had made as a result of the programme (and the improvements in existing contacts) and stated their intentions to maintain those links.

- Most commissioners reported that they had gained useful information, awareness and evidence about the nature and substance misuse service needs of the participating organisations.
- All DATs reported positive change in their relationship with the community organisations. They stated that the Community Engagement Programme reports would inform their plans for the development of appropriate services in the future.
- A significant number of the links established between DATs and community organisations as part of the Community Engagement Programme were made for the first time.
- The majority of community organisations reported their influence over commissioners had improved.
- Training and access to education was successful and widely appreciated. 379 people went through an accredited University education programme.
- A third of community organisations in the first tranche reported that new services had been developed as a result of the Community Engagement Programme.
- The vast majority of participants and stakeholders expressed high levels of satisfaction with the project.

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

2.2 The focus of this report

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

National Institute for Mental Health in England Community Engagement Programme:

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

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

The focus of our work was to “investigate potential barriers to accessing mental health services within the Black and minority ethnic community in Cornwall”.

Volunteers were recruited as community researchers through the Penwith Volunteer Bureau and the West Cornwall Healthy Living Centre Forum from the local community to form a research team to carry out this research study. A team leader was also employed 2 days per week for 10 months to support the volunteers/team members. The research team was also supported by the project support worker from the University who visited the project on a regular basis, the staff of PCDT and a steering group consisting of the representatives from a wide range of statutory and voluntary agencies. The University also provided a 7-day training programme for the volunteers/team members in order to build their capacity and train them to conduct the research work.

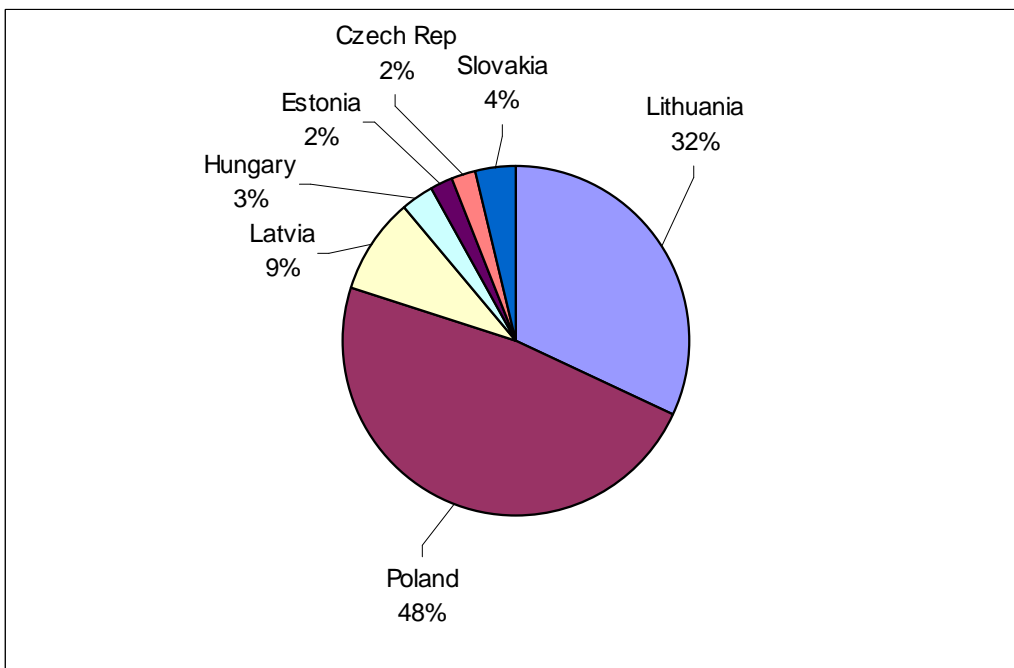
The views expressed in this report collated by the research team are not necessarily those of the Penwith Community Development Trust, the Centre for Ethnicity and Health Unit at the University of Central Lancashire and the Department of Health.

3. BACKGROUND

Cornwall is the most westerly county in Britain. There are 6 districts within the County, which are Caradon, Carrick, Kerrier, North Cornwall, Penwith and Restormel. According to the 2001 Census, there were 501,267 residents living in Cornwall and the Isles of Scilly. Of these 97.08% (486,580) classed themselves as “White British”, 0.44% (2,205) as White Irish and 1.49% (7,470) as White Other. Residents of mixed race account for the single biggest minority ethnic group (0.46% of total population) in Cornwall followed by people of Indian and Chinese origin (about 0.1% respectively). All ethnic minority groups in Cornwall account for a smaller share of the total population than England as a whole, with residents of Pakistani, African, Caribbean and Bangladeshi origin particularly under-represented within the regional population (<0.065%). Appendix 6 illustrates the population of Cornwall.

According to the West Cornwall Profile Baseline Report March 2006 conducted by the Amethyst on behalf of West Cornwall Together, Cornwall traditionally supports a high percentage of transient seasonal workers and an increasing number of these workers are taking up year round residence. The Home Office state register of workers⁴ gives a figure of 743 international workers for the TR postcode area (which includes West Cornwall). The majority are from Poland (48%) and the next largest group is from Lithuania (32%).

Figure 1 - Ethnic breakdown of international workers in West Cornwall, HO stats register



⁴ Approved figures at 30/09/05

3.1 Eastern European communities (migrant workers)

According to the Commission for Rural Communities Briefing Paper: Migrant Workers in Rural Areas, nine and a half million people, one in five of the overall population, live in rural England. The rural population is growing and is projected to grow at a faster rate than England's urban population.

Cornwall is a very rural region. Many migrant workers settle in Cornwall to work in the agricultural sector. A Migrant worker is *“an individual who arrives in the host country either with a job to go to or with the intention of finding one”*.

Research carried out by the Local Intelligence Network Cornwall (LINC) showed Poland as the main country from which migrant workers were recruited to work in Cornwall (62%), with Lithuania, Slovakia, Latvia, and Portugal also being listed. Migrant workers do not always come into the county alone, some bring families and are building lives, homes and careers in Cornwall, and the work is no longer strictly seasonal. Due to inadequate public transport, most people living in rural areas in Cornwall find that owning a car is essential to their daily life. Frequently, people who are already in financial hardship get further into poverty from the costs of buying, insuring and maintaining a vehicle. This in turn increases isolation and social exclusion.

Cornwall is not unique in these problems but the rurality, high levels of deprivation, poor housing and language problems will only increase an individual's susceptibility to mental ill health. Economies of scale mean that most services are located in urban areas, which are more highly populated. This is especially true of specialist services, such as care and support services for people with mental health problems. Not only are there fewer specialist services in rural areas, but those that exist are likely to be many miles from a patient's home.

Cornwall Local Area Agreement has an outcome to *“Reduce Social Exclusion for Migrant Workers addressing equality of access to services for health, education, crime and worklessness”*. One key element to this outcome is to work with migrant workers and partners to ensure migrant workers effectively access all public services, including health services.

The most common country of origin in the sample of migrant workers was Lithuania, although these were exclusively employed at one farm near Hayle, Cornwall.

- the next largest groups were from Poland and Portugal, respectively
- in contrast, Poland is by far the most common country of origin for Link into Learning ESOL learners, followed by Lithuania, Slovakia, Portugal and China
- there is a higher proportion of male migrant workers than male Link into Learning ESOL learners (53% and 43% respectively), i.e. in this sample of migrant workers, the gender balance is fairly even
- 79% of the migrant worker sample were aged less than 50, with 31% aged 18-25
- the sample of migrant workers were assessed as having significantly lower language skills than those of enrolled Link into Learning ESOL learners, with the largest group (65%) assessed at Entry Level one

- all the SEF Farms employees were Lithuanians, and assessed Entry Level 1
- all the Ginsters employees (mainly Polish and Iraqi) had the higher levels of assessed skill
- 87% of the migrant worker sample had spent all of their time in the UK in Cornwall
- 36% of the sample had spent less than 6 months in Cornwall, and 38% more than 18 months (the majority of the longer term workers were employed by Roach Foods and SEF Farms)
- 45% of the migrant worker cohort had their family with them in the UK - this included all the Ginsters employees and the Carlyon Bay Hotel, and some at Roach Foods
- the entire SEF Farms cohort, the care home, and most of the Roach Foods employees did not have family with them
- the most common roles undertaken by workers in the sample were packers, field workers, meat processors, bar and kitchen staff, drivers and carers
- the most common previous roles of the migrant workers in their country of origin were students, unemployed and shop assistants
- the top concentrations of Link into Learning ESOL learners by home postcode are Falmouth, Penzance and Launceston, followed by Bodmin and Plymouth/Torpoint/Saltash.

For further information please see tables 1 to 6 and figures 2-3 in appendix 6

4. RESEARCH AIMS AND OBJECTIVES

The research title is *“To investigate potential barriers to accessing mental health services within the Black and minority ethnic community in Cornwall”*

4.1 Research aims

This research project conducted by the PCDT aims to encourage community involvement and participation by empowering local individuals, including people from BME communities, to participate in the research work. Through this research project, it aims to address the key issue of rurality and isolation, which will contribute to the Government’s overarching strategies for tackling inequalities and social exclusion.

The results of this research project will also contribute to the following three key aims of the Delivering Race Equality in Mental Health Care Five Year Action Plan, which is part of wider programmes on inequalities and social exclusion within the Department of Health and across government:

- Equality of Access
- Equality of Experience
- Equality of Outcomes

It also aims to empower local individuals (as volunteers/community researchers) and service providers to work together to explore the following themes within the Delivering Race Equality in mental health care document in order to improve the understanding for both service providers and service users from the BME communities on the area of mental health. Through the dissemination of the results of this research, better information and good practice can be shared in order to plan, develop and improve future services to meet the identified needs for the BME communities living in Cornwall.

- Less fear of mental health care and services among BME communities and BME service users
- Increased satisfaction with services
- A more active role for BME communities and BME service users in the training of professionals, in development of mental health policy, and in the planning and provision of services
- A workforce and organisation capable of delivering appropriate and responsive mental services to BME communities

This project conducted by the PCDT aims to link with the following two of the four national priorities:

- The development of more appropriate and responsive services for the black and minority ethnic communities by statutory service providers.
- Better collection and more effective use of information to assess and target service developments.

It also aims to help work towards the other two national priorities, which are:

- The development of a health workforce capable of working with and treating different communities.
- Better engagement of Black and minority ethnic groups in shaping mental health services and supporting innovative, community informed services.

4.2 Research objectives

The objectives of this research project conducted by the PCDT are:

- To develop and engage with the BME communities
- To investigate the availability of mental health services for BME communities
- To identify statutory and complementary services that are available to BME communities and to find out the potential barriers of BME communities to accessing mental health services in order to identify service gaps
- To increase the knowledge and awareness of mental health services
- To highlight the awareness of mental health issues in the community

5. RESEARCH METHODOLOGY

5.1 Recruitment and training of volunteers/research team

Originally three volunteers were recruited from the community through the Penwith Volunteer Bureau and the West Cornwall Healthy Living Centre Forum in May 2006 as community researchers, however, one volunteer dropped out halfway through this project. PCDT employed a part-time team leader/ researcher (2 days per week for 10 months) to provide support for the volunteers to conduct this research project. The Strategic Development Manager of the PCDT also acted as project co-ordinator to provide project management support for the research team. A total of 7 training workshops on 'Mental Health' and 'Community Research' were provided to volunteers/team members by the trainers of the Ethnicity and Health Unit of the University of Central Lancashire, in order to train them to carry out the research project confidently and successfully. The support worker from the university provided on-going support and visited the project on a regular basis. The staff at the Penwith Community Development Trust provided day-to-day support and supervision to the volunteers.

The volunteers were involved in all stages of this research process, including planning the research area, designing research methodology, data collection and analysing, report writing and disseminating findings.

5.2 Steering group

A steering group consisted of the following representatives who provide advice and support to the project team on a regular basis. Cornwall and Isles of Scilly Primary Care Trust also provided the meeting room free for all steering group meetings as in-kind contribution.

- Sandra Benjamin – Chair of CPT Mental Health Trust
- Dr. Philip Brighma – Cornwall & Isles of Scilly Primary Care Trust
- Eileen Bortey – Chair of Council Racial Equality in Cornwall
- Victor Downer – Equality & Diversity Advisor of Cornwall & Isles of Scilly PCT and Chair of Unity Cornwall
- Louise Knox – Chief Executive of Pentreath Ltd
- Paul Green – Social Inclusion Officer of Cornwall Rural Community Council
- Jason Lehman – Social Inclusion Officer of Cornwall Rural Community Council
- Trythaena Doyle – Mental Health Commissioner Cornwall & Isles of Scilly PCT
- Joanna Hicks – Support Worker of University of Central Lancashire
- Mark Patterson – Race Equality Lead of Care Services Improvement Partnership

The Roles of the BME Mental Health Research Project Steering Group Members:

- To provide advice, support and guidance to the research project
- To assist in steering the direction of the research so that it fits with local priorities and with picking up the findings and recommendations of the work so that the opportunities for sustainability are maximised
- To function as a further check against any ethical issues that may arise as the project develops

The steering group met every 6-8 weeks to provide the following support to the research team:

Date of Steering Group Meeting	Details
8th June 2006	Provided support and guidance on project planning and developed the terms of reference for the steering group
18 th July 2006	Reviewed the terms of reference for the steering group and provided support on developing the project plan and the ethics Performa for the University of Central Lancashire
20 th September 2006	Provided support and advice on draft questionnaire for service providers and BME individuals
18 th October 2006	Provided advice and support on the final draft questionnaire for service providers and pilot questionnaire survey
29 th November 2006	Provided advice and support on draft questionnaire for BME individuals, identifying potential BME participants and interviewing process
17 th January 2007	Provided advice and support on interviewing, focus group and data analysing
6 th March 2007	Provided feedback on the 1 st draft research report

5.3 Methodology

5.3.1 Sampling

Research methodology of ‘purposive sampling’ and ‘snowball sampling’ were used for this research study in order to find out the service gaps and barriers for BME communities to access mental health services in Cornwall. Postal questionnaires were sent out to 93 service providers listed in the Cornwall Mental Health Directory 2007, which provided a useful and relevant source of information for the purpose of the questionnaire survey.

‘Snowball sampling’ process was used in this research study for conducting interviews with BME individuals, as at the beginning of the research, it was difficult to identify BME participants for this research project. The research team first interviewed a few of the volunteers/researchers’ friends with BME background and then through ‘word of mouth’, other friends from those who were interviewed knew about the research project and came forward and took part in the interviewing process. As a result, the researchers interviewed a total of 31 people from a wide range of BME backgrounds through the process of ‘snowball sampling’ including 9 interviews which were conducted in the Polish language.

There is an increasingly growing community of Polish migrant workers in the Penwith area, employed mainly in factories, farms, fish industry and catering. Because of the nature of their work it was difficult to approach Polish groups: different shifts including weekends, located in isolated sites near farms, no transport etc. Even though the Polish team member managed to spread the word about interviews through ‘snowball sampling’ the barriers listed above stopped a considerable number of Polish people who expressed interest in taking part. The interview period also collided with a Christmas break, when the

majority of Polish migrant workers were visiting their families in Poland, and a flower picking season during which interest and referrals notably decreased.

While visiting different sites people generally seemed to be interested in the research but some felt discouraged once 'mental health' was mentioned. The team attributed such reactions to personal prejudices and stigma.

As a result of conducted interviews, a number of Polish people came back to the centre, at times with relatives or friends, to speak to the Polish research team member. They wanted to seek help and advice on housing, benefits, tax returns, English courses, employment, child care, volunteering. They explained that the level of their English was unsatisfactory to engage with various agencies and they were hoping that the Polish team member would provide them with some information or act on their behalf.

5.3.2 Ethics Performa

An Ethics Performa was drawn up and approved by the University of Central Lancashire for this research work (see Appendix 5)

5.3.3 Data collection techniques

This project used the following data collection techniques as research methodology:

- Postal questionnaire survey
- Face-to-face Interviewing
- Focus group

Postal questionnaire survey

A total of 93 postal questionnaires were sent out to 93 service providers listed in the Cornwall Mental Health Directory 2007 during November and December 2007. The response rate for this questionnaire was 28%. The Cornwall mental health directory illustrated all service providers for mental health services in Cornwall including statutory organisations and voluntary sector organisations. It provided useful and relevant information for this research study. Some of these organisations only targeted mental health, but some organisations targeted other issues as well.

Face-to-face Interviewing

A total of 31 BME individuals were interviewed by the researchers during December 2006 to February 2007. Through the interviewing process, researchers were able to talk to a sample of BME individuals from a wide range of cultural and diverse backgrounds in order to find out more detailed information about their knowledge and personal experience on barriers of accessing mental health services locally.

The researchers also recruited the BME individuals through the following organisations/events and invited them to take part in the interviewing process:

- OJs Club – a regular event (normally held every Friday night in the OJs Club in Penzance) for Eastern Europeans

- Lescudjack Centre – a multicultural group for parents and children which registered 44 families from 22 nationalities
- Link into Learning – an organisation which offers different courses including English classes for BME individuals (residents)
- Sure Start – voluntary organisation working with children and their families which referred their BME volunteers to the project

Focus group

A focus group was also used in this research project in order to explore further information on a particular theme and issues identified through the analysed data collected from the interviews with BME individuals in order to collect more in-depth information. The focus group was conducted with 6 BME participants on 6 February 07 and it was facilitated by two researchers/volunteers. The participants for the focus group were recruited from the face-to-face interviews. During the face-to-face interviews, participants were asked whether they would like to explore this subject further at a focus group and those that agreed to take part were invited to attend.

A £20 Tesco voucher was given out to each participant who took part in the focus group as a gesture of appreciation for their time and contribution given.

5.3.4 Scope and limitations of the research

Due to the constraints of time and resources available, this research study was unable to cover the whole of Cornwall but mainly focused on the BME individuals living in Penwith. However, the questionnaire survey for service providers covered the whole of Cornwall in order to identify service gaps in Cornwall. Attempts were made to include the Romany and Irish Traveller population in this research study. However, this proved not to be possible.

Also we were unable to meet the target of interviewing between 40-60 BME individuals in this research study as originally planned. This was mainly due to the fact that there were 11 BME individuals (including 5 Polish, 1 Italian, 1 Chilean, 1 Romania, 1 Lithuanian, 1 Black and 1 Mixed Race background) who did not turn up to their interviews as agreed. Figure 1 illustrates the Ethnic breakdown of international workers in West Cornwall and Appendix 6 shows the ethnic groups in Penwith. We attempted to rearrange the interviews, but this was unsuccessful. A possible reason for some of the BME individuals not turning up may have been due to work commitments. The majority of our interviews were conducted during the daytime, which may not have been convenient for people who work long hours. As a result, there was a total of 31 BME participants who took part in the interviewing process.

