

**COMMUNITY ENGAGEMENT PROJECT:
Delivering Race Equality in Mental Health**

**Report of the community led research project by the Hikmat Group focussing on
the mental health experiences and outcomes of BME elders and their carers in
and around Exeter**

Like Suffer in a Dark Fridge

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Central Lancashire



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

Fiona Hutton was recruited to co-ordinate the project as a development of her supervisory role at the Hikmat BME Elders Centre. She welcomed the opportunity to learn project management skills within a supportive and rigorously academic framework. She is an integrative counsellor and medical anthropologist with many years experience of working in older people's mental health. Fiona chaired the Steering Group and research meetings and wrote the final report.

Fakhira Ashfaq joined the team as a link to the South Asian community. She has been developing a career in BME health and social care for a year, after bringing up a family of three boys and developing a retail business with her husband. While engaged on the research project, she became Centre Manager at Hikmat and acknowledges how the training she received from UCLan helped improve her speaking skills and confidence.

Sevil Fertinger studied social science in Germany, and was already involved in consultation and service provision to the Turkish Kurdish asylum seeker and refugee communities in and around Exeter. Sevil took particular interest in the design of the questionnaire and hopes to use the research skills she acquired in further consultation events.

Ghania Tahari was Centre Manager at Hikmat when it opened at the end of 2005, joining the Olive Tree Association as part-time administrator six months ago. Ghania took charge of the finances and monitoring forms, printing and distribution of paperwork, room bookings and general administration as well as contributing to the design of the questionnaire. Unfortunately for her team, but fortunately for her husband, Ghania left the project in February to marry Mahmud and move nearer to his military base in Iraq.

Justin Wan has worked at the Hikmat Centre with the Chinese community since they started attending in May 2006 and is becoming increasingly dedicated to improving opportunities for all age-groups. He generated almost half the raw data for the project and contributed to the design of the questionnaire. Justin also attended several Steering Group meetings to help members make sense of the findings.

Nrvan Zowal juggled hard to manage her responsibilities as joint-chair of the Olive Tree Association and her commitments to the project, as she also has two year old Omar and a home fighting for her attention. Nrvan acted as primary research liaison at Steering Group meetings, contributed to the design of the questionnaire and analysis of the qualitative raw data. She acted as the main link into the Arabic and North African communities and hopes to continue developing the research and mental health skills she is adding to her nursing experience to find work serving the local Muslim and other local BME communities.

Moez Khan joined the team as a link to Muslim men attending the local Mosque. He worked on the ethics pro-forma and questionnaire and then was unexpectedly offered an academic opportunity elsewhere in the country and, understandably, left the project.

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Dr Susan Bedford, Older People's Psychiatric Services, Wonford House
Lyne Bradshaw, Diversity Lead, Exeter and East Devon Primary Care Trust, Clyst Honiton

Brenda Laker, Hikmat Management Team

Lynne McLellan, Department of Clinical, Doctorate and Community Psychology,
University of Exeter

Ian Pearson, Local Implementation Lead Co-ordinator, Devon and Torbay
Primary Care Trusts, Dean Clarke House

Lindsey Stewart, Social Work Training Co-ordinator, Foxhole, Dartington

Nichola Weate, Services Manager, Age Concern Exeter

Nrvan Zawal, Joint Chair, Olive Tree Association

The Steering Group was chaired by Fiona Hutton and also included the following:

Mark Patterson, Regional Race Equality Lead, National Institute of Mental Health in
England

Jo Hicks, South West Region Support Worker, Centre for Ethnicity and Health,
University of Central Lancashire

Particular thanks are due to Lyne Bradshaw who arranged for the PCT to host all Steering Group meetings.

CONTENTS

Team Members	2
List of Tables and Graphs	6
Executive summary	7
Introduction	12
The Centre for Ethnicity and Health's Community Engagement model	
Background Information	
Delivering Race Equality in Mental Health	18
Olive Tree Association	18
Demographic context	19
Material environment	20
Service demand	20
General and mental health of bme elders in Exeter	21
The Primary Care Trust	21
Consultation review	22
Service provision	23
National strategy – local capacity	24
Aims and objectives of the project	25
Methods	
Recruiting the team	26
Training	26
Recruiting the Steering Group	27
Ethical considerations	27
Research tool design	28
Sample selection	29
Data collection	29
Limitations, obstacles and challenges	30
Results	
Core questions	32
Project specific questions	37
Qualitative responses	45
Discussion	
Core questions	52
Project specific data – general health	53
Project specific data – mental health	61
Conclusions	68
Recommendations	71
Appendices	72
References	81

LIST OF TABLES AND GRAPHS

Key ingredients of a Community Engagement project

The Community Engagement Team

Summary of Demographic Statistics, 2001

Instances of over- crowding and central heating in bme households in Exeter

Limiting long- term illness and/or general ill- health

Main categories from questionnaire Removing the Barriers

Core data questions (1- 12)

Project specific data questions (13- 26, & 31)

Graph - How old are you?