There were 7 people who would have liked to have participated in the focus group but they felt that their English was not good enough to do so and they decided not to take part. Due to the constraints of time and resources, we were not able to facilitate a focus group with the support of translator(s) in order to overcome the identified language barriers. The focus group was conducted in English, which meant that participants had to have a sufficient understanding of English. As stated earlier in the report, participants for the focus group were recruited from the interviews.

6. Results

6.1 Types of organisations that responded to the questionnaire survey

A total of 26 organisations completed and returned their questionnaires with 28% response rate (see appendix 1).

Table 7 Types of Organisation

Types of organisation	Number	Percentage
Community group	2	8%
Statutory	9	34%
Voluntary Sector	14	54%
Other	1	4%
Total	26	100%

Table 8 Services provided in respect to mental health

Service provided	Number	Percentage
Advice and guidance	20	77%
Signposting	19	73%
Talking therapies	14	54%
Support group activities	13	50%
Support to carers	12	46%
Other	11	42%
Medication	10	38%
Befriending	5	19%
Mentoring	5	19%
Complementary therapies	3	11%
None of the above	0	0

Note: Percentages add up to more than 100 due to multiple responses

Table 9 How service providers publicise their mental health services?

Method of publishing services	Number	Percentage
Leaflets	22	85%
Signposting through other agencies	21	81%
GP surgeries	18	69%
Websites	16	61%
Network events	10	38%
Magazines	6	23%
Other	5	19%
Road shows	1	4%

Note: Percentages add up to more than 100 due to multiple responses

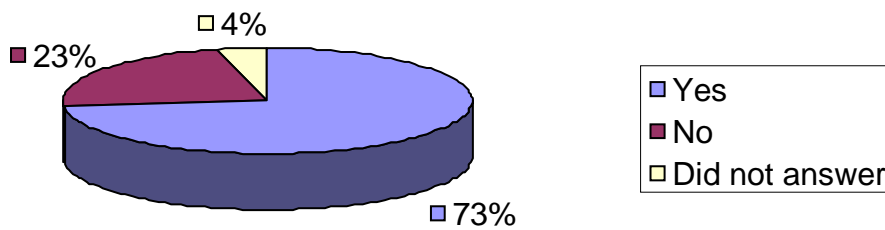
Table 10 How people access service providers' mental health services?

How services are accessed	Number	Percentage
Agency referral	21	81%
GP	20	77%
Self referral	18	69%
Referred by friends or family	12	46%
Drop in	11	42%
Other	5	19%

Note: Percentages add up to more than 100 due to multiple responses

Figure 4 Have you ever heard of the Delivering Race Equality in Mental Health document?

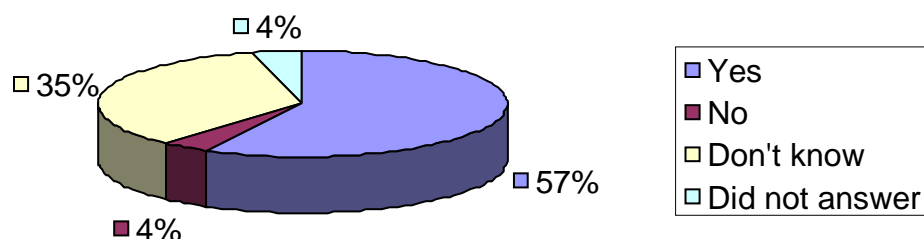
Have you ever heard of the Delivering Race Equality in Mental Health document?



Of the 26 respondents 19 (73%) service providers had heard of the Delivering Race Equality in mental health document, 6 (23%) had not heard of it and 1 (4%) service provider did not answer.

Figure 5 In your opinion do you consider that there are defined Black and minority ethnic communities in Cornwall?

In your opinion do you consider that there are defined black & minority ethnic communities in Cornwall?



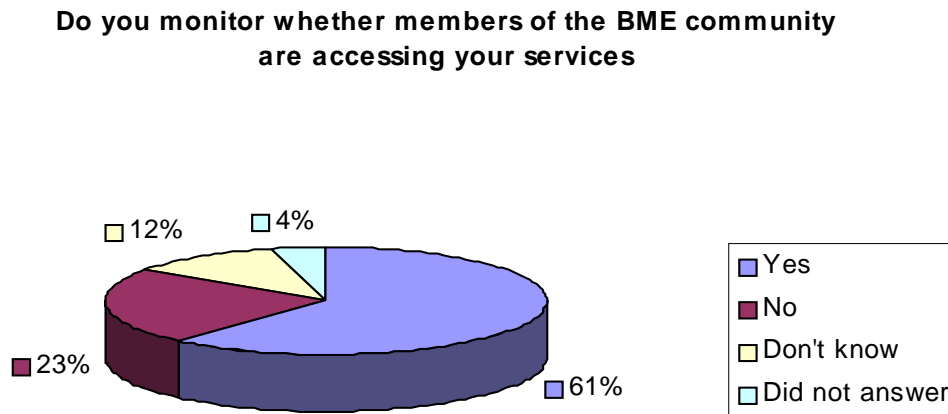
Of the 26 respondents 15 (57%) agreed that there was a defined Black and minority ethnic community in Cornwall, 1 (4%) stated that there was not, 9 (35%) did not know and 1 (4%) respondent did not answer.

Table 11 Different communities that service providers are aware of in Cornwall

Community	Number
Eastern European	8
Chinese	5
Travelling community	4
Portuguese	3
Gypsy	3
Irish	2
South Asian	2
Asian	2
Polish	1
Kurdish	1
Foreign nationals	1
Coloured minorities	1
Black	1
European Migrant workers	1
Transient migrant workers	1

Table 11 shows the communities that respondents felt were present in Cornwall. This was an open question so the examples of different communities in the list are what service providers came up with. The questionnaire did not provide a list of possible communities.

Figure 6 Do you monitor whether members of the BME community are accessing your services?

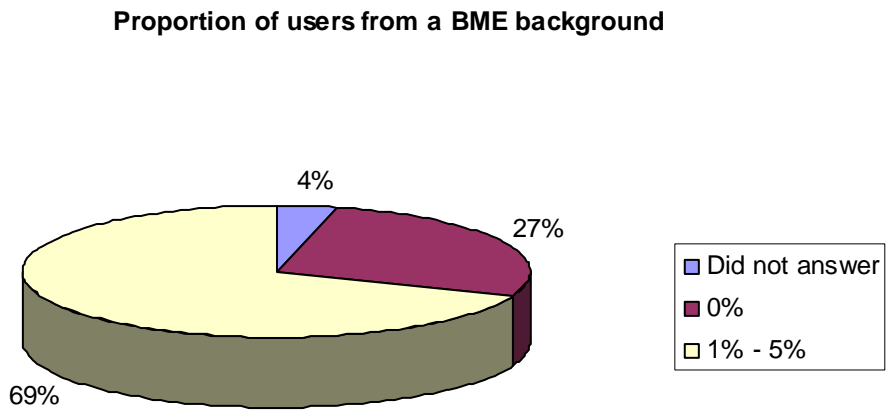


Of the 26 respondents, 16 services providers (61%) stated that they monitored whether members of the BME community are accessing their services, whereas 6 (23%) did not monitor, 3 (12%) did not know and 1 (4%) did not answer the question.

Table 12 How do service providers monitor whether BME Communities are accessing their services?

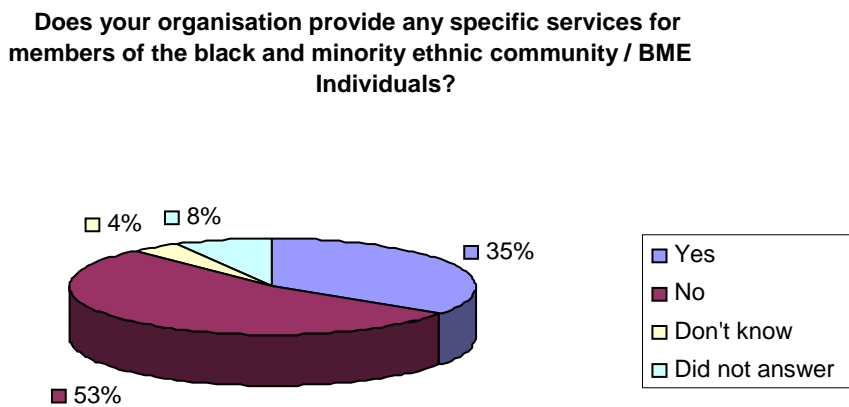
How do they monitor	Number of service providers	Percentage
Registration/own record	7	47%
Referral	5	33%
Don't know	2	13%
Appearance/accent	1	7%
Total	15	

Figure 7 Proportion of users from a BME background



7 (27%) of the 26 respondents stated that they had no BME users while 18 respondents (69%) suggested that they had between 1% - 5% users from a BME background and 1 respondent (4%) did not answer.

Figure 8 Does your organisation provide any specific services for members of the black and minority ethnic community/BME individuals?



9 (35%) out of 26 respondents provided specific services for members of the BME community. 14 (53%) did not, 1 respondent (4%) did not know and 2 respondents (8%) did not answer the question.

Respondents that answered yes were asked to specify what specific services they offer. This included the following:

“We stock or will try to access mental health information in different languages. Have Chinese link on website, we will expand this service”

“Access to list of interpreters/language line – if English is second language”

“Multi faith/spiritual space at each In patient site. Interpreting. Dietary needs met”

“Interpretation service”

Table 13 Reasons for respondents not providing any specific services for members of the BME community

Reason	Number	percentage
Has not been an issue	10	71%
Low numbers	8	57%
Lack of resources	4	29%
Lack of funding	3	21%
Other	2	14%

Note: Percentages add up to more than 100 due to multiple responses.

Table 14 How service providers ensure there is equal access to services for members of the BME community.

How equal access is ensured	Number of service providers
Equal Opportunities Policy / Diversity action plan	6
Publicising services	4
Run a competent service	1
Cornwall County Council’s Policy	1
Equal Treatment	2
Staff training	1
Reduce stigma	1
Improve access to information	1
Monitor performance	1
Feedback from BME individuals	1

The following points are quotes from service providers regarding how equal access to services is ensured:

“Not sure there is equal access. Specific access to services for BME is relatively neglected in Cornwall probably due to low numbers historically and a lack of awareness amongst mental health professionals and the community. I feel that people from BME are less likely to access services than other individuals for a number of reasons and this is particularly pertinent in Cornwall”

“Our Equal Opps policy ensures that if a person from the BME group is referred we will make every effort to accommodate their needs e.g. language so that they can still receive a service.”

“Equality of opportunity for all and has Equal Opps plus Diversity policies in place.”

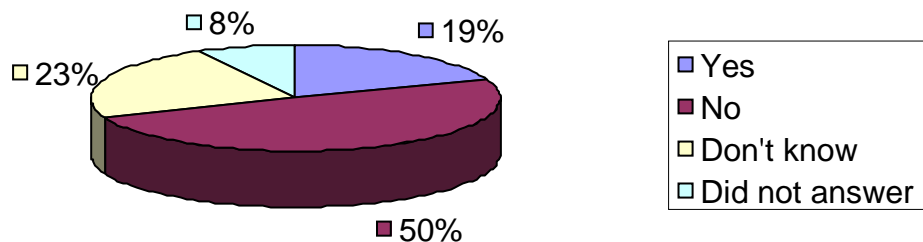
“We compare our client profile with the community profile, & try to see variances – showing where we are not being accessed. We believe that best way to increase access is by ensuring a competent service to those from the BME communities – and by 'word of mouth' within their communities – sometimes very small groups – as to how useful we are / or are not. We run a liaison forum & invite representatives from groups/communities to feed into our service”

“Our service is mainly accessed via urgent referral from A & E & medical admissions wards & via other medical/surgical & maternity wards at RCH. I do not believe minority groups are discriminated against in referral to our service by RCH health care staff particularly as many medical staff are Black/ethnic minority staff.”

*“All referrals are treated the same - no group is given preferential treatment”
“BME individuals not seen as a priority”*

Figure 9 Within your organisation is there a designated staff member responsible for race equality?

Within your organisation is there a designated staff member responsible for race equality?



Out of the 26 respondents 5 organisations (19%) had a designated staff member for race equality, 13 (50%) did not, 6 (23%) did not know and 2 respondents (8%) did not answer the question.

Table 15 Does your organisation provide any of the following training to your staff? Are any of them compulsory?

Type of training	Training provided	Compulsory training for staff	Don't know
Community Development	2	1	4
Diversity training	11	8	0
Equal opportunities	9	10	0
Mental health	18	1	1
Racial equality	5	6	3
Training in BME issues & concerns	3	1	4

The last 5 questions of the survey were open questions, which allowed the respondents the opportunity to give a more in-depth answer.

Table 16 In your experience are there any particular factors or circumstances that need to be considered by your organisation when engaging with individuals from a black and ethnic minority background?

Factors or circumstances	Number of Service Providers
Language	7
No/None	5
Culture	4
Religion	2
Equal Opportunities Policy	1
Training	1
Establish what are the specific needs	1
Partnership working	1
Treat people equally	1
Unsure	1

Comments included:

"No as two members of my team have one parent who is Black"

"Cultural difference, language difficulties, may not know what's available or how to access"

"We could utilise interpreter services through the CPT if necessary"

"Importance of use of interpreters if English is second language & complex statutory issues – choice. Difficulty in accessing interpreter in some eastern European languages at short notice"

"No BME individuals are service users at present – is this due to barriers to accessing service, lack of need etc."

Table 17 What might stop individuals from a BME background accessing your services?

Reason for not accessing services	Number of service providers
Language barriers	7
None	6
Cultural reasons	4
Lack of information available	4
Stigma	4
Fear	2
Lack of BME staff	3
Not knowing how to access services	2
Lack of awareness/knowledge of services	2
Lack of recognition of mental health problems	1
Not knowing where to go	1
Lack of understanding about services	1
Transport	1
Mental health services are perceived as unfriendly	1
Not being referred	1
Don't know	1

Table 18 What barriers, if any, does your organisation face when trying to improve services for individuals from a BME background?

Barriers	Number of service providers
Financial/resources	6
None	6
Language	4
Lack of awareness of BME problems/needs	3
Don't know	2
Knowledge	1
Lack of data about the local BME population	1
Hard to raise awareness due to low population	1
Stigma	1
Low numbers of BME staff	1
Understanding of cultural need	1

Table 19 How can access to services be improved for BME communities / individuals?

How can services be improved	Number of service providers
Improve information/awareness of services and needs of community	8
Training	4
Interpreters/language services	4
Don't know	3
Consulting with BME groups	1
Recruit more staff from BME communities	1
Partnership working	1
Reduce stigma	1
No improvement needed	1

Comments included:

<i>"Information in different languages, advertising in appropriate community based places"</i>
<i>"Community training on different cultures, improved access to interpreters, outreach to community."</i>
<i>"To supply a list of support groups, places of worship, meeting group representatives in the community for us to contact and advertise organisation. More awareness to referring agents"</i>
<i>"Improvement is not necessary"</i>
<i>"Greater awareness of ethnic mix and needs of the community"</i>
<i>"Recruitment of staff from BME backgrounds"</i>

Table 20 If you had a wish list, what 3 things would you like to change about the way your organisation delivers mental health services to BME individuals?

Changes to be made	Number of service providers
Don't know	4
Promotional material in other languages	3
More advertising	3
Would not change anything	3
Monitor performance	2
Reduce stigma	2
More funding	2
Improved outreach/communication with BME communities	2
Identify barriers with service users	1
More data about the situation in Cornwall	1

More accessible venues in the community	1
Service directory	1
Free training to staff in this area	1
Access to translators	1

Comments included:

“Funding to identify number, funding for training, funding to be able to set up specific groups”

“Improved links + communication with BME communities”

“Info leaflets in different format and languages, access to translators, advocates, free training to staff in this area (BME)”

“More advertising to raise awareness and reduce stigma of mental health in general and specifically for BME communities”

“More funding would enable us to do more i.e. Staff, networking, resources”

“Nothing as we already treat everyone as an individual & tailor their care to their needs”

“We provide a good service, as a telephone advice line so would not change anything”

The final question asked service providers to add any further comments / or questions they would have liked to have been included in the questionnaire. Responses included:

“Cornwall feels like a separate County which struggles with integrating with individuals from BME who move here and often end up living together and separately from the community. I feel it is important to address these community issues as preventative strategies for the development of anxiety and depression in people from BME backgrounds as well as increase local services understanding of different cultural needs.”

“Our services are person centred and on referral basis, care programmes make services available to anyone if risk assessment found satisfactory”

“Our service is purely an advice and guidance, telephone helpline - we do not ask the person calling which background they are from as this, to us is irrelevant to our service provided”

“Very difficult to comment on some of the questions due to the lack of BME referrals into our service”

“We already treat everyone as an individual and tailor their care to their needs”

“Isolated initiatives in Health/social care will have a limited effect on reducing discrimination. No BME users at present, is this due to barriers to accessing service, lack of need etc”

“The BME community is not very visible in Cornwall and so tend to be over-looked instead of grand plan or bland phrases we need parts upon which to base future services. This cannot depend of figures produced solely by statutory agencies who may not keep good data but need to be done independently by competent researchers.”

“Cornwall is not a particularly welcoming place for BME individuals, people currently living here (not from BME) can feel threatened by others moving here from outside the County. Since moving here from London I have been surprised by the level of racism and segregation across communities (but not necessarily from organisations.)

6.2 FACE-TO-FACE INTERVIEWS WITH 31 MEMBERS OF THE BME COMMUNITY

The following are the analysed data from interviews with members of the black and minority ethnic individuals (see Appendix 2).