Graphs - Were you born in the UK? If not, how long have you lived here?

Graph - What languages are you fluent in?

Graph - Do you feel confident in asking for treatment?

Graph - How easy is it to communicate with your GP?

Graph - Do you feel understood by your GP?

Graph - If you need one, were you offered an interpreter?

Graph - How often has the treatment or advice been helpful?

Graph - How would you describe your current state of general well- being?

Graph - Are you suffering from an acute medical condition?

Graph - Are you suffering from a chronic medical condition?

Graph - How would you describe your current state of mental well- being?

Graph - What helps to keep yourself mentally well?

Graph - Have you experienced any of these events in either your home country or the UK?

**Graph - Have you experienced any of the following in the last three years?
(x 2)**

EXECUTIVE SUMMARY

Background

Since the year 2000, UCLan has managed approximately 250 community groups conducting Department of Health funded community engagement projects. These projects have explored a range of topics, and whilst each community is different, a common model has been used within each group.

The Department of Health had two key things in mind when it commissioned the work. First, it wanted a number of reports to be produced that would highlight the needs of a range of Black and minority ethnic communities.

And second, the Department of Health was clear that it did not want researchers to go into the community, to do the work, and then to go away. It wanted local black and minority ethnic communities to undertake the work themselves and remain as links between service commissioners, providers and the users themselves.

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**.

It is important that this host community organisation has good links to the target community (whoever this is), such that it is able to recruit a number of people from the target community take part in the project and to do the work.

The Hikmat BME Elders Centre in Exeter was one of 40 groups selected to provide this role in the 2006/07 Delivering Race Equality in Mental Health initiative.

A team comprising six researchers and a co-ordinator attended seven UCLan training sessions on Community Research and on Mental Health Policies and Practices before designing questionnaires for service users, potential service users and carers.

Respondents aged 45 and over, and those who care for them, were identified from within the Hikmat BME Elders Centre (who attend either a Chinese community day or a Muslim community day), a Turkish/Kurdish refugee and asylum seeker support group, and the Arabic Muslim community.

The project was developed by the team between June and November 2006. Data was collected during the period December to February. The data was collated, analysed and written up during February, March and April 2007.

Aims and Objectives

The aim of the project was to explore experiences and outcomes around mental health issues for older people from BME communities in a 30 mile radius of Exeter.

Objectives were

- to map the existence of current/recent mental health problems and treatments within older BME populations;
- to build a team of BME workers trained in Community Engagement principles and practices;
- to contribute to six of the twelve national priorities of the action plan Delivering Race Equality in Mental Health
- to inform commissioning agents and service providers.
- To contribute to the development of culturally competent social work and clinical psychology courses in Devon.

Data collection techniques used

Most members of the project Steering Group contributed to a questionnaire, which was consensually agreed early on in the UCLan training to be the best means of gathering data for Hikmat respondents. It was agreed that ubiquitously poor levels of English among target communities (older Chinese, South Asian, Middle Eastern and North African people) justified the additional expense of bi lingual semi structured interviews to complete them.

A second questionnaire was devised for BME carers.

Both questionnaires include obligatory core questions provided by University of Central Lancashire.

Respondents were identified through purposive and snowball sampling across the Olive Tree Association's range of projects. The researchers and co ordinator provided links to the Mosque, refugee, asylum seeker and other ethnically orientated groups, and some statutory agencies.

Questionnaires were completed between December 2006 and March 2007 and stored in a locked cabinet in a secure community building.

Results

The data showed that almost all the respondents were born overseas, had lived in the UK for more than 6 years and were registered with a GP in Devon, whom they consult for physical *and* emotional ill health. There were gender differences in both general and mental well being.

Communication difficulties were most commonly seen as impacting adversely on the therapeutic relationship and treatment outcomes. This is in part because of poor levels of spoken, and written, English on the part of the patients, and in part because of cultural insensitivities on the part of the doctors.

Many participants had experienced trauma and a high proportion reported self diagnosed depression, anxiety, poor memory, sleep and appetite disturbance, and other presenting mental health problems.

Hardly anybody had accessed statutory mental health or social services to help with their problems, although the few who had reported positive outcomes. Neither was much support elicited from elsewhere, including from religious leaders, despite more than four fifths subscribing to a world religion.

More than half the participants identified treatments they accessed in their originating communities that are unavailable here.

Respondents confirmed a range of self help behaviours, almost all of which can be capitalised on by black and minority ethnic (bme) community support groups working in partnership with city and county council services.

Recommendations

1. That the full report is made available to lead executives in the Devon PCT, Devon County Council and Devon Partnership Trust.
2. That Devon PCT, possibly through their Public Health Directorate, are invited to:

build on the skills and experience of the UCLAN trained researchers,

further develop systemic links and communication flows with the local bme populations,

consider further research into the needs of the bme populations.

3. That Devon PCT and Partnership Trust are invited to:

support the development and evaluation of culturally distinct interventions, linked as appropriate to –

- a) the Improving Access to Psychological Therapies initiative,
- b) identified surgeries, or clusters of surgeries,

improve access to current services, with particular focus on GPs and primary care.

support the creation of learning and development programmes for both people who may use service and staff that provide services

enable extended appointment time with GPs and practice staff.

INTRODUCTION

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

Background

We often hear the following words or phrases:

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

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

The Department of Health had two key things in mind when it commissioned the work; first, the Department of Health wanted a number of reports to be produced that would highlight the drug related needs of a range of Black and minority ethnic communities. Second, and to an extent even more important, was the process by which this was to be done. If all the Department of Health had wanted was a needs assessment and a 'glossy report', they could have directly commissioned a number of researchers who could have gone into local Black and minority ethnic communities, talked to them about their needs, written up a report, and produced yet another set of reports that potentially do not have any long term impact. This scheme was different however. The Department of Health was clear that it did not want researchers to go into the community, to do the work, and then to go away. It wanted local Black and minority ethnic communities to undertake the work themselves. These groups may not have known anything about drugs, or anything about undertaking a needs assessment at the start of the project; what they would have is proven access to the communities they were working with, the potential to be supported and trained and the infrastructure to conduct such a piece of work. They would be able to use the nine month process to learn about drug related issues and about how to undertake a needs assessment. They would be able to benefit and learn from the training and support that the Ethnicity & Health Unit would provide, and they would learn from actually managing and undertaking the work. In this way, at the end of the process, there would be a number of individuals left behind in the community who would have gained from undertaking this work. They would have learned about drugs, and learned about the needs of their communities, and they would be able to continue to

articulate those needs to their local service providers, and their local Drug Action Teams. It was out of this project that the Centre for Ethnicity and Health's model of community engagement was born.

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

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

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

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

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

The Key Ingredients

According to the Centre for Ethnicity and Health model, a Community Engagement project must have the community at its very heart. In order to achieve this, it is essential to work through a **host community organisation**. This may be an existing community group, but it might also be necessary to set a real or virtual group up where one does not exist already. The key thing is that this host community organisation should have good links to the target community¹ (whoever this is) such that it is able to recruit a number of people from the target community take part in the project and to do the work (see

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

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

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

The second key ingredient is the **task** that the community is to be engaged in. According to the Centre for Ethnicity and Health model, this must be something that is meaningful, time limited and manageable. Nearly all of the community engagement projects that we have run have involved communities in undertaking a piece of research or a consultation exercise within their own communities. Sometimes we have been met with an initial resistance to doing 'yet another piece of research', but this misses the point. As in the initial programme that we ran on behalf of the Department of Health, *the process (i.e. of getting ordinary people involved in doing the work) is as important, if not more important, than the report that they produce at the end of the day.* The task or activity is something around which lots of other things will happen over the lifetime of the project. Individuals will learn and new partnerships will be formed. Besides, it is important not to lose sight of the fact that it will be *the 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. We do not expect community groups to become involved for nothing. Typically we would make in the region of £15 20,000 available to the host organisation. We would expect that the bulk of this money would be used to pay people from the target community as community researchers². We then allocate a named member of staff from our Community Engagement Team as a project support worker. This person will visit the project at for at least half a day once a fortnight. It is their role to support and guide the host organisation and the researchers through the project. We also provide a package of training – typically in the form of a series

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.

of accredited workshops. The accredited workshops give participants in the project a chance to gain a University qualification whilst they undertake the work. The support workers will also assist the group to pull together a steering group for the project³. The steering group is an essential element of the project: without one, it is difficult to see who the community are engaging with and it is unlikely that anything out of the project will be sustained in the longer term. The group will be doing a needs assessment or a consultation exercise, but for what purpose? It is the role of the steering group to ensure that the work that the group undertakes sits with local priorities and strategies, and that there is a mechanism for picking up the findings and recommendations that the group may make. It is also their role to help to pick up the key individuals who are developed through the project process to help them to take their 'next steps'.

The Community Engagement Team

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

National Programme Directors			
Northern Team	Midlands Team	Southern Team	Senior Programme Advisors
Senior Support Worker	Senior Support Worker	Senior Support Worker	
Support Workers X 3	Support Workers X 3	Support Workers X 6	Drug Interventions Programme
			Regeneration
			Mental Health
Teaching And Learning Team			
Administration Team			
Communications Officer			

Programme Outcomes

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

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.

hard to reach communities are formed as a direct result of community engagement projects.

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

The Focus Of This Particular Report

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

For example:

National Institute for Mental Health In England Community Engagement Programme:

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

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

The focus of the Hikmat BME Elders Mental Health Project was to discover the self-identified level of mental ill-health of BME people over the age of 45 living within a 30 mile radius of Exeter. It was also to map use of local mental health and other services by BME older people within the last 3 years, and to report their perceived effectiveness.

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

BACKGROUND INFORMATION

Delivering Race Equality in Mental Health

When John Reid, then Secretary of State for Health, wrote the Forward to the Government's document, *Delivering Race Equality: A Framework for Action - Mental Health Services*⁴, he made it clear the report had convinced him that,

"...there is clear evidence of the need to transform the services and outcomes experienced by (people from bme communities)."