Figure 10 Age Profile

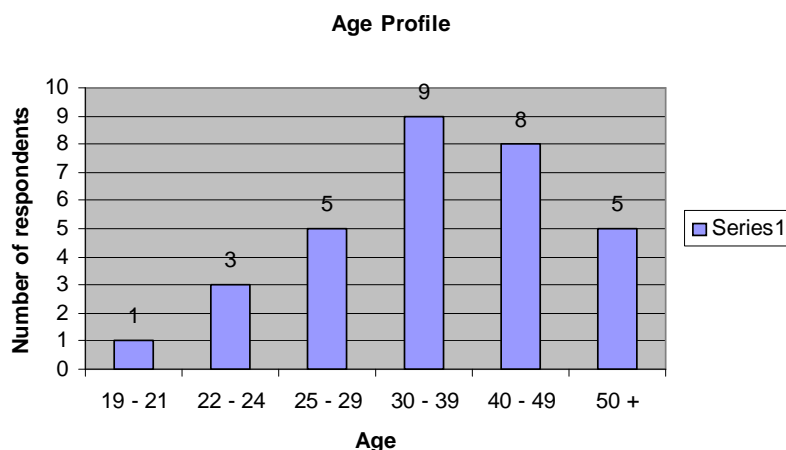


Table 21 Gender Profile

Gender	Number of respondents	Percentage
Female	21	68%
Male	10	32%
Transgendered or transsexual	0	0%

Table 22 Ethnicity

Ethnicity		Number	Percentage
White	Other	17	55%
Asian or Asian British	Other	3	10%
Black or Black British	Caribbean	3	10%
	African	1	3%
Chinese or Other Group	Chinese	2	6%
	White & Asian	1	3%
Mixed	Other	1	3%
Other		3	10%
	Total	31	100%

Figure 11 Were respondents born in the UK?

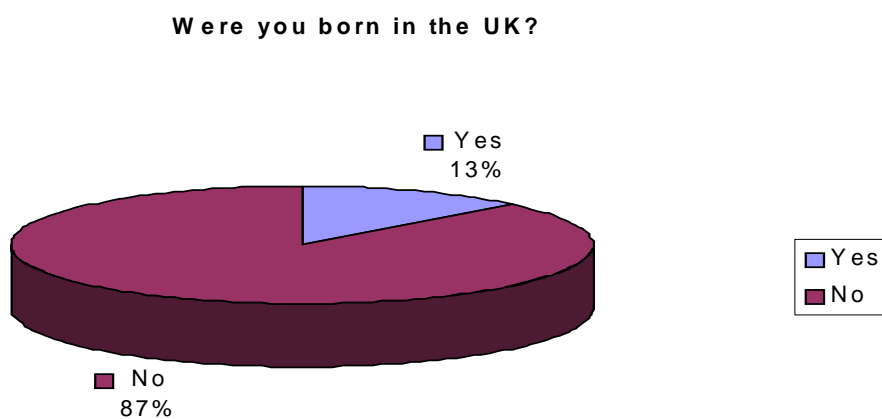


Figure 12 If no, how long have you lived in the UK?

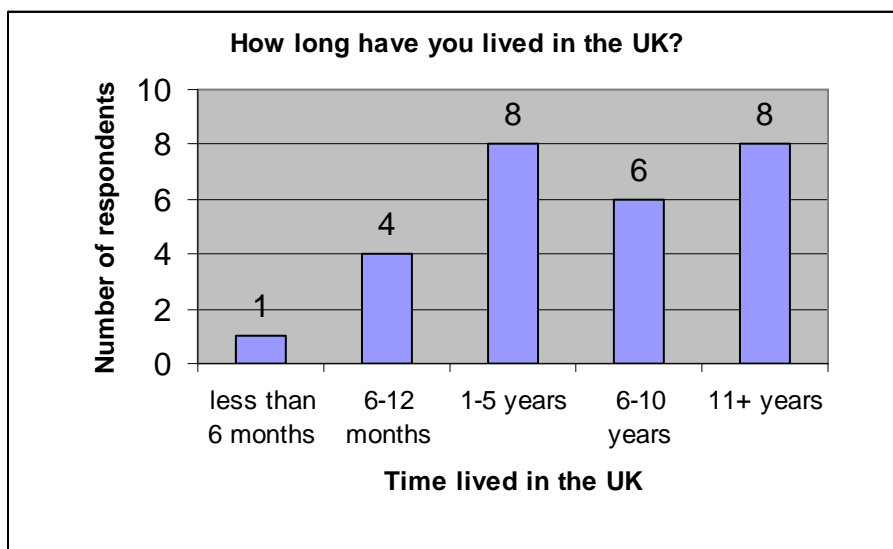


Table 23 How respondents described themselves

How respondents described themselves	Number	Percentage
British Citizen	14	45%
Refugee	0	0%
Asylum Seeker	0	0%
Other	17	55%

Respondents who described themselves as 'other' were asked to explain this. The following explanations were given:

- European Citizen
- British resident
- Resident
- Migrant worker
- Chinese
- Polish Migrant Worker
- British and Turkish nationality
- Australian
- French resident
- German

Table 24 What is your first language?

What is your first language?		
	Spoken	Written
Polish	11	11
English	8	8
Thai	3	3
Chinese	2	2
Turkish	2	2
Spanish	1	1
French	1	1
German	1	1
Italian	1	1
Others	1	1

Table 25 What other languages are you fluent in?

What other languages are you fluent in?		
	Spoken	Written
English	18	15
Spanish	3	2
French	3	3
German	2	0
Italian	1	1
Portuguese	1	1
Norwegian	1	1

Table 26 What is your religion?

Religion	Number of respondents	Percentage
Buddhist	4	13%
Christianity	19	61%
Hindu	0	0%
Jewish	0	0%
Muslim	2	6%
Sikh	0	0%
Other	0	0%
None	6	19%
Preferred not to answer	1	2%

Table 27 Sexuality

Sexuality	Number of respondents	Percentage
Lesbian or gay woman	0	0%
Homosexual or gay man	0	0%
Heterosexual	26	84%
Bisexual	0	0%
Do not wish to answer	5	16%
Other	0	0%

Table 28 Disability

	Yes	No	Do not wish to answer
Do you have a disability?	1 (3%)	29 (94%)	1 (3%)

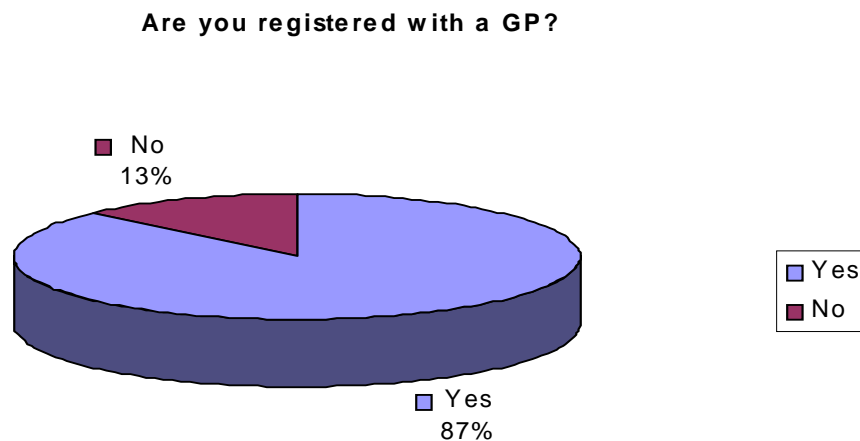
Figure 13 How long have you lived in Cornwall?



Table 29 What part of Cornwall do you live in?

Cornwall's districts	Number of respondents who live there	Percentage
Caradon	0	0%
Carrick	1	3%
Kerrier	2	6%
North Cornwall	0	0%
Penwith	28	90%
Restormel	0	0%

Figure 14 Are you registered with a GP?



The reasons for not being registered with a GP included no need to go, no problems with health.

Respondents were asked if they were unwell what would be their first point of contact. The following list shows the responses:

“Physical it would be the GP. Mental well being it would be friends & family. Being brought up in Poland, we don’t have a GP as a doctor who sees a person for anything, eh, we have specialists and you can go to them directly and then make an appointment’. When I first came here I was surprised that I still have to go to GP to see other specialist for other things, because I would want to go to...I don’t know psychologist straight away, I would seek that kind of help because that is what I had in my country.”

“GP/Doctor (21 responses)”

“Depends, for medical attention – GP or pharmacist at Boots – I work there”

“Depends, go home and have a rest. If really unwell see a GP. I don’t need to see a GP to tell me about a cold, but if it went to my chest I am there.”

“Difficult to say. Equal thoughts towards contacting my CPN at Bolitho house or my doctor at Morrab surgery, which ever one was nearest. An extreme emergency I think it would be an emergency doctor or 999”

“Social worker”

“My son”

Table 30 Have you experienced any difficulties in registering with or contacting your GP?

Experienced difficulties	Number of respondents	Percentage
Yes	5	16%
No	22	71%
Did not answer	4	13%

Typical comments included:

<i>"No, never been to a doctor"</i>
<i>"Problems accessing my own GP"</i>
<i>"I never had any problems."</i>
<i>"In London I was refused to be registered. I was told because they were so busy and they have so many patients. Maybe after that I was a bit put off, and when I moved down to Cornwall I was afraid to register."</i>
<i>"Yes, accessing my own GP, you can see any other GP"</i>
<i>"No, he's brilliant, I only need to walk in there and he will find me an appointment"</i>

Table 31 What respondents thought about the standard of Cornwall's mental health services?

Standard of service	Number of responses	Percentage
Good	3	10%
Satisfactory	1	3%
Poor	4	13%
Have not experienced	23	74%

Table 32 Possible symptoms of mental health

Possible symptom of mental health	Number of respondents who said it could be a possible mental health symptom	Percentage
Hearing voices	26	84%
Flashbacks	24	77%
Anxiety	23	74%
Not wanting to go out and see other	22	71%

people		
Sleeping problems	19	61%
Crying	17	55%
Mood swings	17	55%
Constant homesickness	16	52%
Nightmares	16	52%
Headaches	14	45%

Table 33 Would you seek help if you were suffering from the following symptoms?

Symptom	Number of respondents who would seek help	Percentage
Anxiety	24	77%
Flashbacks	22	71%
Not wanting to go out and see other people	22	71%
Hearing voices	22	71%
Sleeping problems	18	58%
Crying	16	52%
Mood swings	15	48%
Constant homesickness	12	39%
Nightmares	12	39%
Headaches	11	35%

Table 34 Preferred help for anxiety

Preferred help for anxiety	Number of respondents who would seek this help	Percentage
Support from family and friends	14	45%
Counselling	9	29%
Talking therapies	6	19%
Advice and guidance	5	16%
Support group activities	3	10%
Mentoring	2	6%
Spiritual / religious guidance	2	6%
Support from your community	1	3%
Complementary therapies	1	3%
Social Services	1	3%
Medication	0	0%
Hospitalisation	0	0%
None of the above	0	0%

The following comments were made by respondents for the possible symptom of ‘anxiety’:

“A doctor would give you some stupid tablets that would make it worse”

Preferred help? – *“Family or friend, not a big fan of doctors, if I can avoid them I will!”*

Reasons for not seeking help? – *“I’m used to it and know everything about it”*

Preferred help – *“Get on with it, sort yourself out. Self help really”*

Table 35 Preferred help for flashbacks

Preferred help for flashbacks	Number of respondents who would seek this help	Percentage
Counselling	9	29%
Support from family and friends	8	26%
Talking therapies	5	16%
Advice and guidance	2	6%
Complementary therapies	2	6%
Medication	2	6%
Support from your community	1	3%
Spiritual / religious guidance	1	3%
Support group activities	1	3%
Mentoring	0	0%
Social Services	0	0%
Hospitalisation	0	0%
None of the above	0	0%

The following comments were made by respondents for the possible symptom of ‘flashbacks’:

“I would love to explore this with my mind”

“Probably if it persists over and over it could drive you crazy, but flashbacks are natural because if you lose someone from your family and you love that person the flashback will never go”

Table 36 Preferred help for not wanting to go out and see other people

Preferred help for not wanting to go out and see other people	Number of respondents who would seek this help	Percentage
Support from family and friends	9	29%
Counselling	8	26%
Advice and guidance	3	10%
Support group activities	2	6%
Talking therapies	2	6%
Medication	1	3%
Mentoring	0	0%
Spiritual / religious guidance	0	0%
Complementary therapies	0	0%
Support from your community	0	0%
Social Services	0	0%
Hospitalisation	0	0%
None of the above	0	0%

The following comments were made by respondents for the possible symptom of 'anxiety':

<p><i>"Personal choice"</i></p> <p><i>"Counsellors that you could phone up . . . I don't know if there is a counselling helpline you can ring in the UK. If you couldn't leave the house you wouldn't want to go and visit anybody so it would have to be someone you could call and talk to"</i></p> <p><i>"Not wanting to go out or see other people can have different causes. It could be laziness and tiredness or a real fear, phobia of leaving home"</i></p> <p><i>"Doctor would be the last person you would want to talk to if you made it there"</i></p> <p><i>"You chose to be alone and not go out"</i></p>
--

Table 37 Preferred help for hearing voices

Preferred help for hearing voices	Number of respondents who would seek this help	Percentage
Support from family and friends	8	26%
Counselling	5	16%
Medication	3	10%
Advice and guidance	2	6%
Spiritual / religious guidance	2	6%
Hospitalisation	2	6%
Social Services	1	3%
Talking therapies	1	3%
Complementary therapies	1	3%

Support group activities	0	0%
Mentoring	0	0%
Support from your community	0	0%
None of the above	0	0%

The following comments were made by respondents for the possible symptom of 'hearing voices':

"In my tradition I would go to the church first. Spiritual healing, prayers"

"With hearing voices it's definitely a severe mental health issue. Even if the voices you're hearing are friendly you should get help."

Reasons for not seeking help – *"Fear of being locked up, stigmatised, depends on your spiritual beliefs, I wouldn't trust anyone"*

Seek help? – *"First place would be a GP, who would recommend a therapist or counsellor"*

"If I hear a voice, yeah, maybe I would go to see a doctor. But if I'm hearing voices because I'm just nuts so I wouldn't go there anyway."

Table 38 Preferred help for sleeping problems

Preferred help for sleeping problems	Number of respondents who would seek this help	Percentage
Counselling	4	13%
Medication	3	10%
Complementary therapies	2	6%
Support from family and friends	1	3%
Advice and guidance	1	3%
Support from your community	0	0%
Mentoring	0	0%
Spiritual / religious guidance	0	0%
Support group activities	0	0%
Talking therapies	0	0%
Social Services	0	0%
Hospitalisation	0	0%
None of the above	0	0%

The following comments were made by respondents for the possible symptom of 'sleeping problems':

Preferred help? – *"GP but I would ask for alternative solutions rather than pills"*

"Sleeping problems is a symptom of mental health problem, stress, anxiety. So you need help to calm yourself down, to relax. Complementary therapies are great."

Would you seek help? – *“Once it started to affect my everyday running”*

Table 39 Preferred help for crying

Preferred help for crying	Number of respondents who would seek this help	Percentage
Support from family and friends	10	32%
Counselling	4	13%
Talking therapies	4	13%
Spiritual / religious guidance	3	10%
Support from your community	1	3%
Advice and guidance	1	3%
Mentoring	0	0%
Complementary therapies	0	0%
Support group activities	0	0%
Social Services	0	0%
Medication	0	0%
Hospitalisation	0	0%
None of the above	0	0%

The following comment was made by a respondent for the possible symptom of ‘crying’:

“You laugh and cry, it’s normal”

Table 40 Preferred help for mood swings

Preferred help for mood swings	Number of respondents who would seek this help	Percentage
Support from family and friends	6	19%
Counselling	5	16%
Medication	2	6%
Advice and guidance	1	3%
Talking therapies	1	3%
Social Services	1	3%
Complementary therapies	0	0%
Support group activities	0	0%
Support from your community	0	0%
Spiritual / religious guidance	0	0%
Mentoring	0	0%
Hospitalisation	0	0%
None of the above	0	0%

The following comment was made by a respondent for the possible symptom of ‘mood swings’:

“Happens to everybody”

Table 41 Preferred help for constant homesickness

Preferred help for constant homesickness	Number of respondents who would seek this help	Percentage
Support from family and friends	9	29%
Counselling	2	6%
Advice and guidance	1	3%
Support group activities	1	3%
Medication	1	3%
Support from your community	0	0%
Mentoring	0	0%
Spiritual / religious guidance	0	0%
Complementary therapies	0	0%
Talking therapies	0	0%
Social Services	0	0%
Hospitalisation	0	0%
None of the above	0	0%

The following comments were made by respondents for the possible symptom of ‘constant homesickness’:

“I’m ok in here. If I miss my family I go on the web”

“It’s a person’s choice. Perhaps move if unhappy or move back home”

“What could anybody tell you other than go back there then, but that’s my situation, choice not an option for someone seeking refuge”

Table 42 Preferred help for nightmares

Preferred Help for nightmares	Number of respondents who would seek this help	Percentage
Counselling	3	10%
Support from family and friends	2	6%
Medication	2	6%
Talking therapies	1	3%
Support from your community	0	0%
Advice and guidance	0	0%

Mentoring	0	0%
Spiritual / religious guidance	0	0%
Complementary therapies	0	0%
Support group activities	0	0%
Social Services	0	0%
Hospitalisation	0	0%
None of the above	0	0%

The following comments were made by respondents for the possible symptom of 'nightmares':

"Possible mental health symptom – "Yes, it could be. Depends on the severity and how often you have them. If it's related to an accident you had or a bad experience then yes"

"Not mental health problem on their own"

Table 43 Preferred help for headaches

Preferred help for headaches	Number of respondents who would seek this help	Percentage
Counselling	3	10%
Support from family and friends	1	3%
Advice and guidance	1	3%
Mentoring	0	0%
Spiritual / religious guidance	0	0%
Complementary therapies	0	0%
Support group activities	0	0%
Support from your community	0	0%
Talking therapies	0	0%
Social Services	0	0%
Medication	0	0%
Hospitalisation	0	0%
None of the above	0	0%

The following comments were made by respondents for the possible symptom of 'headaches':

"There are lots of reasons for headaches"

Reasons for not seeking help? – *"It happens a lot"*

General comments about preferred help included:

"I'm sensitive about medication. I prefer to talk to a doctor."

"Not a big fan of doctors, if I can avoid them I will. Eat healthy, sport"

"Medication? I run miles from it. I think its all government's conspiracy. I don't think they know what they're doing with it. You're stuck on one and try one but I ended up taking two. I had tablets to counterattack the side effects. It was a horrible experience for me. And they tell you that there aren't any side effects."

"Like to change approaches of psychiatrists. Too quick sometimes, bully and aggressive and they are ignorant, which can damage people."

"You need talking therapies, counselling to get to the bottom of the problem, to find out the cause of your problem and then to try to treat through talking."

"I am not really sure about these sleeping tablets they give people, I think it's a shame if people have to resort to sleeping tablets. To be quite honest I had a problem with street drugs at one time and you managed to learn when you try to self prescribe for yourself administer drugs for yourself to help with your own nerves and stuff like that and you end up learning what is going to relax you to this point and what puts you to sleep to that point and the switch in your brain that a sleeping tablet controls. Quite a scary thought really."