In August 2006, twelve months' later, the Healthcare Commission audited NHS trusts' compliance with the new race relations legislation and, finding the results disappointing, reminded the sector that,

*"The duty to promote race equality is not an optional extra*⁵*".*

It seems the clear evidence must, however, be **local** evidence to convince local decision makers. Central government kept up the pressure but there was still no local response. October brought further reminders from the National Director for Mental Health⁶ and new Minister for State for Health Services⁷, Rosie Winterton, of the Government's timescale for recruiting Community Development Worker (CDW) (Mental Health) posts, seen as pivotal to the success of *Delivering Race Equality in Mental Health*. Restructuring the Primary Care Trust (PCT) had left the region without a Chief Executive for some weeks, and budget constraints had compounded an already difficult situation, resulting in none of the seven proposed, and Government resourced, Devon CDWs in post by the start of the new year. Progress was indeed slow.

The Olive Tree Association

The Olive Tree Association has a history of providing consultation and community led services to bme people in and around Exeter, and has experienced first hand the impact dedicated bme workers can have on their communities. Some of the elders, in particular, had successfully lobbied commissioners for a drop in day opportunity to increase health and benefits awareness, and reduce isolation and depression⁸.

The Community Engagement programme was seen by service users and staff of the Hikmat BME Elders Centre as a way of providing robust evidence to confirm what they knew anecdotally; that bme people with mental health issues are going untreated.

⁴ *Delivering Race Equality in mental health care*, 2005. Department of Health, London.

⁵ *Healthcare watchdog puts NHS trust on notice over compliance with race relations law*, 21 August, 2006. Healthcare Commission press release, London.

⁶ Correspondence: *Mental Health: Community Development Workers for Black and Minority Ethnic Communities*, 4 October, 2006.

⁷ Correspondence: *Black and Minority Ethnic Mental Health*, 4 October, 2006.

⁸ *A Question of Fairness*, 2004. Hutton, DCC and Age Concern, Exeter.

Demographic Context

Devon has, until very recently, had a very small bme population. A handful of people from South and East Asia and the Middle East arrived in Exeter to study or start businesses during the '60s and '70s, even fewer in the more rural towns and villages. Some settled, raised families, and now make up a significant proportion of those who are currently contemplating retirement, and worsening health.

Then, in the 1980s, global disruption and significant investment in the Islamic Studies Institute at Exeter University combined to attract a wider variety of foreign nationals to the city. As the new wave of immigrants established themselves, many invited elderly parents and other relatives to join them and this group makes up another considerable proportion of Exeter's bme elders.

This pattern continued through the '90s with Exeter featuring regularly in the Government's resettlement of refugees and asylum seekers programme. Amongst this group there are a few older individuals, whose families and informal carers have been unable to follow them, but whose treatment at the hands of political extremists has left them physically and emotionally damaged.

The last ten years have seen numbers rising still further as the university, relaxed rural lifestyle, and improving job opportunities attract bme people from other cities in the UK as well as continuing to welcome economic migrants, refugees and asylum seekers. Exeter now has identifiable communities of Kurdish, Iraqi, Afghani, Palestinian, North African and Polish people, as well as the more embedded Pakistani, Bangladeshi, Indian, and Chinese communities.

In 2003, Sam Magne and the Link team⁹ identified 54 languages being spoken across Devon; thirty-nine of these were first languages. Much has changed here in the last thirty years.

The table below identifies the increase in population change in Devon between 1991 and 2001 as more than twice the national average. Our average age is nearly 10% higher and at least 28% more of us than the national average are aged 60 or over.

Summary of Demographic Statistics, 2001¹⁰

	Devon	South West	England
Population (000)	704	4,928	49,139
% population change 1991-2001	+8.9	+6.9	+4.3
Average age	42.3	40.6	38.6
% of population aged 60+	26.7	23.9	20.8
% of population White British	97.0	95.4	87.0

⁹ Magne, 2003.

¹⁰ Census statistics, ONS, *Population and Ethnicity, Big Picture*, 2006. Age Concern Research and Development Unit, London

Material environment

The 2001 *Census* also shows that a higher proportion of households from bme communities in Exeter inhabit sub-standard accommodation, which it determines by levels of overcrowding and access to central heating.

Instances of Over-crowding and Central Heating in BME Households in Exeter

	White	Non-White
All	103,664	1,963 ¹¹
Overcrowded (O/C)	8,662	386
No central heating (NCH)	19,621	335
O/C & NCH as % of All	27.3%	36.8%

Much has been written on the inequalities of health for ethnic groups¹². Poverty is a contributory factor, in material environment as much as opportunity. The figures show 36.8% of the non-white population of Exeter live in sub-standard housing, almost 35% up on the white population. Surprising figures perhaps, for Exeter.

Service demand

Low figures have traditionally been given in rural areas as the reason not to invest in culturally competent approaches to service provision, but this is no longer tenable.