"Without any doubts – spiritual guidance. It's great. I really needed it. Everybody needs it, the whole world needs it but people just don't realise it."

"I think it's easier for them. Because obviously it's more expensive to offer counselling and stuff... and to give people medication without offering any other services to go with it I think it's diabolical."

"In order to cure someone you need to find out the reasons of the problem. So if you're anxious about something you have to go back to the core and seek the causes. People fear the unknown. So you need to seek the light, the knowledge to cure."

"Medication helps for short periods of time. Sometimes makes you more depressed is my opinion which is the experience I had with my ex husband, you get to a period where the body does not take it any more."

"Problem shared is a problem eased. What do they say? Problem shared is a problem halved? Something like that."

"I'd like to think that counselling would help but it depends what sort of counselling you would get. And I'm actually biased anyway cause I've had counselling and I know what it looks like. But basically I would keep it to myself"

Table 44 Possible mental health symptoms and preferred help

Possible mental health symptoms and preferred help						
	Support from Family & Friends	Counselling	Medication	Advice & Guidance	Talking therapies	Complementary therapies
Anxiety	√	√			√	
Flashbacks	√	√			√	
Not wanting to go out and see other people	√	√		√		
Hearing voices	√	√	√			
Sleeping problems	√		√			√
Crying	√	√			√	
Mood swings	√	√	√			
Constant homesickness	√	√		√		
Nightmares	√	√	√			
Headaches	√	√		√		
Total	10	9	4	3	3	1

Table 44 illustrates that ‘support from family and friends’ and ‘counselling’ were the most preferred choices of help from respondents if they had the above mental health symptoms.

Table 45 How long would you wait before you would seek help for the following symptoms?

Symptom	How Long would you wait?					
	Straight away	Up to 1 week	More than 1 week to 1 month	More than 1 month to 3 months	More than 3 months to 6 months	6 months +
Anxiety	8	4	2	2	1	0
Flashbacks	7	0	3	1	2	0
Not wanting to go out and see other people	4	2	5	1	0	0
Hearing Voices	10	3	4	0	0	0
Sleeping problems	1	4	5	0	0	0
Crying	2	1	5	2	0	0
Mood Swings	3	2	4	1	0	0
Constant	2	2	1	0	1	1

homesickness						
Nightmares	3	3	4	1	0	0
Headaches	1	3	3	0	0	0

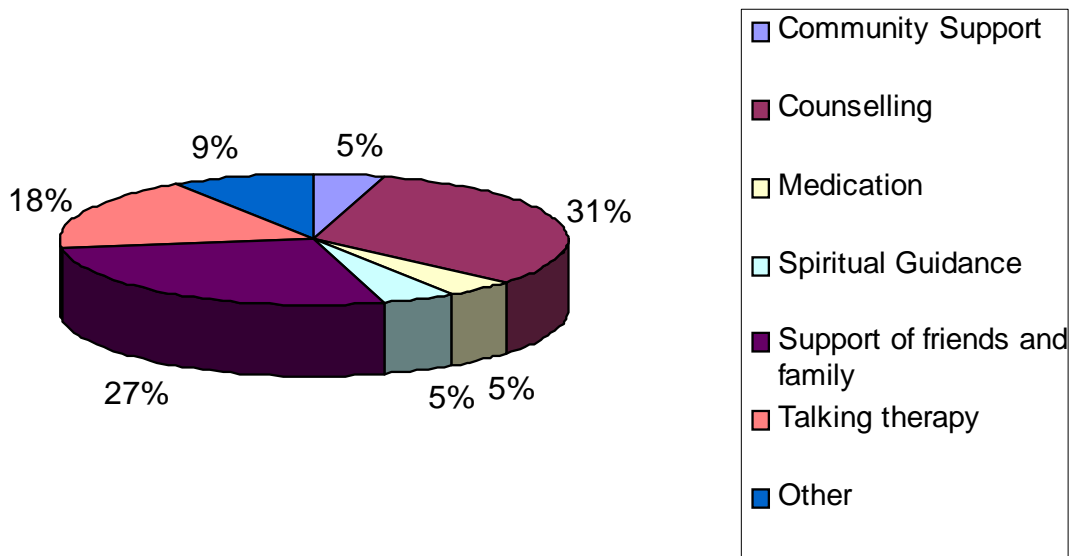
Table 46 Have you or any of your family or people you know ever used or experienced any of the following for a mental health condition?

	You	In Cornwall	Family	In Cornwall	Other People you know	In Cornwall	TOTAL
Medication	10	5	4	1	3	2	25
Support of friends and family	9	6	3	2	2	1	23
Counselling	6	5	3	1	4	3	22
Hospitalisation	2	1	4	1	6	4	18
Complementary therapies	4	4	2	0	5	1	16
Advice and Guidance	6	4	1	0	2	1	14
Others – GP (5 respondents) the internet, Citizens Advice Bureau and psychologist	4	3	1	0	3	2	13
Social Services	5	2		0	2	2	11
Talking therapy	3	2	2	0	1	0	8
Mentoring	1		1	1	2	2	7
Spiritual Guidance	3	0	1	0	1		5
Support group activities	3	0	0	0	1	1	5
Community Support	1		1	1	0	0	3
No help required	0	0	1	0	0	0	1

Medication, support of friends and family, counselling, hospitalisation, complementary therapies, and advice & guidance were most used or experienced by the respondents, their family or people they knew for a mental health condition.

Figure 15 In your opinion which have been most effective?

In your opinion which has been most effective



The above pie chart shows that counselling (31%), ‘support of friends and family’ (27%) and medication (18%) were the types of help respondents thought were most effective from the list in table 44. Some of the listed helps were not picked out as being most effective by respondents including advice and guidance, Complementary therapies, mentoring, hospitalisation, social services, and support group activities.

Typical comments regarding the most effective sources of support from the list in table 44 included:

“Counselling if I could speak English”

“Counselling definitely, but with someone that you feel is really trying to relate to you and you are relating to”

“I tried counselling. Here in Cornwall. I went to doctor and then had counselling. It was very good for me. Very nice. I had some language problems but it helped.”

“Difficult to say because it depends on what kind of mental health problem you have. For some, friends and family would be enough. For some other mental health problems you would go to counselling, talking therapy or something. Some people would go to spiritual leader, but I wouldn’t really.”

“Medication helps for short periods of time. Sometimes makes you more depressed is my opinion with experience I had with my ex husband, you get to a period where the body does not take it any more.”

“Without any doubts – spiritual guidance. It’s great. I really needed it. Everybody needs it, the whole world needs it but people just don’t realise it.”

Figure 16 Have you ever suffered from depression?



Respondents were then asked what they did when they had depression. The following list shows some of the responses:

“I didn't get help, I didn't know the culture, the language, the system, I didn't know whether there was any help I can get to get rid of it because it was difficult”

“Nothing”

“Nothing, waited, no help received”

“No, waited till it went away, but I was quite young back then”

“Went to GP who referred me to someone who did homeopathic counselling”

“Went to GP”

“Counselling”

“Mental health team carer support worker come to talk to me every week or every time I needed”

The above comments illustrate 4 (50%) of the 8 respondents suggested that they did nothing to seek help if they had depression. 2 (25%) would go to see a GP, 2 (25%) would have counselling and 1 (12%) would see a mental health team carer support worker.

Table 47 Mental health services that respondents have heard of or used

Service	Heard of	Used
NHS mental health services	19 (61%)	1
Mental health community development workers	9 (29%)	0
Mind	9 (29%)	0
Pentreath	6 (19%)	0
Rethink	4 (13%)	0
NIHME	3 (10%)	0
Other	2 (6%)	0

Figure 17 Have you heard of the Delivering Race Equality in Mental Health document?

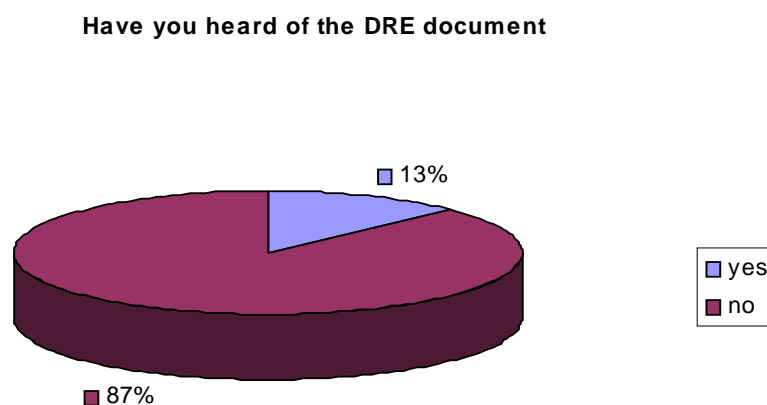


Figure 18 Have you heard of David Bennett?

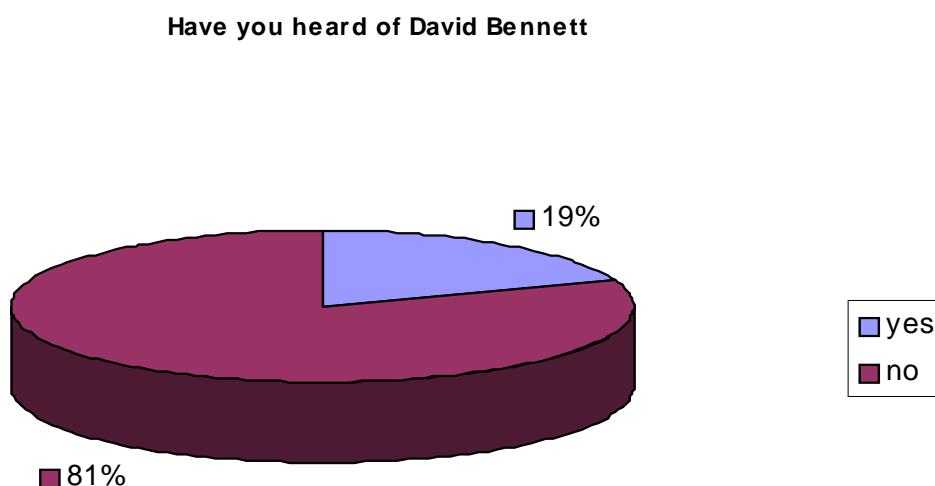
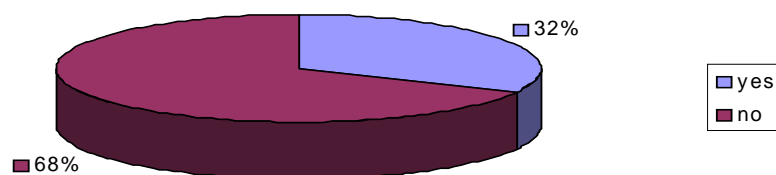


Figure 19 Are you aware that the government is making changes to improve mental health services for people from BME backgrounds?

Are you aware that the government is making changes to improve services



The interviewees were asked to comment on their response from the question from figure 19. Comments included:

"Haven't noticed them"

"I don't think it's possible to publicise their things too much"

"I don't remember hearing about them"

"I haven't been in this country long enough"

"I haven't noticed anything and haven't been interested"

"Never been looking for services"

"Never seen anything about mental health"

"Rarely see something in the surgery, public places or public libraries."

"Stigma, keep it quiet unless you go into that"

"Taboo, stigma"

"Would not know where to look for a start. Never suffered from mental illness."

"You don't hear about them on the news or advertisements"

Table 48 What would stop respondents and other people from BME backgrounds accessing mental health services in Cornwall?

Reason	Would stop the respondent	Would stop other people	TOTAL
Language barriers	12 (39%)	24 (77%)	36
Embarrassment	9 (29%)	20 (64%)	29
Don't know where to go	8 (26%)	19 (61%)	27
Fear of being deported	1 (3%)	21 (68%)	22
Fear of being locked up	7 (23%)	15 (48%)	22
Cultural beliefs	5 (16%)	18 (58%)	23
Lack of time	5 (16%)	15 (48%)	20
Shame	5 (16%)	14 (45%)	19
Poor quality of services	3 (10%)	14 (45%)	17
Transport/travel cost	6 (19%)	11 (35%)	17
Spiritual beliefs	3 (10%)	12 (39%)	15
Lack of appropriate services	5 (16%)	8 (26%)	13
Other	8 (26%)	2 (6%)	10
Nothing	8 (26%)	0	8

Other reasons included:

- Not being English
- Stigma
- Racism
- Not trusting the system
- Lack of knowledge
- Lack of confidence
- Problems with own GP

This section brought up several comments, which are listed below:

“Jargon, you just don't understand them. And I speak the same language so other people who can't speak English I think it would be a real big problem, especially in this area.”

“For other people I suppose language barriers is the strongest one. I mean to explain what's wrong with you even in your own, first language is very difficult so for others who struggle with English that must be really hard. It's extremely hard to put it in words”

“Fear of being deported or locked up. I mean there are so many people working illegally. They wouldn't talk to anyone; they wouldn't go anywhere because they're scared. They don't want to be chucked out of this country.”

“Actually I would be very worried about going to get help with hearing voices. Because of chances of being locked up and being stereotyped as a black man are as high as you get. And actually I think I wouldn't tell anyone and keep it to myself. I wouldn't trust anyone.”

“You don’t really want to go to a GP. You’re scared that a doctor will label you “oh, she’s mad, dangerous and you will be sectioned. And other people will see you as mad.”

“People just don’t have time to see anyone. I mean you have to work, you can’t just waste time. Especially for Polish people. They work so hard, so much. They can’t just miss a day and not to go to work.”

“There should be more publicity. There’s loads of people who hide their problems. They don’t say anything to anyone and don’t know where to go.”

“And also they could also find it hard to find out where to go and when to go. In college where I used to work we had student services and students could always go there to find out as first point of contact or find out where to seek help from other agencies.”

“You don’t know how to get help. If you talk to people about it they think you’re mad.”

“Culture is very important. I mean it’s obvious that if you treat someone from a different culture or anyone at all first what you need to do is to make them feel comfortable and safe. If you want to help them you need to make them trust you. You need to know about where they’re coming from, what they’re like, what they need. They’re not going to open up and be ready to recover if they don’t feel safe. It’s logical, isn’t it?”

“...it’s important. Because there are religions and cultures. Like women. In some religions women can’t see a male doctor. So services need to look into things like that. They need to respect them.”

Stigma was also listed as a reason for not accessing mental health services as well as embarrassment and fear of being judged. The following comments show this.

“...mental health issues are something for a lot of people unseen, something brushed under a carpet. And maybe part of that is that it’s not advertised well enough. I’m talking about the topic in general it’s just like a taboo.”

“In a sense you need to do something about it and you have to talk to someone, but sometimes it shouldn’t be like really, really open because as I have said mental health is like a taboo, it is a topic that a lot of people do not understand and they make judgements that could make your case worse.”

“In most cases it’s better to keep it to yourself. Unfortunately people are biased. You can’t talk freely about your problems and stuff like this. They will judge you.”

“There’s certain element of embarrassment, of cultural beliefs that sort of puts stigma on a problem with mental health. But I suppose it’s almost in every culture.”

“General perception – people are sympathetic when they read about, they say: yeah it’s very sad. But how do they act when they actually meet someone with a problem in a street, when you are faced with it. Most people look funny, stay away, run or don’t know

what to do. You don't see people trying to help, trying to make contact."

"My family over here don't talk about depression because it's not something you talk about. My family in America do... but down here I think it's considered shameful to talk about things like that, it's a sign of personal weakness."

"As a Black person with a mental health problem you're just walking into a field of stereotypes. It's about being big, Black and dangerous. It's the known one, it's the phrase that people use."

Some people admitted that they would be afraid to seek help for a mental health condition as they would be worried about having a permanent record.

"The reasons why people may not want to access mental health, the fact that fear maybe of having a permanent record, and that something that in the future when you apply for a job or you know, there's something that can come up as a record that you have experienced mental health problem um which can maybe I don't know, cause that you not gonna get this job, or you know the word will spread in twenty years time you know, long gone, but still its going to stay with you for the rest of your life. So maybe people, maybe I would be actually worried that in the future something's gonna come up cause the record will stay with a GP."

"I didn't want to take time off work cause I didn't want to lose a job or I would have to go back and tell them what problem is and there's a matter of stigma. I know that a lot of clients that I counsel don't go through work because they don't want it on their record."

"I wouldn't tell anybody especially when I was working because of the fear of going on a permanent record."

Opposite views were also expressed about BME communities' responsibilities to trying to adapt.

"From what I see people are eager to know you. I don't believe any cultural isolation would affect anybody. Its your fault if you don't come out to talk."

"It is up to you to mingle with people. Lot of places to make friends and up to you to do that."

Figure 20 Would you tell anyone if you thought you were suffering from a mental health problem?

If you were suffering from a mental health problem would you tell anyone?

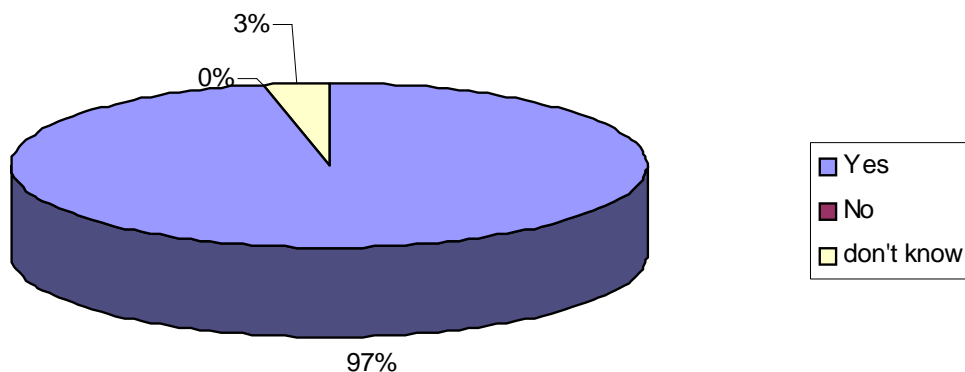


Table 49 If yes who would you tell?

Who	Number of respondents	Percentage
Family	22	71%
GP	21	68%
Friends	13	42%
Spiritual leader	3	10%
Other	2	6%

Note: Percentages add up to more than 100% due to multiple responses

Table 50 Where respondents would go to find out about mental health services

Where	Number of respondents	Percentage
GP	23	74%
Websites	18	58%
Family	7	23%
Friends	6	19%
Other	6	19%

Note: Percentages add up to more than 100% due to multiple responses

Other places that respondents would go to access mental health services included:

- Practice nurse
- My interviewer
- Pharmacist
- Mental health directory
- Media

Many people thought that the internet is an excellent source of information especially for BME communities who do not know the system or where to get help. They also highlighted other advantages such as anonymity, privacy, easy and quick access to relevant information.

Comments included:

"Website in the first instance because you can just do it in private"

"I'm a great believer in the internet. If you have access to the internet you can find out so much and it's anonymous. You don't have to tell anyone about your problem if you don't want to. And it gives a very broad spectrum of services available, people to talk to – from a medical profession to support groups, alternative therapies etc. and also different perspectives on a topic. So you have a choice."

"I think with the advent of the internet, people can find out more but not all people have even access to internet."

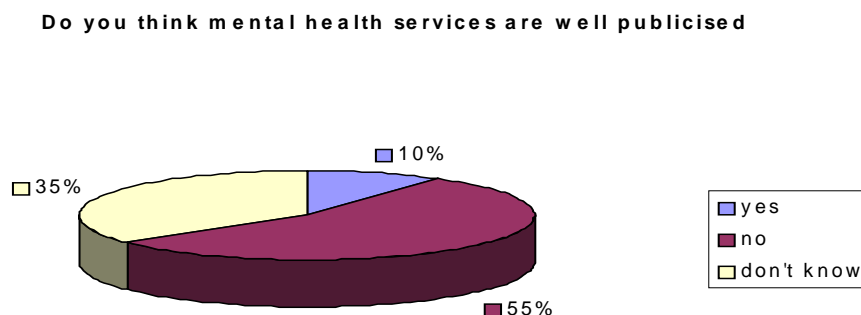
"Internet is fantastic. Especially for us, minority groups. It gives you all the information , it helps you to communicate with other people, your family. It gives you a choice that in a real world we don't have."

"I think website is quite good one to think about. There is that word I mentioned earlier 'embarrassment' for a lot of people. At least with websites you could do some research yourself without telling anyone."

"Internet. Yeah, it's the quickest, best and first where I would try to get some information."

"I've always recommended the internet. It gives you the power. You can have full anonymity and find out what you need".

Figure 21 Do you think mental health services are well publicised?



The respondents were read a list of 8 statements and asked whether they strongly agree, agree, neither agree or disagree, disagree, strongly disagree. The next 8 figures will show how participants responded.

Figure 22 People who have a mental health problem should always be given medication?

People who have a mental health problem should always be given medication?

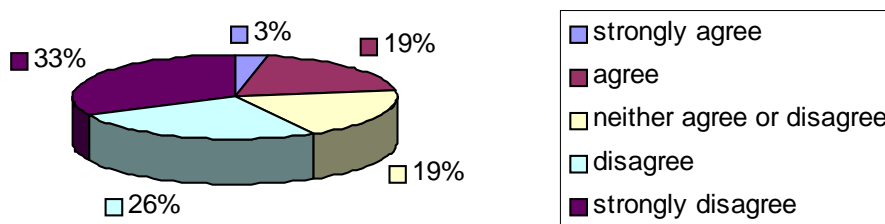


Figure 23 Mental Health services in this country treat everybody equally?

Mental health services in this country treat everybody equally?

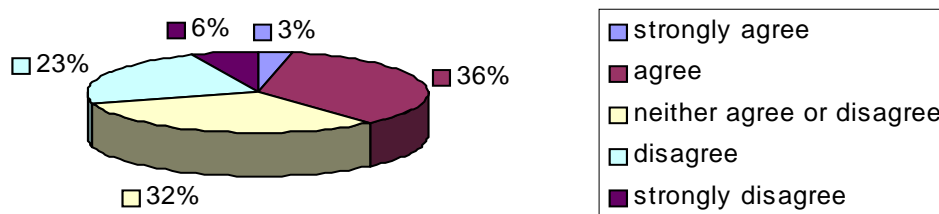


Figure 24 Mental health is a sign of weakness?

Mental health is a sign of weakness

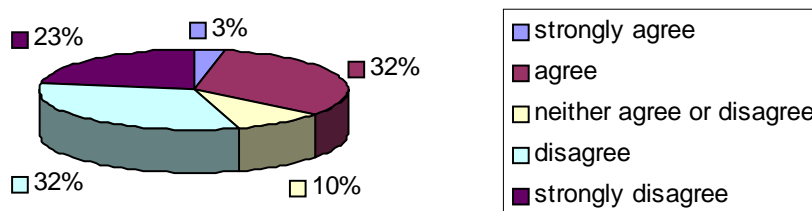


Figure 25 People with Mental health problems should always be locked up?

People with mental health problems should always be locked up?

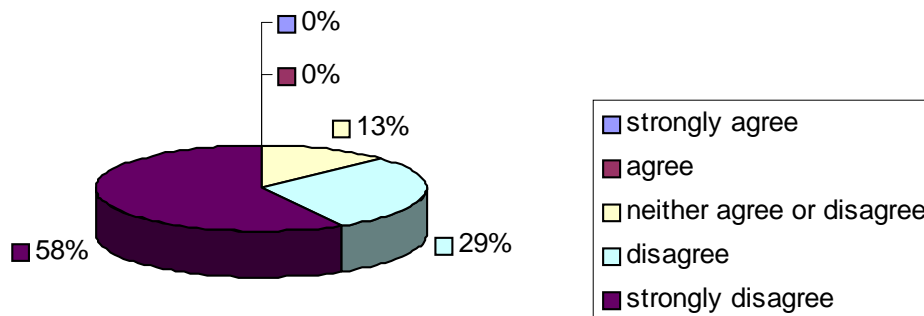


Figure 26 Mental Health services need to take into account people's cultural background?

Mental health services need to take into account people's cultural background?

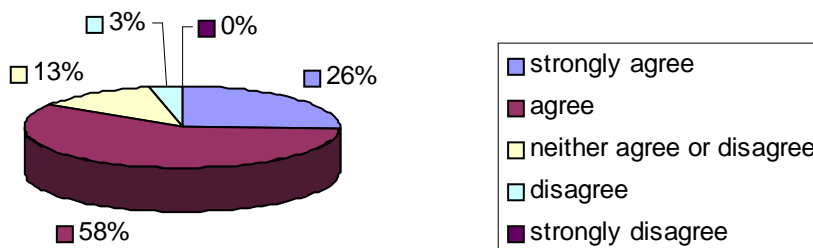


Figure 27 Mental Health problems should be kept a secret?

Mental health problems should be kept a secret?

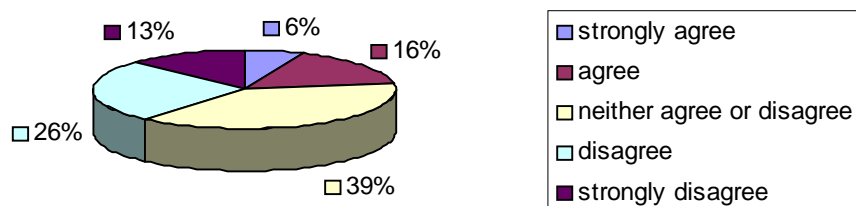


Figure 28 People with mental health problems are dangerous?

People with mental health problems are dangerous

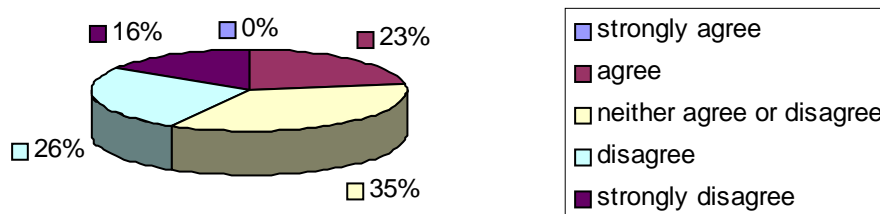


Figure 29 Most people make a full recovery from a mental health problem?

Most people make a full recovery from a mental health problem

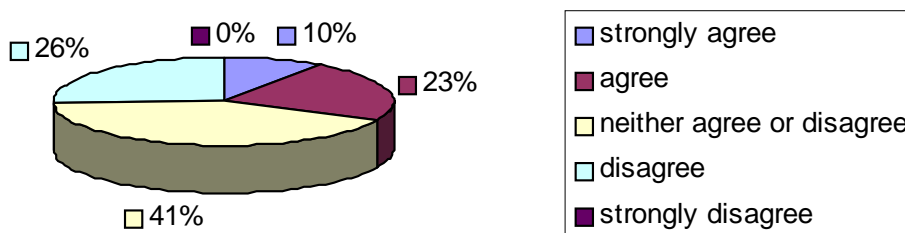


Table 50 What may affect the mental health of a person from a BME background?

Reason which may affect the mental health of a person from a BME background?	Number of respondents	Percentage
Racism	26	84%
Loneliness	24	77%
Lack of employment opportunities	24	77%
Language barriers	24	77%
Financial hardship	23	74%
Discrimination	23	74%
Cultural isolation	22	71%
Housing difficulties	22	71%
Social isolation	22	71%
Verbal abuse	19	61%
Fear of violence	19	61%
Other	4	13%

Note: Percentages add up to more than 100% due to multiple responses

Negative experiences/ opinion of mental health services

Throughout the interviews a negative picture of mental health services was frequently expressed. The team does not intend to highlight the validity of these accounts but wish to show that such opinions or experiences could stop people from BME communities accessing services.

“I mean you hear about services on the news but it’s normally about shutting more places down. Sadly it’s because of abuse or non-productiveness, too expensive to run etc. There’s a not a very healthy picture of mental health services we hear of in media.”

“Especially the mental health services have been publicly, openly criticised. In the media, there were so much negative reports. So you kind of question their ability to do much, to help you. That can stop a lot of people who try to get help. Ok, if I get them to go there they’ll end up in a health institution that won’t be able to look after them properly. They’d rather not... because they don’t have a faith and trust in the institution.”

“In London I was refused to be registered. I was told because they were so busy and they have so many patients I was told until I feel unwell they told me to wait till that because they just don’t have the space to work. Maybe after that I was a bit put off, and when I moved down to Cornwall I was afraid to register.”

“I don’t think doctor surgeries are very good for advice and guidance. They don’t respect your anonymity very much.”

“I was going backwards and forwards to the mental health team because you need this piece of paper, that piece of paper. It’s not a great system, it’s been faulty.”

"I spoke to someone yesterday who'd gone through a really bad depression wanting to kill themselves. And after two months of getting himself up for it ready which is a very dangerous time. But they still haven't given him counselling appointment and he's not going... which is ridiculous. So that's person's life was at risk. He went through it luckily; he went through this very life-threatening patch. But the actual service wasn't there when he needed it."

"I suppose it's down to personal experiences. If you were treated right from the start, treated with respect and you haven't been dismissed then yeah, but if something went wrong, somebody dismissed you, put you down, that would definitely stop people from accessing the service in the future."

"From what I heard people are not happy with doctors. They prescribe medication all the time."

"The information how bad this medication is for Black people compared to being a white for the same medication. The statistics which say that it's not dangerous or there are no side effects are for white people. But statistics and side effects for Black people are completely different. But they try to give us the same medication. I think it's all awfully disgusting."

"If I say that I don't believe that the government will make any changes at all so I think it's really valid because this is what I truly believe which is another reason why I wouldn't access any of the mental health services."

"My colleague's son was such a healthy young teenager. He was taking drugs and as a result he developed a mental health problem – hearing voices. Now he's in his late thirties. He was given too much medication and lost it completely. He was sectioned since his twenties. He's a destroyed man and without any chance to do anything with his life. This is a typical picture of how they treat people with mental health problems. They just section them and put them on drugs. There is no other intervention. They don't explore other new things, new treatments to help patients."

People have also had positive experiences of the service.

"I tried counselling. Here in Cornwall. I went to doctor and then had counselling. It was very good for me. Very nice. I had some language problems but it helped."

"No, he's brilliant, I only need to walk in there and he will find me an appointment."

"They are quite good, but my husband also in hospital and he felt that they didn't treat it properly, they just gave drugs not what he needed. Not ill enough to need. My ex had been on strong drug. Had a lot of good service but didn't make it for himself."

The comments below are a list of opinions that came up throughout the interviews:

“There’s not much that came up about racism and I think racism is one of the main causes of mental health problems in my experience, for BME communities it’s constant. I think a lot of mental health problems come from that and it’s a barrier to accessing mental health services.”

“If it happened to me I would be down. I’ve tried everything. I came here, I learnt the language, and tried to understand the culture, made friends – what else can I do? Why are you mean to me? I’ve done everything and you still discriminate against me, why?”

“I would need a second opinion whether I should do more about it. I would talk to someone I trust and value. It’s difficult to say and be aware of something like that. How can you tell that you have a serious problem and need a professional help?”

“How do you define normality? Who is to say what’s normal and what’s not. There’s so much to think about, so complex. It’s all down to society’s standards.”

“I mean I also don’t know much of mental health problems. So how would I know if I should go and get professional help or not? So yeah another thing that would stop me would be probably lack of knowledge.”

“You need a job to live to survive, pay rent, transport, food, if that is the situation you are in you will definitely go mad because it’s very difficult to get a job especially in this area. Even a cleaner job I couldn’t find. I have been educated to a masters degree, in Europe, not Africa, nobody cares what I can do, so it could drive you mad.”

“The whole time I’ve been using mental health services I haven’t seen one person working there that looks like me.”

“I don’t believe anything will happen unless you change people running the system. That means getting more people from BME community into the system and the system needs to be more open. I think most of the time it’s just a lip service and pushing money around.”

“If you can talk to someone from your own culture, someone similar but a barrier is there. If I talk to someone who doesn’t have that sort of problem how do you relate to me? I talk to you about my homesickness but then what? You don’t understand. The support is not there.”

“Service needs to be more out there with the people. They need to understand these people and try to communicate. That will help to develop services for people’s needs.”

“It would be good have someone, a staff member, who could speak the same language, who could help, give advice... in Polish that is.”

“They don’t want to learn, always so many excuses. Which causes a lot of misunderstanding, differences in cultures. And they call English people racism but it’s their fault too.”

"I've been treating myself with my Polish medicine... a lot of people do it. Each time we visit Poland we buy medicine. All sorts of medicine: painkillers, medicine for sore throat, digestion, upset stomach, chamomile etc. It's much cheaper... and we know the language."

"I've got everything from Poland, all sorts of medication. It's just different in our country in Poland. And if I didn't have drugs that I needed I would just ask someone to send it to me. But I've got loads."

6.3 FOCUS GROUP ANALYSIS

This section draws from the transcripts of focus group recordings to report findings on principal themes and sub-themes which emerged from the discussions. It highlights areas of consensus and contradiction as well as examining common beliefs, expectations, and assumptions that could be associated with the following 3 themes/topics.

- What does mental health mean to you?
- What, if any, are the barriers that may stop you from accessing Mental Health Services?
- How could we engage and empower the communities to access Mental Health services?

The focus group for the BME Mental Health Research was held on 6 February 2007 between 2pm-4pm at the Penwith Centre.

The group was made up from diverse ethnic and cultural backgrounds:

1 facilitator 1 note taker 6 participants

Present	Ethnicity	Gender	Religion	Age
Facilitator	Black Caribbean	Male	none	40 – 49
Note taker	Polish	Female	Christian	25 – 29
1	Thai	Female	Buddhist	50 +
2	Turkish	Male	Muslim	19 – 21
3	Black African	Female	Christian	50 +
4	Black Caribbean	Male	none	40 – 49
5	Mixed race	Female	Christian	25 – 29
6	Turkish	Male	Muslim	30 – 39

The focus group was divided into two 45-minute sessions with a 10-minute break in-between.

Part 1 **Welcome, introduction, ground rules etc.**
Question 1: 'What is mental health?'

Part 2 **Question 2: 'What are the barriers stopping individuals from BME background accessing mental health services?'**
Question 3: 'How to overcome these barriers?'

Part 1

- **Welcome**
- **Introduction of the project**
- **Health & safety, ground rules, house keeping information**
- **Introduction of the group participants**
- **Question 1: 'What is mental health?'**

During the first part of the focus group the facilitator welcomed everybody and thanked them for taking part. The facilitator gave a brief overview of the project, its background and aims. Ground rules along with health and safety regulations were also explained.

The facilitator then asked each individual to introduce themselves by giving their first names (optional), describing their favourite meal, their favourable place to consume that meal and what they did for fun. The ice-breaking question was aimed to familiarise the group with each other and to ensure that all participants had an opportunity to speak.

The facilitator gave an explanation of the structure and a timeframe for the session, including what it would entail for the participants. The plan was to discuss three topics:

- 1. What is mental health?**
- 2. What are the barriers stopping individuals from BME background accessing mental health services?**
- 3. How to overcome these barriers?**

The decision had been made to use a third person approach when asking the group for information on the main topics. This was achieved with the drawing of a stickperson on a board. This stickperson was a representation of all or any member(s) from any of the BME communities.

By using this technique it was felt that any pressure or stigma that any member of the focus group may feel around these topics, or any concerns around confidentiality of personal details or disclosures would be alleviated through the process of attribution to an imaginary character.

Question 1 What is mental health?

The facilitator distributed pens and paper and asked the participants to write down three words they associated with mental health which would help to define the topic. After a few minutes all present were going to choose one word to add to the list, which the facilitator was going to put together on a flipchart.

The following suggestions were made by the focus group members:

Healthy individual common sense
vit-deficiency lack confusion Mind
sad death David Emotive drugs
Debilitating Impairment isolated
Acting unusual ordinary behaviour

The group had expressed great difficulty in capturing the concept of mental health. No firm definition could be put forward. Some participants did not speak or write anything down. Over all there was agreement that mental health is indeed a difficult subject.

There was a wide spectrum of responses ranging from a positive mental well-being to negative descriptions and symptoms of mental illness.

A brief explanation taken from the DRE document was presented to the focus group. The group seemed to be touched by the story of David Bennett. A discussion about David's death unfolded and all present questioned the quality of services he had received. Participants wondered whether or why hospital staff did not take any notice of David's deteriorating condition.

"It must be pretty obvious. Like these people in there, they must know. Especially when they go home and come back, refreshed with new energy. They must be able to see: hang on, we're not benefiting this guy at all. He's not got better over the years. If anything he's deteriorating. It's just such an obvious observation. It's just strange. They're just not around. If they're not in authority to make that sort of conclusion that's crazy in it self."

These quotes are an accurate reflection of this emotive subject of David Bennett's death. However we appreciate the focus group was not in possession of all the facts, but we feel that the level of emotion shown in these comments demonstrate the negative perceptions that this group had of mental health services in this country. This could be seen as one of the barriers that members of the BME communities experience when accessing mental health services.

A suggestion was made that mental health institutions do not take a genuine interest in well being of their service users.