The percentage of older people is increasing steadily, as is the percentage of bme people. The 2001 Census gives the bme population of Exeter as 2,644, and this figure is already six years out of date. Despite this, only *seven* bme people aged 65 and over and living in Exeter underwent an eligibility assessment for Devon County Council Adult and Community Services during the whole of the following year¹³.

Our guess was then, and is now, that this is unrepresentative of the real position. As Age Concern Exeter's recent investigation into the housing needs of Exeter's Chinese community reports¹⁴,

"many of Exeter's Chinese community do not know how to call the fire services or an ambulance",

which would explain why one woman,

"lay on her couch for four days, believing she was dying, unable to make the GP receptionist understand that she needed a home visit."

¹² *Ethnic inequalities in health in later life*, 2000. Evandrou, 8 HMSO, *The General Household Survey (GHS) and The Health Survey for England 1999* (HSE99)

¹³ Devon County Council Social Services Performance Assessment Framework Indicators E49 and E50

¹⁴ *Old Chinese people just disappear...*, 2006. Mackinder, Age Concern Exeter

Age Concern Exeter also, rather alarmingly, reported in their document that Exeter PCT had been unable to provide a link into this community and that general health care was,

“shown to be an area of outstanding need”.

The General and Mental Health of BME Elders in Exeter

Devon’s *Census 2001* provides figures only for long-term illness and general ill-health categorised by faith; patterns of mental ill-health are not distinguished. More than fifty years of evidence, much of it government driven, points conclusively to a statistical relationship between the two, however, leaving us no choice but to assume from the following figures that incidents of mental ill-health among bme people **approaching** retirement are significantly higher than reported.

With limiting long-term illness and/or general ill-health - all

	Muslim, Hindu, Sikh	All Others
Aged 50-64	33.7% (32)	26.8%
Aged 65+	36.8% (14)	50.8%

With limiting long-term illness and/or general ill-health - males

	Muslim, Hindu, Sikh	All Others
Aged 50-64	38.6% (22)	28.6%
Aged 65+	37.9% (11)	48.7%

With limiting long-term illness and/or general ill-health - females

	Muslim, Hindu, Sikh	All Others
Aged 50-64	26.3% (10)	25.1%
Aged 65+	33.3% (3)	55.8%

The Primary Care Trust

The Local Implementation Team (LIT) Co-ordinator and recently appointed Diversity Lead, who both represented the PCT on the project Steering Group, clearly suspected this to be the case and lobbied hard, and successfully, for questions concerning the general well-being of respondents, and their experiences of GPs, to be included in the questionnaire.

No doubt they were in part responding to the South West Peninsula Strategic Health Authority's re-organisation document *Ensuring a Patient-led NHS*¹⁵ which promises, among other things:

"...new relationships with a wider range of providers,"

and welcoming the opportunity for partnership approach CE offers.

A receptive context to this intention has been created over the last eight years by the *National Service Framework for Older People* and the *National Service Framework on Mental Health*, both of whom advocate person-centred care planning as the only really viable approach to creating culturally relevant care pathways.

More locally, the LIT Co-ordinator had been involved, in consultation with a Service Redesign and Recovery Programme Board, in developing a Devon-wide community-based approach to meeting the mental health needs of adults in Devon and Torbay¹⁶, whose objectives seemed co-terminous with *Delivering Race Equality in Mental Health* and, more particularly, those of the Community Engagement project, eg:

"Encourage the wider community to tackle stigma and discrimination and provide support and opportunities for people to recover and maintain their mental health and wellbeing."

Consultation review

The first consultation event addressing health and social care issues for Exeter's bme communities was staged by the Building Bridges multi-disciplinary race equality group in 2002 as an opportunity for service providers to hear what problems existed first hand. Service users from some of Exeter's ethnic groups described experiences of professional insensitivity, discrimination and poor outcomes in service delivery. Common themes included:

- communication problems
- lack of information
- lack of understanding of culture
- inability to access services

With the intention of exposing a more detailed picture of the support needs of the older people who maintain contact with Exeter's Mosque, an affiliated working group designed a questionnaire, *Removing the Barriers; meeting the needs of minority ethnic elders in Exeter*. This was completed by 17 older Muslims with the help of two Social Services student practitioners.

¹⁵ *Ensuring a Patient-led NHS*, 14 December, 2005. Consultation Team, Saltash.

¹⁶ *Vision to Reality*, August 2006. Pearson, Devon Primary Care NHS Trust, Exeter.

Respondents were aged between 52 and 70, divided equally between men and women. Almost all lived with other family members and were dependent on informal carers for part of their daily living routines (although almost two thirds were receiving no benefits at the time).