“We mustn’t forget that most of these institutions were created by the budget from the government. If they don’t have patients in their hospital maybe they should close. So what they do they keep... whoever, whether they’re nuts or not to have people in there. In order to get money to fund their jobs. That’s what I believe is happening. In order to change these people, doctor, nurses etc. in order to change their conscience...I mean how do you change a conscience about keeping people in the institution just for the sake of the money from the government?”

The groups thought that numbers of in-patients are quite often unjustified. A negative opinion of the government was communicated.

“And most of these people. They don’t have to be there. They’re not there because they want to be there. It’s because the government is making them be there.”

We’re all down to being held down, controlled.

In the opinion of one of the participants the cause of many problems lay in cultural differences and misunderstanding or a reluctance to understand people from BME background.

“What I think is that when these people do go to get help and they’re misunderstood or their cultural background is not looked at. And a lot of people come from different cultures, or are deprived of a lot of things. That will definitely contribute to your frustration. So if they look at it from this sort of angle and try to understand these minorities better they may not think ‘oh he’s just a nutter.’

The group expressed their concerns around the issue of the same drugs being prescribed for individuals from all ethnic backgrounds and side effects it could have on different people.

“If we have Chinese it’s suitable for Chinese, if you’re small and skinny I cannot give you the same drug as for like a heavy big black African six foot tall if you have the same symptoms. As you’re not going to react to the same drug the same way. Now if we live in a country... advanced country as they say... advanced compared to other parts of the world. Health system is developed. Why don’t they address this problem?”

“The same medicine for different problems. And that’s wrong. That thing could harm me or harm him. So that also could lead to mental health. I am very concerned.”

“Definitely. There can cause a lot damage – brain damage, liver...it’s genetic. So they definitely need more control and understanding what they prescribe.”

Part 2

- Summary of Part 1
- Plan for Part 2 of the focus group
- Question 2: What are the barriers stopping individuals from BME background accessing mental health services?
- Question 3: How to overcome these barriers?
- Summary of the focus group

After a 10-minute break the group returned to explore potential barriers a person from a BME background could encounter in accessing mental health services. As the facilitator explained earlier, a stick person was going to be used as a representative of anyone from a BME community.

Question 2 What are the barriers stopping individuals from a BME background accessing mental health services?

The group put forward the following suggestions:

No care	fear
Trust	stigma
Stereotype	why is he unhappy
Lack of information	personal opinions
Language barriers	misunderstanding
Hygiene	GP
Outcast	isolation
Shame	lonely
Proportions	anxiety
Difference	upbringing
Poverty	deprived
Confidence	self esteem
dysfunctional	

Conclusions:

The group actively engaged in this exercise and many suggestions of the barriers preventing BME individuals accessing mental health services were put forward.

The participants made more comments about obstacles such as:

Lack of information, fear, language barriers, shame, stigma, cultural and religious beliefs, very low numbers of staff members from BME communities.

“Of course, there’s a stigma or stereotype of people with mental health.”

“Poverty could be another one....And also deprivation. I mean it’s different when you’re deprived; things that you used to have are taken away from you”.

“And that’s also affects your confidence and self esteem.”

(Staff from BME communities)...“Yeah definitely. It’s like you can open up more. You can talk to this person easily because he’s like you. They’re more likely to understand you and know more about you.”

One of the participants stated that each person from a BME background takes certain responsibility for their own mental well-being.

“It’s your choice. If I’m sad, I feel not well I have to do something about. I go and do different things, meet other people. If I can’t speak the language I make effort I go and learn English.”

Question 3 How to overcome barriers to accessing mental health services by BME individuals?

The facilitator proposed another exercise. It was explained that the group was going to be in charge of building a mental health hospital for people from a BME background. The money was not an issue so all present could put forward any suggestions to offer services that would meet needs of BME groups and to breakdown the barriers identified in the previous exercise.

The group put forward the following suggestions:

Communication	responsible	
Counselling	kind	
Understanding	homeopathic	
Education	publishing	
Help before you become ill	up to date	
Multicultural staff	open minded	
Well paid	suitable	
Regular health	well informed	
Smart	translation service	
Researched	community building	
Sharing information	market	
Our services	all documents on website	
Medication	monitored	carefully
good complaints procedure		
Open grouping	respectful of people's religious beliefs	
Rehabilitation	education	
After care		research into
what drug are prescribed in your country		
Holiday	healthy food	
Get well centre	tests on data base	
Show success		

Conclusions:

The emphasis was put on communicating with BME communities, identifying and responding to their actual needs.

"Well, first of all what we have to do is ask people from these minority groups, from the community. We need to know what they want."

"You need to communicate with them; you need to listen to them, what they want. You should talk to man, women, and children as we will have wards for female, male and children in our hospital."

“They need to find out about different people in order to help them. Like a field work.”

“I think we need to be an organisation within a community. We need to catch problems before they become serious. You have to go out there, visit people at work or children at school, to look at that.”

People were in favour of alternative treatments and talking therapies. Participants were hesitant towards prescribing drugs. However, if used, the group would like to prescribe the most suitable drug for a specific ethnic group, instead of ‘one size for all’.

“We also need like homeopathy, and counselling. And they need to register these counselling sessions so then they can listen to it again and go over it again.”

“Yeah, and all natural. Nature. I love nature and freedom.”

“We also need to be specialising... you know and be reluctant towards any drugs. No drugs, other things instead. We would have like monitoring forms for taking drugs and we would be very careful with them.”

“We need to have different medication for different people and to make sure they’re suitable for them.”

“We also need to do community research. To find out what they want. Like for example with that 1 drug for all.”

“So we would find out what sort of drugs are offered in their countries and cultures. So we would be very careful with prescribing any medication.”

Publicity was considered an important way of challenging stigma and prejudices existing within the communities. Necessity of keeping services up to date was also noted. Also showing success was one of the means of breaking the existing derogatory stereotypes and labels.

“You need to talk to them, teach them”.

“Absolutely, you need to educate people. And put it in media, papers, leaflets, all sorts of information, in clubs, pubs, in the street.”

“Yeah, we need to overcome bad reputation. To get to people and talk about services.”

“We need to put it on the internet. And any other useful information in different language. It would be a way of addressing stigma as well and fighting off, building up our reputation. We need to market our services.”

"I also think we need to be trendier, you know, more catchy and up to date. I would like to see more interesting classes".

"And also cool name. We should have like a cool name."

"And also open to any new suggestions, new treatments, new things..."

"And you should show our success. Showing the ratings, how many people we help."

As for the staff working within mental health institutions and organisations the groups agreed that there should be more professionals representing BME communities. Their work should be valued through adequate salaries. The participants recommended regular mental health checks for the staff as well.

Employing more staff from different BME communities were also seen as a solution to overcoming language barriers.

The group would like to see more documents translated and published in various languages.

"Of course, they have to be multicultural."

"And professionals. From different backgrounds, and very open-minded."

"And give them good salary."

"Well, of course. You have to pay them well. Otherwise, they won't have any interest in the job. They must be happy at work, to help others."

"I personally think that mental health check would be great."

"Why not? If you work with people with mental health problems you should also have a regular checks to see that you're ok. After a while it can hit you too."

"I would say that not translators. We need more staff who can speak their languages. With translators it's more expensive. You would need someone for each case. You need to ring them and wait and if you pay them per hour it become expensive. Staff should come from different background and speak different languages. They need to be there, work there in hospital."

"Sharing information and having like all the documents translated into different languages for all people."

However, the participants noted that learning English was also a responsibility of BME individuals to facilitate communication with health professionals and the outside world.

“But you bring people from here and there. You have Asian, Turkish, Polish, all together in one room. And all the staff can talk to them, in their language. How to talk between them?”

“I agree that patients also have a responsibility of the language. But sometimes, even now, we speak English, we talk about mental health and we can mean two completely different things.”

Cultural and spiritual differences were also addressed during the conversation. Recognition and knowledge of various cultures seemed paramount in engaging with BME service users. BME staff partly considered an answer to this issue.

“And well informed. They should have like information about various cultures and people from different backgrounds. Like books or something on different cultures.”

“They need to find out about different people in order to help them. Like a field work.”

(BME staff members)... “And they already know so much about cultural differences, where you come from and so on.”

“But being respectful of people’s religious beliefs.”

Healthy food was going to be served in the hospital created by the focus group.

“Come on, let’s not get carried away. We can’t give everybody different food. You come from Asia so you’ll get Asian food, or Turkish or Polish or any other food. What we should do is to serve healthy food, you know. Food that our experts, doctors would prescribe. Not food from all over the world. You’re not here to live all your life. You’re here just to get better so you should get healthy food.”

The facilitator concluded Part 2, the focus group and thanked everybody for attending and making contributions.

In addition

One of the participants contacted a note taker the day after the following day. The person felt guilty that she/he did not contribute much to a general discussion.

Therefore, the participant typed up few comments on the three topics explored during the focus group.

Mental health

'From a layman point of view such as myself, I think that mental health should embrace the entire well being of the mind, nourished in every way to develop to its full potential, undisturbed and well functioning. As it was discussed in the group, anyone can go through ill mental health at any time in life and reasons triggering such illness could be numerous for example: depression, high expectation, disappointments, SAD, love, hate, greed, drug abuse, ill treatment by others such as being mistrusted, racially discriminated against getting jobs, services or other opportunities, social isolation and abuse/insults/code names, bullied,...'

Barriers to seeking mental health care for ethnic minorities

- *The fear originated from the knowledge of bad experience by others from same social group*
- *The apparent 2nd thought of the mental health service providers on ethnic minorities who habitually choose to put such groups on drugs and/ locking them up without initial exhaustion of counselling opportunities*
- *Information – anyone from a minority ethnic group should be well informed about his/her rights to getting timely and the same pre-drug counselling services to the natives. Having said this, I am afraid that in most cases mentally ill individuals from the ethnic minority get the services after it is too late, either the patients themselves didn't timely approach the services or that they have been on waiting list for long and that their conditions gotten worse/violent/dangerous, in which case, the service providers have no choice but put him on drugs/lock them up. Difficult whom to blame here but I want to add that the ethnic minorities should be well informed and that they need to seek the services early enough to avoid the prejudices as well as excuses for a bad treatment by service providers.*

The ideal mental health services hospital

- *At the start, there should exist a policy guideline that clearly defines the right of every citizen, native or immigrant, with mental health problem, to get non-discriminatory and medically approved mental health problem services as early as possible for their ill mental health. This policy should be translated in as many languages as the number of ethnic minorities and be accessible on a website.*
- *The website should also be educative by giving clear definition of a mental health and why and when should an individual seek mental health care.*

- *Timeliness and appropriateness of treatment should be strictly monitored.*
- *Waiting time should be eliminated as a mental ill person's condition could deteriorate/go dangerous and will unnecessarily fall into undesired treatment such as drugs & locking up.*
- *Suitability of medication/drugs for ethnic minorities should be researched, this is necessary because the one fits all drug prescription system at present is less effective – perhaps seeking sharing information with medical professionals of the mental health care from the ethnic minorities origin could help.*

Summary/Recommendations (Focus Group)

The group found it difficult to capture a sound definition of mental health. The participants remained dubious about the quality of mental health services in this country as, in their opinion, mental health institutions are more interested in sectioning patients for the sake of funding and meeting targets rather than improving people's well-being through the alternative means.

The group expressed a concern about prescribing one drug for all minorities in this country. As discussed, one-size-for-all medication could have dangerous side effects on the non-White British. The government should invest in more research into suitable drugs for various ethnic minorities.

In fact the participants would like to see more alternative treatments such as alternative therapies, counselling and talking therapies.

The groups identified that language barriers could create problems in offering this service to various ethnic groups. Recognising different cultural and spiritual beliefs was also an important factor and should shape mental health services offered to the community. Employing more staff from a BME background could be a solution as well as encouragement for many people from these communities to seek help.

There is a need to publicise mental health services more, especially in various languages. The internet could play a vital role in raising more awareness within the community as well as ensuring anonymous wide range of services available to all.

7. DISCUSSION

7.1 Availability of mental health services for BME communities

26 service providers returned their questionnaires, the majority of these were returned by voluntary sector organisations followed by statutory organisations. The most popular services provided included: advice and guidance, signposting, talking therapies and support group activities. 35% of respondents provided specific services for the BME community including translation services, alternative language links on websites, faith / spiritual consideration and dietary needs and 53% did not.

There were several reasons why more than half of respondents did not provide specific services to members of the BME community including: it had not been an issue, low numbers of BME communities in Cornwall, lack of resources and lack of funding. However, more than half of respondents agreed that there was a defined Black and minority ethnic community in Cornwall.

Not all respondent organisations monitored their number of users from the BME community. 61% did monitor this and the majority of them used registration/records and referrals. Over a quarter of respondents stated that they had no users from a BME background accessing their services.

The service providers' questionnaire also identified that language barriers and cultural beliefs might have stopped individuals from a BME background accessing their services. The lack of finance and resources and lack of awareness of BME problems and needs were the major barriers for their organisations to face when trying to improve services for individuals from a BME background. Some respondents believed that in order to improve access to services for BME communities/individuals, they need to improve information and awareness of services and needs of community, training and interpreters and language services for BME individuals.

7.2 Lack of BME communities in Cornwall

There were less than 3% of BME individuals living in Cornwall according to the 2001 census. Although there has been an increase in migrant workers especially Eastern Europeans moving to Cornwall, all ethnic minority groups in Cornwall still only account for a smaller share of the total population than England as a whole.

The questionnaire survey indicated that 57% of service providers did not provide specific services to members of the BME community, this mainly was due to low numbers of BME individuals in Cornwall. The 2001 census showed that less than 3% of Cornwall's population was not white British. However, more than half of service providers recognised that there was a defined BME community in Cornwall whereas only 4% said no and 35% said they did not know.

Service providers recognised that there were several different communities living in Cornwall including Eastern European, Chinese and the Travelling community. 69% of respondents stated that between 1-5% of their users were from a BME background.

7.3 No clear understanding of what mental health is

It was quite difficult for the 31 BME participants (face-to-face interviews) to answer what were the possible symptoms of mental health. The most popular symptoms that participants thought may be a symptom of a mental health problem were hearing voices, flashbacks, anxiety, not wanting to go out and see other people, sleeping problems, crying, mood swings, constant homesickness, nightmares and headaches.

The focus group session asked participants to write down three words associated with mental health. The group had expressed great difficulty in capturing the concept of mental health. No firm definition was put forward. Some participants did not speak or write anything down. The group all agreed that mental health is a difficult subject. There was a wide spectrum of responses ranging from a positive mental well-being to negative descriptions and symptoms of mental illness.

7.4 POTENTIAL BARRIERS

The following points are potential barriers that were identified for BME communities accessing mental services:

7.4.1 Language barriers

The researchers identified language as one of the major barriers for accessing mental health information and services. Out of 31 face-to-face interviews with BME individuals, 11 of them were conducted in Polish due to those participants not being able to speak English. Also there were 7 people who would have liked to have participated in the focus group but felt that their English was not good enough to do so and they decided not to take part.

Of the 31 participants, 74% of them stated that English was not their first language although 58% considered themselves to be fluent speakers of English and 15 (48%) in written English. 8 participants (26%) had lived in Cornwall over 11 years, 12 (39%) between 1 to 5 years, (5) 16% between 6 to 12 months, 3 (9.5%) between 6 to 10 years and 3 (9.5%) less than 6 months. The majority of them (90%) lived in Penwith, Cornwall.

40% of respondents in the face-to-face interviews said that language barriers would stop them accessing services and 80% believed that it would stop other people from BME backgrounds accessing services.

When a respondent was asked what help was most effective for mental health he/she replied *"counselling but only if I could speak English very well"*. Other respondents highlighted how much of a problem language barriers were by saying:

- *"If you can't speak the language you can't go and ask for anything. They can't help".*
- *"It's difficult to explain your symptoms if you don't know the language very well."*

The service providers questionnaire also identified that language barriers might have stopped individuals from a BME background accessing their services.

Service Providers were asked whether they provide any specific services for members of the BME community. 23% stated that they offer either translation services, interpreters, or have links in other languages on their website.

This part of the research highlights the need for translation services.

7.4.2 Cultural beliefs

The focus group highlighted the importance of cultural beliefs. The group believed that recognising and having a knowledge about different cultures was essential for engaging with service users. BME staff partly considered an answer to this issue.

The importance of cultural beliefs was shown during the interviews with BME individuals because 60% of respondents believed that cultural beliefs may stop a member of the BME community accessing mental health services in Cornwall. 15% of service providers in the survey believed that cultural reasons may stop people from BME backgrounds accessing their service. A Polish participant commented that being brought up in Poland, they did not have a GP as a doctor who sees a person for anything. So therefore they may not understand the culture in the UK.

Cultural and spiritual differences were also identified as the barriers for accessing mental health services in the focus group. The focus group felt that recognition and knowledge of various cultures seemed paramount in engaging with BME service users. It was suggested in the focus group that BME staff should have awareness and information on *various cultures and people from different background in order that they know how to help them* .

26% strongly agreed and 58% agreed in the face-to-face interviews that mental health services need to take into account people's cultural background.

7.4.3 Lack of information

The respondents did not believe that mental health services are well publicised and very few respondents had heard of the services they were shown during the interview. Only 10% of respondents who were interviewed believed that mental health services are well publicised, 55% thought they were not and 35% did not know. The most well-known service was the NHS mental health service (61%) followed by mental health community development workers (29%), Mind (29%), Pentreath (19%), Rethink (13%) and NIHME (10%). 63% of respondents felt that not knowing where to go would stop people from BME backgrounds accessing mental health services.

According to the questionnaire survey for service providers, the most popular methods for publishing their services were leaflets, signposting through other agencies, GP surgeries and websites. Due to the language barriers as identified in section 7.4.1, most BME individuals may not understand the information. The focus group would like to see more documents translated and published in various languages in order to overcome the language barriers.

87% of the respondents had not heard of the Delivering Race Equality in Mental Health document, 81% had not heard of David Bennett and only 32% were aware that the

government was making changes to improve mental health services for people from BME backgrounds.

The focus group identified that publicity was considered an important way of challenging stigma and prejudices existing within the communities. Necessity of keeping services up to date was also noted. Also showing success was one of the means of breaking the existing derogatory stereotypes and labels.

7.4.4 Fear, shame and stigma

58% strongly disagreed and 29% disagreed that people with mental health problems should always be locked up.