Main categories from questionnaire Removing the Barriers

Benefits	Receiving	37.5%	Not receiving	62.5%		
Mobility	Poor	62.5%	Good	37.5%		
Medication	Taking	81.3%	Not taking	18.7%		
Regularly Using Private Health Professionals	Yes	87.5%	No	12.5%		
Health Status	Poor	68.8%	Fair	6%	Good	24.2%
Personal Care	Needs help	56.3%	Doesn't need help	34.7%	Didn't answer	7%
Outings	Would like	56.3%	Would not like	23.7%	Didn't answer	20%
Exercise (walking)	Does do	87.5%	Doesn't do	5.5%	Didn't answer	7%
Social Services	Know of	60%	Don't know of	33%	Didn't answer	7%
Age Concern Exeter	Know of	60%	Don't know of	33%	Didn't answer	7%
Muslim Elders Drop-In Centre	Would like	93.8%	Wouldn't like	0%	Didn't answer	6.2%

Service provision

Devon's psychiatry and psychology services have been compromised by "outdated concepts inherited from the old psychiatric institutions" for a long time¹⁷. This will have had impact on all service users, but reductionist, one-size-fits-all interventions are the antithesis of the approach preferred by many hard-to-reach groups, such as those from minority ethnic communities.

The introduction of Equality and Needs Impact Assessments is starting to focus attention and our services research found at least one service which was treating disproportionately **large** numbers of bme people, particularly women. The NHS Walk-in Centre on Sidwell Street reported this group to be one of its two biggest service user

¹⁷ *Vision to Reality*, 2006

groups, its ancillary mental health clinic taking many referrals as well as its practice nurses.

Snowball sampling across Exeter's bme communities and services brought to light only a handful of mental health service users, however, and none over the age of 45. Neither statutory or voluntary. Anecdotal evidence from Hikmat's staff, however, show individuals and their carers suffering both chronic and acute episodes unsupported, and it is because they are afraid. Not particularly of any one thing, it seems, but themes are discernible: incarceration of the cared for; domestic violence; risk to family honour, and being misunderstood.

The Clock Tower Surgery has, over the years, become a centre of excellence in its treatment of refugees and asylum seekers, travellers and gypsies and continues to offer the services of a limited, but culturally sensitive GP practice.

When approached to discuss the impact of mental health issues on his work as Exeter's Imam, Mr Saied was frank. He wasn't really coping adequately, he confessed. Domestic violence particularly, and other relationship difficulties, were his most pressing problem and threatened to overwhelm both him and his wife.

National strategy – local capacity

One of the benefits of the preparatory training for the project was a clearer understanding of how the action plan *Delivering Race Equality in Mental Health* might be applied to reduce this level of unmet need. The team and Steering Group agreed to explicitly include six of its twelve national priorities in the project's Aims and Objectives (see below).

These priorities were seen by us all as those which could quickly and significantly impact local bme communities, while also being expedient choices, given existing networks of co-operation within the sector.

The Community Engagement project got underway in June 2006, supported by an optimistic and determined Steering Group, representing a wide range of stakeholder groups. It was seen by all as an opportunity to move the agenda on, albeit along twelve marginally different trajectories.

AIMS AND OBJECTIVES

Aims

To discover the extent of mental health service take up among self diagnosing bme people aged over 45 and their carers living within a 30 mile radius of Exeter, and to explore barriers to engagement with these services.

To start to monitor levels of take up and satisfaction with support services for carers of bme people with mental health problems.

Objectives

- To map the experiences of older bme people in and around Exeter who have suffered a self diagnosed mental health episode within the last three years.
- To explore the barriers which prevent engagement with and positive outcomes from statutory mental health and other services.
- To inform six of the twelve national priorities for this project:
 - less fear of Mental Health care and services among bme communities and bme service users;
 - increased satisfaction with services;
 - an increase in the proportion of bme service users who feel they have recovered from their illness;
 - a more balanced range of effective therapies such as peer support services, psychotherapeutic and counselling treatments, as well as pharmacological interventions that are culturally appropriate and effective;
 - a more active role for bme communities and bme service users in the training of professionals, in the development of mental health policy, and in the planning and provision of services; and
 - a workforce and organisation capable of delivering appropriate and responsive mental health services to bme communities.
- To build a team of community researchers with the skills and experience to contribute to the on going development of bme services.
- To create and support a project Steering Group which brings together stakeholders from service commissioning and provision, professional training, and local bme communities.

METHODOLOGY

Recruiting the Research Team

Right from the beginning, news of the project generated interest among the bme communities who were already in contact with the Hikmat BME Elders' Centre and a number of people came forward to express interest in becoming involved. By alerting other bme organisations in the area we were also able to extend the invitation to communities with whom Hikmat was not already connected. At the first planning meeting of the project, eight potential team members gathered round the coffee table with two potential steering group members.

Seven people agreed at the meeting to commit to attending the requisite number of training events and roles and remuneration were agreed, including those of administrator and co ordinator. The team, between them, confirmed access to local Arab, South Asian, Chinese and North African communities, thus delineating the cultural parameters of the project. The co ordinator contributed links into statutory and voluntary sectors' older people's health and social care services, and experience of research in public health.