70% of respondents said that fear of being deported may stop other people from BME backgrounds accessing mental health services, and 50% of respondents said fear of being locked up would stop other people accessing mental health services. The following quote is from a respondent describing her friends experience in hospital *“she felt really ill, so her sister took her to a doctor and then locked her in hospital. She was Thai and after she came out she’s scared. She doesn’t want to see a doctor. She doesn’t want to be locked up again.”*

- *The fear originated from the knowledge of bad experience by others from same social group*

7.4.5 Lack of BME staff in mental health services

Very low numbers of staff members from BME communities in mental health services were seen as a potential barrier for individuals from a BME background accessing services. The focus group agreed that mental health organisations should employ more professionals representing the BME community. Employing more staff from the BME community could help overcome language barriers. Comments included:

- *“It’s like you can open up more. You can talk to this person easily because he’s like you”*
- *“Staff should come from different backgrounds and speak different languages”.*

11% of the respondents in the questionnaire survey for service providers stated that lack of BME staff might prevent BME individuals accessing services. One service provider suggested that access to services could be improved by *“Recruitment of staff from BME backgrounds”*.

7.4.6 Service providers unaware of BME needs

The focus group identified that communication is the key element of identifying and responding to the actual needs of BME communities. This could be achieved by field work or visiting people in the community. Comments from the focus group included:

- *“Well, first of all what we have to do is ask people from these minority groups, from the community. We need to know what they want.”*
- *“I think we need to be an organisation within a community. We need to catch problems before they become serious. You have to go out there, visit people at work or children at school, to look at that.”*

7.5 Service gaps identified

The focus group highlighted some gaps in services. Firstly, participants would like to see more alternative treatments in services, such as alternative therapies, more talking therapies, and more counselling offered. Participants were also concerned about the way one drug is prescribed for all minorities, so therefore participants would like to see the government invest money into research about suitable drugs for various ethnic minorities.

The analysis from the interviews and the focus group has shown that members of the BME community are concerned about the problem of language barriers in services. If a person cannot speak English it makes it harder to access the service unless there is good access to interpreters. Participants suggested that employing more BME staff who could speak different languages or using more interpreters could be away of filling this service gap.

During the interviews some participants described how the health care system was different in their country. For example, in Poland you do not have a GP because you go straight to a specialist who deals with your particular problem. Another respondent said that in Turkey you would go to see a specialist for mental health as your first point of contact rather than a GP, but you used to need an insurance claim or be claiming benefits to receive this help. The respondent suggested that this may have improved since they moved to the UK. From what we have heard from the interviews, In Poland and Turkey you would need to be aware that you had a mental health problem because your first point of contact would be a mental health specialist, where as in the UK people could go to the GP for any health problems. In some cases you may not know you have a mental health problem which a GP may be able to pick up on. However, 13% of the 31 participants in the face-to-face interviews were not registered with a GP, so would therefore not be able to access mental health services if they needed to.

7.6 Team member outcomes

The four team members completed and obtained the University Certificate in Community Research and Mental Health which is worth 30 credits. The certificates involved producing a 1000 word portfolio on community based research, a 500-word reflection exercise and a 1500 word portfolio on mental health policies and practices. As well as the certificates, the team attended a 4-day training session on mental health and a 3-day session on research.

All of the team members participated in conducting the research including conducting face to face interviews, taking notes at interviews, and two of the team facilitated the focus group which is something they had not previously experienced.

The team were invited to attend the Local Implementation Team/Mental Health Advisory Group to give a presentation on the project. This group is made up of Voluntary and Community Sector organisations, GPs, Cornwall Partnership Trust and the PCT. The group were very supportive of the project. This was a good opportunity for the team to promote the work they were doing to mental health service providers.

9. RECOMMENDATIONS

The following recommendations were suggested and to be implemented within the next 18 months. These recommendations will be able to contribute to the key aims of the Delivering Race Equality in Mental Health Care Five Year Action Plan, which is part of wider programmes on inequalities and social exclusion within the Department of Health and across government.

- Service providers should improve their knowledge about the local population. Service providers should not assume that if they have no BME clients then there is no need for services to reflect BME individuals needs. Cornwall, like most rural parts of the UK, does not have a large BME community population. However, BME individuals do exist in this area, therefore services should be available in order to meet BME users' needs. This knowledge can be improved by greater community engagement from service providers through forums and focus groups in the local community. Also all staff working in mental health services including GPs, health professionals and front line staff should undertake Diversity Training as compulsory and induction training.
- Service providers should improve their understanding of other countries' health care systems. The research highlighted that some respondents from the BME community did not understand that in the UK you see a GP as your first point of contact, who will then refer you if appropriate. Therefore, the NHS should work with other BME organisations to provide better information in appropriate languages for other BME groups in order to enable them to understand the health care system in the UK and know where to get help if they have a mental health problem.
- Produce a mental health website including information about what is mental health and all the services that are available. This website should have the option to translate the information into a number of different languages. This would be achieved by putting the national flags of different countries on the homepage so that when a person clicks on a particular flag the information would be translated into that language. This website could be produced and updated on a regular basis by the NHS and linked with other mental health service providers' websites.
- The way mental health services are publicised needs to be improved, because a significant proportion of members of the BME community who were interviewed had not heard of that many mental health services nor believed that they were well publicised. Improvements could be made by producing leaflets and other promotional material in different languages.

- More alternative treatments and services available such as supporting networks for friends and family, counselling, advice and guidance, talking and alternative therapies
- Further research on migrant workers and mental health. The largest BME group that was interviewed were from the Polish community. Polish people and many other people from Eastern European countries are one of the highest BME populations in the county. It would be very useful to find out more about what the needs are of these communities.

REFERENCES

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West Cornwall Profile, Baseline Report, the Amethyst on behalf of West Cornwall Together, March 2006

Commission for Rural Communities, Tackling Rural Disadvantage, A8 Migrant Workers in Rural Areas Briefing Paper, January 2007

APPENDICES

Appendix 1: Service provider questionnaire

Questionnaire for service providers

Thank you for taking the time to answer the following questions, your help is greatly appreciated. Please return this questionnaire to Penwith Community Development Trust in the enclosed pre-paid envelope by Friday **the 24th November 2006**.

1) Name of organisation

2) Job title

3) Address

.....

.....

4) Telephone No

5) What type of organisation do you work for?

Community group

Statutory

Voluntary Sector

Other (please specify)

.....

6) What services does your organisation provide for people in respect to mental health? (Please tick boxes)

Advice and guidance

Befriending

Complementary therapies

Medication

Mentoring

Signposting

Support group activities

Support to carers

Talking therapies

Other (please specify)

.....

None of the above

**7) How does your organisation publicise its services relating to mental health?
(Please tick all that apply)**

- GP Surgeries
 - Leaflets
 - Magazines
 - Network events
 - Roadshows
 - Signposting through other agencies
 - Websites
 - Other (please specify)
-

8) How do people access your mental health services? (Please tick all that apply)

- Agency referral
 - Drop in
 - GP
 - Referred by friends or family
 - Self referral
 - Other (please specify)
-

9) Have you ever heard of the Delivering Race Equality in Mental Health document?

- Yes
- No

10) In your opinion do you consider that there are defined black & minority ethnic communities (BME)⁴ in Cornwall?

- Yes
- No
- Don't know

If yes please list the communities you are aware of?

11) Do you monitor whether members of the BME community are accessing your services?

- Yes

⁴ “. . . is used to refer to all people of minority ethnic status in England. It does not only refer to skin colour but to people of all groups who may experience discrimination and disadvantage, such as those of Irish origin, those of Mediterranean origin and East European migrants” DELIVERING RACE EQUALITY IN MENTAL HEALTH CARE (2005). The Department of Health

No
Don't know

a) If yes, how do you do this?

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

b) What percentage of your users are from a BME background? Please estimate if you do not have statistics.

0%
1% - 5%
6% - 10%
11% - 20%
21% - 50%
51% +

12) Does your organisation provide any specific services for members of the black and minority ethnic community / BME individuals? (Please tick)

Yes
No
Don't know

(a) If yes please specify

.....

.....

.....

(b) If no, is it for any of the following reasons

Lack of funding
Lack of resources
Low numbers
Has not been an issue
Other (please specify)

.....

13) How do you ensure there is equal access to services for the black and minority ethnic communities / BME Individuals?

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

14) Within your organisation is there a designated staff member responsible for race equality: (Please tick)

Yes
 No
 Don't know

**15) Does your organisation provide any of the following training to your staff?
 Are any of them compulsory? (Please tick boxes)**

	Training provided	Compulsory training for staff	Don't know
Community development	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diversity training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Equal opportunities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Racial Equality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Training in BME issues and concerns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did this include mental health			
Yes <input type="checkbox"/> No <input type="checkbox"/>			



16) In your experience are there any particular factors or circumstances that need to be considered by your organisation when engaging with individuals from a black and ethnic minority background?

.....

17) What do you think might stop individuals from a BME background accessing your services?

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

18) What barriers, if any, does your organisation face when trying to improve services for individuals from a BME background?

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

19) How do you feel access to services could be improved for BME communities / individuals?

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



20) If you had a wish list what 3 things would you like to change about the way your organisation delivers mental health services to BME individuals?

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

21) We value your contribution and invite you to add any further comments and/or questions you would have liked to have been included in this questionnaire.

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



Penwith Community Development Trust

The Penwith Centre Parade Street Penzance Cornwall TR18 4BU

Section 1

I am going to ask you a set of questions which are core questions from the UClan. Remember that you do not have to answer any question that you do not feel comfortable with.

1) How old are you?

15 or under	<input type="checkbox"/>
16 – 18	<input type="checkbox"/>
19 – 21	<input type="checkbox"/>
22 – 24	<input type="checkbox"/>
25 – 29	<input type="checkbox"/>
30 – 39	<input type="checkbox"/>
40 – 49	<input type="checkbox"/>
50 +	<input type="checkbox"/>

2) What is your Gender?

Male	<input type="checkbox"/>
Female	<input type="checkbox"/>
Transgendered or transexual	<input type="checkbox"/>

3) What is your ethnicity:

Mixed

White and Black Caribbean	<input type="checkbox"/>
White and Black African	<input type="checkbox"/>
White and Asian	<input type="checkbox"/>
Other (please explain)	<input type="checkbox"/>
.....	

Asian or Asian British

Indian	<input type="checkbox"/>
Pakistani	<input type="checkbox"/>
Bangladeshi	<input type="checkbox"/>
Other (please explain)	<input type="checkbox"/>
.....	

Black or Black British Caribbean
 African Other
 (please explain)

Chinese or Other Group Chinese
 Other (please explain)

Gypsy Gypsy
 Other (please explain)

Traveller Irish Traveller
 Other (please explain)

White British
 Irish
 Other (please explain)

4) Were you born in the UK? Yes
 No

If no, how long have you lived here:

Less than 6 months
 6 months -12 months
 1 – 5 years
 6 – 10 years
 11 years or more

5) Would you describe yourself as a:

British Citizen
 Refugee
 Asylum Seeker
Other (please explain)

6) What is your first language?

Spoken:

Written:

7) Which languages are you fluent in?

Spoken:

Written:

8) What would you describe as your religion, if any :

- Buddhist
- Christianity
- Hindu
- Jewish
- Muslim
- None
- Sikh
- Other (please explain)
-

9) What would you describe as your sexuality:

- Lesbian or gay woman
- Homosexual or gay man
- Heterosexual
- Bisexual
- Do not wish to answer
- Other (please explain)
-

10) Would you describe yourself as having a disability?

- Yes (please explain)
-
- No

11) How long have you lived in Cornwall?

- Less than 6 months
- 6 months -12 months
- 1 – 5 years
- 6 – 10 years

11 years or more

.....

12) What part of Cornwall do you live in?

Caradon

Carrick

Kerrier

North Cornwall

Penwith

Restormel

Section 2

13) Are you registered with a GP?

Yes

No

If no, are there any particular reasons for this?

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

14) If you were unwell what would be your first point of contact?

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

15) Have you experienced any difficulties in registering with or contacting your GP?

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

16) What do you think about the standard of Cornwall's mental health services?

Good

Satisfactory

Poor

Have not experienced

17) Have you ever suffered from depression?

Yes

No

18) What did you do?

.....
.....

Section 3

I am going to read you a list of possible mental health symptoms followed by a number of questions for each symptom. (Card 1)

19) would you consider X to be a possible mental health issue?

Would you seek help or advice if you were experiencing X

If yes, which ones and who would you consult?

If no, what would be the reason for not seeking help?

If yes how long would you wait until you went for help?

20) (Card 1) What sort of help do you think you would prefer for X ?

- 1) Anxiety
- 2) Constant homesickness
- 3) Crying
- 4) Flashbacks
- 5) Headaches
- 6) Hearing voices
- 7) Mood Swings
- 8) Nightmares
- 9) Not wanting to go out /
See other people
- 10) Sleeping problems

- 1) Advice and guidance
- 2) Community support
- 3) Complementary therapies
- 4) Counselling
- 5) Hospitalisation
- 6) Medication
- 7) Mentoring
- 8) No help required
- 9) Social Services
- 10) Spiritual guidance

- 11) Support group activities
- 12) Support of friends and family
- 13) Talking therapy
- 14) None of the above
- 15) Other (please specify)

Section 4

Please look at the card of the list of mental health services. I am going to ask you if you, your family or any one you know has used any of them? Please just state yes or no for each one. You will be able to make comments after I have read them all out.

21) Have you or any of your family or people you know ever used or experienced any of the following for a mental health condition?

	You	In Cornwall	Family	In Cornwall	Other people you know	In Cornwall
Advice and guidance						
Community Support						
Counselling						
Complementary therapies						
Medication						
Mentoring						
Hospitalisation						
No help required						
Social Services						
Spiritual guidance						
Support group activities						
Support of friends and family						
Talking therapy						
None of the above						
Other (Please specify)						

.....

b) In your opinion which have been most effective?

.....
.....

22) Are there any mental health services you may have heard of or used?

23) Which of the following services have you heard of or used? (Card 2)

	Heard of	Used
Mental Health Community Development workers		
Mind		
NHS mental health services		
NIHME		
Pentreath		
Rethink		
Other		

Section 5

I am now going to ask you a series of questions that involve a yes / no answer

24) Have you ever heard of the Delivering Race Equality in Mental health document?

Yes

No

25) Have you ever heard of David Bennett, who was a young black man who died in a psychiatric hospital in 1998?

Yes

No

26) Are you aware that the government is making changes to improve mental health services for people from BME backgrounds?

Yes

No

Section 6

27) Evidence suggests that people from BME backgrounds are less likely to access services than white British.

What do you think would stop you and other people from BME backgrounds accessing mental health services in Cornwall? (Card 3)

	You	Other People
Cultural beliefs	<input type="checkbox"/>	<input type="checkbox"/>
Embarrassment	<input type="checkbox"/>	<input type="checkbox"/>
Fear of being deported	<input type="checkbox"/>	<input type="checkbox"/>
Fear of being locked up	<input type="checkbox"/>	<input type="checkbox"/>
Lack of appropriate services	<input type="checkbox"/>	<input type="checkbox"/>
Lack of Time	<input type="checkbox"/>	<input type="checkbox"/>
Don't know where to go	<input type="checkbox"/>	<input type="checkbox"/>
Language barriers	<input type="checkbox"/>	<input type="checkbox"/>
Poor quality of services	<input type="checkbox"/>	<input type="checkbox"/>
Shame	<input type="checkbox"/>	<input type="checkbox"/>
Spiritual beliefs	<input type="checkbox"/>	<input type="checkbox"/>
Transport / Travel cost	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify)	<input type="checkbox"/>	<input type="checkbox"/>
.....		

28) If you thought you were suffering from a mental health problem would you tell anyone?

- Yes
- No
- Don't know

29) If yes who would you tell?

- Family
- Friends
- Spiritual leader

- GP
- Other (please specify)

.....

30) What would be the reason for not telling anyone?

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

31) If you wanted to find out about mental health services where would you go?

- GP
- Websites
- Family
- Friends
- Other (please specify)

.....

32) Do you think mental health services are well publicised?

- Yes
- No
- Don't know

a) Why do you think that?

.....
.....

Section 7

(Card 4) I am now going to read you a series of 8 statements. For each one I would like you to say whether you:

- | | |
|---------------------------|--------------------------|
| Strongly agree | <input type="checkbox"/> |
| Agree | <input type="checkbox"/> |
| Neither agree or disagree | <input type="checkbox"/> |
| Disagree | <input type="checkbox"/> |
| Strongly Disagree | <input type="checkbox"/> |

You will be able to comment after I have read all of the statements

33) People who have a mental health problem should always be given medication?

34) Mental Health services in this country treat everybody equally?

35) Mental health is a sign of weakness?

36) People with Mental health problems should always be locked up?

37) Mental Health services need to take into account people's cultural background?

38) Mental Health problems should be kept a secret?

39) People with mental health problems are dangerous?

40) Most people make a full recovery from a mental health problem?

Comments

Section 8

41) As we are conducting research about members of the BME community, in your opinion which of the following may affect the mental health of a person from a BME background? (Card 5)

- Cultural Isolation
- Lack of employment opportunities
- Financial hardship
- Housing difficulties
- Language Barriers
- Discrimination
- Social Isolation
- Verbal abuse
- Racism
- Fear of violence
- Loneliness
- Other (please specify)
-

42) We realise this can be a sensitive and emotional subject – has anything come up for you during the interview?

FOCUS GROUP EXPLANATION

43) Would you like to take part in a focus group session which will provide you the opportunity to explore in greater detail the experiences of members of the BME community's access to mental health services?

Yes

No

If yes, please fill in your contact details on the sheet provided?

Thank you for completing the questionnaire. How did you find this questionnaire?

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

APPENDIX 3



Penwith Community Development Trust

The Penwith Centre Parade Street Penzance Cornwall TR18 4BU

BME Mental Health Research Project
Interview Information sheet

The BME Mental Health Research Project sets out to *“Investigate the potential barriers to accessing mental health services within the Black and minority ethnic community in Cornwall”*. The BME community will include people from Eastern European and Mediterranean countries.

This 9-month project aims to encourage community involvement and participation by empowering local individuals including people from the BME community, to participate in the research work. We wish to address the key issue of rurality and isolation which will contribute to the Government’s overarching strategies for tackling inequalities and social exclusion. The results of this research project will also contribute to the following three key aims of the ‘Delivering Race Equality in Mental Health Care Five Year Action Plan’, which is part of wider programmes on inequalities and social exclusion within the Department of Health and across government:

- Equality of Access
- Equality of Experience
- Equality of Outcomes

This is an opportunity to share your experiences and to make real changes. Your participation is voluntary. All information provided by you is strictly anonymous and confidential and will not be used for any other purposes. The information you provide during the interview will be recorded by a note taker and a tape recorder and it will remain confidential. The information that is recorded during the interview will remain confidential.