Training

As discussed earlier, a core element of UCLan's Community Engagement model is the formation of a professionally trained team of researchers, who act as a bridge into the designated hard to reach group, and a percentage of whom later gain employment in the sector.

To this end, seven modules of academic and experiential training in Research Methods and Mental Health Policy and Practice are provided, which can, if desired, lead to recognised qualifications. Written work included a reflexive exercise, encouraging participants to consider their own development, as well as their community's.

Five researchers in the Hikmat team registered for the highest level certificated work, one of whom withdrew at a later stage after enrolling with the Open University, and one researcher registered for the foundation certificate. All, in their reflexive exercise, acknowledged the valuable contribution the training made to their increased levels of confidence and ability to articulate complex ideas. Despite most of the researchers never having experienced academic rigour, and all except one having English as their second language, the four team members all passed the Certificate in Community Research and Mental Health Policy and Practice.

Recruiting the Steering Group

In order to maintain strong, productive links into the statutory and other relevant sectors, UCLan and CSIP support CE teams to create and manage a multi disciplinary steering group. The Steering Group are encouraged to meet regularly, primarily to oversee the direction of the project and agree a way forward after consideration of the results.

The Hikmat Project's intention was to create a forum which included as many pivotal influences to improving the mental health of local bme people as possible. A generic letter of invitation was personalised with service specific additions and sent to the following roles:

Local Implementation Lead, Primary Care Trust
Diversity Lead, Primary Care Trust
Services Manager, Age Concern
Services Development Officer, Older People's Integrated Mental Health Team
Psychiatric Services (Older People)
Psychological Services (Older People)
Social Work Training Co ordinator
Department of Clinical, Doctorate and Community Psychology, University of Exeter

All recipients either accepted the invitation themselves or identified someone else to deputise for them. The Steering Group also included UCLan's Community Engagement Regional Support Worker, the NIMHE/CSIP Regional Race Equality Lead, and the Senior Manager from Hikmat. It was chaired by the Project Co ordinator.

Ethical Considerations

Although most of the ethical considerations were identified by the Research Team, either in training or in team meetings, the ethics pro forma¹⁸ requested by UCLan as a prerequisite to client contact had also to be scrutinised by the Steering Group.

The group debated a number of issues at length including:

- the length of time the data would be stored and where;
- the risks involved in lone working; and
- what level of responsibility the project should accept for increasing emotional ill being by the nature of the questioning, particularly as many respondents would be insecure and isolated refugees and asylum seekers.

¹⁸ See appendix 3

The team had also to devise a respondents' consent form¹⁹, setting out clearly the background and reasons for the project, the intended outcome, what would be expected of participants and how confidentiality would be ensured. This, too, had to be scrutinised by the Ethics Committee at UCLan after being agreed by the Steering Group.

Because of the high proportion of Chinese respondents with little or no English it was agreed to have both the Consent Form and the Signposting Leaflet translated into Cantonese. This was done not only to ensure the highest possible standard of ethics around consent but also as a mark of respect and a symbol of our intention to be transparent, inclusive and avoid Euro centricity.

Research Tool Design

It had been agreed by the Research Team early on in the training that the project's research tools would be two questionnaires, one for potential service users and one for carers, which would be completed as semi structured interviews with at least one researcher. This combination had always seemed the most appropriate as so many of the potential respondents had little or no English and would require elaboration and interpretation around some of the issues raised..

As the questionnaires were developed and refined, a broad range of question types was included to produce both quantitative and qualitative information. Many hours of time were invested in this stage of the project as several issues emerged that would be critical to its success and necessitated consensual agreement:

- a mental health vocabulary which would overcome the endemic reticence of most bme communities to discuss a subject which is heavily stigmatised;
- a more refined vocabulary to describe nebulous emotions and feelings, some of which were identified as culture bound syndromes;
- the variety of data requested by the stakeholders (Steering Group); and
- the structure and wording of the questionnaire being analogous to the power inequality and discriminatory experiences of the respondents in their daily lives.

The Steering Group were particularly helpful in guiding the order of questioning, refining successive drafts so that respondents were naturally led from the non intrusive UCLan designed core questions, through a section on general well being, to the final part of the investigation where the information requested was personal and sensitive and required good rapport between participant and interviewer(s).

¹⁹ See Appendix 4

Sample Selection

The research group was fortunate in having members connected to several bme communities whose members were, again, in touch with other groups. For this reason, snowball sampling was used to identify potential respondents.

A geographical restriction of 30 miles radius of Exeter was agreed in consultation with UCLan. The age range was 45 and over and was influenced by Hikmat's service user profile.

Researchers predicted the number of questionnaires they would each be able to complete, a total of between 60 and 70, with at least 45 being from possible service users and 15 from carers.

Data collection techniques used

The CE programme adopts best practice in ethics and issues guidelines in the design and preparation of explanatory leaflets for potential respondents. Having understood the content and purpose of the research, they are asked if they consent to the consultation, during which a researcher would ask questions from a questionnaire. Confidentiality was assured and a high street voucher (together with a list of participating stores) offered as a token of appreciation for time and effort.