The information that is recorded on tape will be locked away in a secure cabinet in the Penwith Centre and all tapes will be destroyed when the project is complete at the end of March 2007. If you decide to participate, you can stop the interview at any time. Also you do not have to answer any questions if you do not want to. If you do not want the interview recorded on tape you must inform the researcher.

Collected information will be analysed and presented in the final report in such a way to ensure that it is not possible to attribute any particular response to any specific individual. The names of participants will not be revealed to anyone outside of the research team.

Your confidentiality will be maintained. We will not pass any information on to anyone else unless you say something that suggests that either you or someone else is at risk of serious harm, including child abuse.

If you would like a copy of the final report please contact Penwith Community Development Trust in March 2007.

Your understanding of the terms and conditions and your consent are preliminary to the proceeding with the interview.



Penwith Community Development Trust

The Penwith Centre Parade Street Penzance Cornwall TR18 4BU

BME Mental Health Research Project
Focus Group Information sheet

The BME Mental Health Research Project sets out to *“Investigate the potential barriers to accessing mental health services within the Black and minority ethnic community in Cornwall”*. The BME community will include people from Eastern European and Mediterranean countries.

This 9-month project aims to encourage community involvement and participation by empowering local individuals including people from the BME community, to participate in the research work. We wish to address the key issue of rurality and isolation which will contribute to the Government’s overarching strategies for tackling inequalities and social exclusion. The results of this research project will also contribute to the following three key aims of the ‘Delivering Race Equality in Mental Health Care Five Year Action Plan’, which is part of wider programmes on inequalities and social exclusion within the Department of Health and across government:

- Equality of Access
- Equality of Experience
- Equality of Outcomes

This is an opportunity to share your experiences and to make real changes. Your participation is voluntary. All information provided by you is strictly anonymous and confidential and will not be used for any other purposes. The information you provide during the focus group will be recorded by a note taker and a tape recorder and it will remain confidential. The information that is recorded on tape will be locked away in a secure cabinet in the Penwith Centre and all tapes will be destroyed when the project is complete at the end of March 2007. However we cannot guarantee that other participants taking part will not share any of the information, so therefore you should not reveal anything that you do not want disclosed outside of this group during the session. If you do not want the focus group recorded on tape you must inform the researcher.

If you decide to participate, you can leave the focus group at any time. Also you do not have to answer any questions if you do not want to.

Collected information will be analysed and presented in the final report in such a way to ensure that it is not possible to attribute any particular response to any specific individual. The names of participants will not be revealed to anyone outside of the research team.

Your confidentiality will be maintained. We will not pass any information on to anyone else unless you say something that suggests that either you or someone else is at risk of serious harm, including child abuse.

If you would like a copy of the final report please contact Penwith Community Development Trust in March 2007.

Your understanding of the terms and conditions and your consent are preliminary to the proceeding with the interview.



Penwith Community Development Trust

The Penwith Centre Parade Street Penzance Cornwall TR18 4BU

BME Mental Health Research Project

Section 1.

Name of Group	Penwith Community Development Trust
Address	Penwith Centre The Penwith Centre Parade Street Penzance Cornwall TR18 4BU
Name of Support Worker	Joanna Hicks
Date	18 September 2006

Section 2.

What kind of work does the group intend to do as part of this project?

The group intends to conduct a piece of community research to investigate potential barriers to accessing mental health services within the Black and minority ethnic community in Cornwall. The work is being formulated with close reference to the 2005 DH Delivering Race Equality in Mental Health action plan.

How do they intend to do this?

Self-completion questionnaires – the research team plans to send out questionnaires to service providers in order to find out what services are available at a local level for the BME community and their awareness and understanding of cultural differences and language barriers of the BME community living in Cornwall. The researchers anticipate to post out questionnaires to approximately 100 service providers.

Interviews - the group also intends to conduct face to face interviews to find out how members of BME communities feel about mental health services and whether or not there are any barriers that would prevent them from using these services. They are also going to look at what, if any, is the need for mental health services amongst the BME community and their experiences of services. The group aim to conduct 40 - 60 one to one in-depth interviews with members of the BME community. These shall be conducted with two researchers and one respondent, one researcher to ask questions, the other to make notes.

Focus group - after the interviews have taken place the team are planning to run a focus group session. This will be achieved by using some of the respondents who have participated in the interviews. Participants will be asked a question during the interview regarding whether they would like to take in a focus group, and names and contact details collected separately from the interview notes/questionnaires in order to preserve anonymity.

Who will the respondents be?

Self-completion questionnaires – Organisations that offer mental health services will be sent a questionnaire for self completion. Organisations that will be sent a questionnaire are currently listed in the Cornwall mental health directory 2006/7.

Interviews - Individuals aged 25+ from a BME background living in Cornwall. The target is to conduct between 40 - 60 face to face interviews. The respondents will be recruited from existing networks including: the Penwith Volunteer Bureau, the team's own network of contacts, which includes access to the Polish community via one of the team members, and through partner organisations. All of the respondents will be invited to come to the Penwith centre for an interview.

Focus Group – The research team aim to invite some of the respondents from the interviews back to the Penwith Centre for a focus group. They will be asked to fill in their names and contact details on a separate sheet.

Who will they get to do the work?

A team of 5 volunteers has been recruited from the local community (3 volunteers from a BME background).

Where they will undertake the work?

Questionnaires – The questionnaires will be sent to organisations that are based all over Cornwall.

Interviews and Focus group - All of the work will be conducted in the Penwith Centre, where the PCDT offices are. For more information on the Centre's building, please see the section below on risk assessment.

How will those who are doing the work be supported and supervised?

A group of volunteers have been recruited and a team leader / researcher have been employed 2 days per week to support the volunteers. Regular team meetings are held with volunteers and team members in order to support the project team to conduct the research work. All volunteers / team members will attend all the training workshops provided by the University.

The UCLan Support Worker visits the project on a fortnightly basis. In between visits, she is available by phone and email.

A steering group, which consists of the representatives from the primary care trusts, mental health services and diversity leads, has been set up and meets monthly in order to support the project team. The UClan Support Worker also attends these meetings.

How will they ensure that participants in the project have given consent? You should have an information sheet about the project which is read out and given to potential participants which explains to them (a) what the project is about; (b) that participation is voluntary; (c) what will happen to the information they provide; (d) that they can stop the interview at any time and (e) that they do not have to answer any questions that they do not want to.

An information sheet about the project has been produced. The interviewer will read this to potential respondents before they begin completing the questionnaire. Respondents will be asked whether they are happy to proceed with the interview based on the information that they have been given. The same will apply at the start of the focus group.

A covering letter and information sheet will be sent out with the questionnaires to service providers, so that they can read it and decide if they wish to participate.

Please enclose the information sheet and confirm that it addresses issues (a), (b), (c), (d) and (e) above.

Information sheet enclosed:

- √ Issue (a) covered
- √ Issue (b) covered
- √ Issue (c) covered
- √ Issue (d) covered
- √ Issue (e) covered

How will the project ensure confidentiality?

Interviews - names will not be recorded on the questionnaires. Interviews will be conducted in private rooms within the Penwith Centre. Completed questionnaires will be stored in a locked filing cabinet in an office within the centre. Only staff working on the project will have access to them.

Data from the questionnaires will be analysed and presented in the final report (and any interim reports) in such a way to ensure that it is not possible to attribute any particular response to any specific individual.

The names of participants / respondents will not be revealed to anyone outside of the research team.

If participants would like a copy of the final report they will be asked to contact Penwith Community Development Trust in March 2007.

Focus Group - The participants who take part in the focus group will be asked not to repeat anything outside of the group. However, it cannot be guaranteed that people won't talk about what was said when they are outside of the group. The participants in the focus group will be told that confidentiality cannot be guaranteed so they should not reveal anything that they would not wish to be disclosed outside of the group.

Questionnaires – completed questionnaires will be locked away in a filing cabinet within the Penwith centre and only staff working on the project will have access to them.

How will data generated by the project be handled and stored?

Completed questionnaires and notes from interviews and the focus group will be locked in a filing cabinet in an office within the Penwith centre. Only staff working on the project will have access to them. All interview and focus group notes / questionnaires will be destroyed by shredding once the final report has been written and accepted.

What risks are there? How will risks be identified and managed?

Self-completion Questionnaires

When we send out the questionnaires to service providers we must make it clear in a covering letter the intentions of this research project and although organisations are providing information about themselves, the data they provide will be confidential and it will be locked up in the Penwith Centre. We must also make it clear that the information they provide will not be passed on to other organisations including the local media and the findings will only be used in our final report.

Our team has discussed the fact that self-completion questionnaires can sometimes lead to a low response rate. If this is the case we can do follow up phone calls to improve responses. Despite this concern, self-completion questionnaires are the best method for this part of the research because of the geography of Cornwall and the fact that we are a small team, which puts limitations on the amount of travelling we can do.

Interviews

Managing anger/ violence/ distress within the Centre from respondents – if a participant becomes agitated during an interview due to the nature of the sensitive discussions the researchers have been instructed not to try to continue an interview. The interviews will be conducted by at least two researchers who should have received training in interview techniques – including body language and non-verbal communication.

Managing disclosure of criminal activity – Your confidentiality will be maintained. We will not pass any information on to anyone else unless you say something that suggests that either you or someone else is at risk of serious harm, including child abuse. This will be explained to respondents at the beginning of the interview as part of the information sheet that is read out to obtain consent.

Venue safety - The interviews will be conducted in the Penwith Centre. The Penwith Centre is a fairly large building, which has several voluntary and community sector projects based there. The building is a busy office environment, but has several private meeting rooms. This means that both the researchers and participants won't feel isolated due to people coming and going in the building, but participants will also feel comfortable to talk in private in the meeting rooms.

Raising mental health issues - After every interview has finished we will provide each participant with some information about mental health services in the area. This is in case the interview has raised issues that concern the respondent. It is hoped that this information may help them by signposting them to appropriate services.

Focus Group

Risks are as above, but in addition the team members who conduct the focus group session must make it clear that they will not pass on any of the information that comes out of the focus group, but they cannot guarantee that another respondent will not pass on any information outside of the group.

Please confirm the make up of the steering group

The steering group is made up of the project Co-ordinator, the UCLan project Support Worker, the chair of CPT Mental Health Trust, Public Health Scientist of Central Cornwall PCT, the Chair of Council Racial Equality in Cornwall, Equality & Diversity Advisor of Central PCT, General Manager of the Pentreath Ltd, Social Inclusion Officer of Cornwall Rural Community Council, Mental Health Commissioner at Central PCT and Race Consultant.

How often does the Steering Group meet?

Every 4-6 weeks.

Is the Steering Group clear that it has a responsibility for helping to manage the ethical issues that may arise as a result of running this project?

Yes.

APPENDIX 6

Table 1 Age Structure in Cornwall (2001 Census)

Total Population	501267	
		%
0-4	26168	5.22
5-7	16657	3.32
8-9	12142	2.42
10-14	31571	6.3
15	6068	1.21
16-17	12387	2.47
18-19	10281	2.05
20-24	22410	4.47
25-29	25091	5.01
30-44	98538	19.66
45-59	109119	21.77
60-64	30107	6.01
65-74	51771	10.33
75-84	35824	7.15
85-89	8618	1.72
90 & over	4515	0.9

Table 2 Marital Status

	People aged 16 and over						
	All people	Single (never married)	Married	Re-married	Separated (still legally married)	Divorced	Widowed
Cornwall and the Isles of Scilly	408,664	97,743	179,539	42,692	8,467	40,381	39,842

Source: Office for National Statistics (Census 2001)

Table 3 Religion

Table KS07 Religion	All people	People stating religion as:								Religion not stated
		Christian	Buddhist	Hindu	Jewish	Muslim	Sikh	Other religions	No religion	
Cornwall and the Isles of Scilly	501,267	372,540	945	240	435	672	105	2,320	83,694	40,316
Caradon	79,649	60,108	125	22	64	115	12	318	12,892	5,993
Carrick	87,865	64,704	185	106	83	179	26	394	14,901	7,287
Kerrier	92,517	68,130	149	15	72	89	22	406	16,119	7,515
North Cornwall	80,509	60,692	128	49	63	33	4	384	12,575	6,581
Penwith	63,012	45,549	198	21	68	117	8	411	11,462	5,178
Restormel	95,562	71,840	153	26	85	139	33	401	15,311	7,574
Isles of Scilly	2,152	1,517	7	-	-	-	-	6	434	188

Source: Office for National Statistics (Census 2001)

Table 4 Economic Activity

Source: Office for National Statistics (Census 2001)

Notes:

* For the Census; part-time is defined as working 30 hours or less a week. Full-time is defined as working 31 or more hours a week.

		Cornwall and the Isles of Scilly	Caradon	Carrick	Kerrier	North Cornwall	Penwith	Restormel	Isles of Scilly	
All people of working age		359,707	57,590	62,726	66,625	57,339	45,090	68,722	1,615	
People aged 16-74:	Economically Active:	Employees: Part-time*	47,799	7,546	8,318	8,820	7,514	6,113	9,277	211
		Employees: Full-time*	116,154	20,469	20,273	21,871	17,388	12,049	23,500	604
		Self - employed	44,255	6,943	7,348	7,024	8,792	6,206	7,495	447
		Unemployed	11,725	1,527	1,933	2,372	1,743	1,897	2,235	18
		Full-time student	7,050	1,281	1,606	1,201	958	753	1,241	10
	Economically Inactive:	Retired	63,023	9,793	11,288	11,333	10,341	8,168	11,884	216
		Student	12,371	1,893	2,813	2,270	1,745	1,564	2,069	17
		Looking after home/family	25,636	3,736	4,153	5,194	4,062	3,482	4,963	46
		Permanently sick/disabled	21,782	2,967	3,374	4,553	3,244	3,440	4,182	22
		Other	9,912	1,435	1,620	1,987	1,552	1,418	1,876	24
Unemployed people aged 16 - 74:	Aged 16 – 24	2,746	359	458	561	422	427	517	-	
	Aged 50 and over	2,899	386	457	560	469	471	549	7	
	Who have never worked	670	82	106	183	85	88	126	-	
	Who are long-term unemployed**	3,463	418	565	786	527	564	601	3	

** 'Long-term unemployed' are those who stated they have not worked since 1999 or earlier.

Table 5 Ethnic Groups

Area		Cornwall and the Isles of Scilly	Caradon	Carrick	Kerrier	North Cornwall	Penwith	Restormel	Isles of Scilly
Variable									
All people		501,267	79,649	87,865	92,517	80,509	63,012	95,562	2,156
White:	British	486,635	77,748	84,877	90,304	78,393	60,499	92,722	2,092
	Irish	2,216	320	413	355	364	322	435	7
	Other white	7,448	1,008	1,425	1,030	1,041	1,516	1,383	45
Mixed;	White and Black Caribbean	603	111	106	92	75	82	134	3
	White and Black African	313	36	55	54	38	42	85	3
	White and Asian	804	86	188	132	153	120	124	3
	Other mixed	580	90	94	98	82	99	116	-
Asian or Asian British;	Indian	411	19	152	53	56	51	80	-
	Pakistani	149	30	16	30	17	12	44	-
	Bangladeshi	231	25	42	47	37	54	26	-
	Other Asian	178	28	70	21	18	18	23	-
Black or Black British;	Black Caribbean	307	17	73	60	53	24	80	-
	Black African	307	24	103	75	34	17	54	-
	Other Black	142	8	22	11	9	4	88	-
Chinese or other ethnic group;	Chinese	531	54	136	98	69	84	90	-
	Other Ethnic Group	412	45	93	57	70	68	78	3

Source: Office for National Statistics (Census 2001)

Table 6 Unemployment in Cornwall May 2005

	May-04		May-05		% CHANGE 2004 - 2005
	TOTAL	% RATE	TOTAL	% RATE	
Cornwall	5,244	1.7	5,409	1.8	3.15%
Devon	5,221	1.3	5,088	1.2	-2.55%
South West	41,790	1.4	42,279	1.4	1.17%
Great Britain	839,239	2.3	839,547	2.3	0.04%

Figure 2 shows the proportions of the resident Cornish population made up of ethnic minorities, generally the proportions are relatively low when compared to national profiles.

Figure 2 Ethnicity of the Cornish population for non-white British groups.

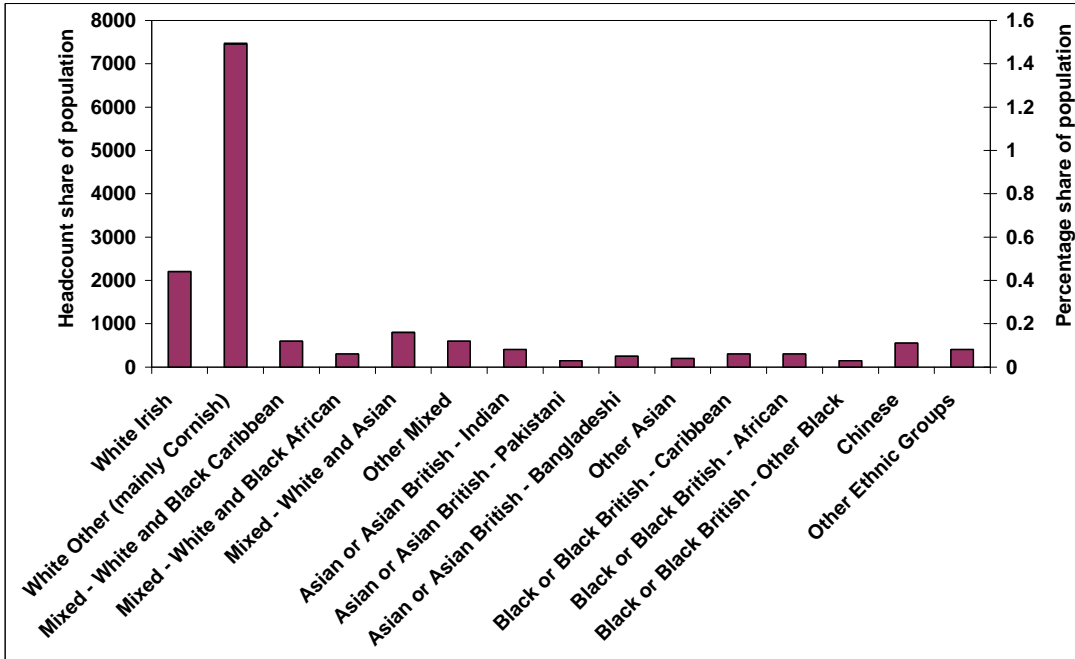


Figure 3 Comparison between Cornwall ethnicity and national average.