Respondents were also given a leaflet, designed by the team, outlining and signposting the range of mental health services currently available through the statutory and voluntary sectors.

The respondent's consent form and the signposting leaflet were both translated into Cantonese and offered to all Chinese participants.

Data collection

The questionnaires were conducted on a one to one basis, and in a private and safe place.

The data requested by various stakeholders, including core questions provided by UCLan, was varied and both qualitative and quantitative. The design of the questionnaires was, therefore, a protracted process and resulted in a document which included more than 20 category, list, scale, and grid questions, plus four or five more open questions asking respondents to expand on their experiences, unmet needs and reluctance to present for treatment.

Completed questionnaires were immediately sealed in an envelope and the name of the researcher written on the front. They were then brought to the Hikmat office and locked in a cabinet.

Periodically, a batch of ten was collected by the Project Co-ordinator for the hard data to be transferred to a sample sheet. At this stage they were catalogued by gender, a number and the researcher's name.

Qualitative responses were then collated by one of the researchers, so that themes and examples could be identified.

Limitations, obstacles and challenges

Piloting the questionnaire prevented a number of design faults and interpretation difficulties from corrupting the data collection.

Right from the start the challenging nature of the material dictated a sensitive and consensual approach to the questionnaire design. This was deliberate, articulated, and agreed by the team: we would not move on until all members understood and agreed on an issue. This is time costly, but results in a questionnaire that has the unequivocal support of the researchers who will be using it, and reduces the risk of resentment and subversion, conscious or subconscious, from within the team.

Early in process, UCLan training highlighted the part stigma has to play in any consultation on mental health, and particularly for those from bme communities. A compromise needed to be reached between the explicit terms of the NIMHE programme and the oblique language of simile and metaphor preferred by most bme people.

Close, but culture bound, links were described by the researchers between emotional conditions and physical sensations or parts of the body. Someone may describe themselves as have 'lost the use of their limbs', for example, or 'shattered their stomachs' when actually describing an experience of mental ill being.

A comprehensive list of emotional conditions and related symptoms were distinguished, discussed and translated by each researcher. Gender issues were particularly sensitive, and a tendency to couch questions in Euro-centric and imperialist language constantly threatened to antagonise.

It had been anticipated that older members of the Sikh community would be able to contribute. An important bereavement prevented members of these families from engaging with the project, however, and this, coupled with losing our researcher with contact to the local mosque, resulted in the number of respondents completing questionnaires being slightly fewer than predicted.

Finding culturally competent child care on a bus route that would accept sporadic bookings was a challenge, although overcoming this and establishing a well-integrated, stable yet flexible placement resulted in an ongoing benefit for everyone affected. Many members of the researcher's family were instrumental in the success of this process and the project acknowledges their contribution.

Data Analysis

Quantitative data was analysed in terms of percentages, gender differentiation, and rank.

That of a qualitative nature was used to give personal expression to the statistical results, and to describe preferred treatments not available through current health service access points.

RESULTS

Do you agree to take part?

Response	Number	Percentage
Yes	42	100

No	0	0
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Core data questions

Q1: How old are you?

Male

Age range	16-18	19-21	22-24	25-29	30-39	40-49	50-59	60-69	70-79	80+
Number	0	0	0	0	0	6	6	5	2	1

Female

Age range	16-18	19-21	22-24	25-29	30-39	40-49	50-59	60-69	70-79	80+
Number	0	0	0	0	0	4	11	4	2	0

Total

Age range	16-18	19-21	22-24	25-29	30-39	40-49	50-59	60-69	70-79	80+
Number	0	0	0	0	0	10	17	9	4	1
Percent age	0	0	0	0	0	24	41	22	10	3

Q2: What gender are you?

Gender	Number	Percentage
Male	21	50
Female	21	50

Q3: What is your domestic status?

Domestic Status	Female	Male	Total	%
Single	1	0	1	2
Married	13	16	29	69
With partner	2	2	4	9
Widowed	4	1	5	12

Divorced	2	1	3	8
Enforced separation	0	0	0	0
Separated by choice	0	0	0	0
Living with other family members	0	0	0	0
Living with friend	0	0	0	0

Q4: What is your employment status?

Employment Status	Female	Male	Total	%
Full- time employment	2	7	9	21
Part- time employment	6	3	9	21
Self- employed	1	3	4	10
Voluntary work	1	1	2	5
Student	0	0	0	0
Retired	3	7	10	24
Not permitted to work	0	0	0	0
Other (please explain)	8	0	8	19

Other explanations - housewife (5), not working (3)

Q5 What is your ethnicity?

		Female	Male	Total
White	British	0	4	4
	Irish			
	Other	2	2	4
Mixed	White & Black Caribbean	0	0	0
	White & Black African	0	1	1
	White and Asian	0	0	0
	Other	1	0	1
Asian or Asian British	Indian	1	0	1
	Pakistani	0	0	0
	Bangladeshi	1		1
	Other	3	2	4
Black or British Black	Caribbean	0	0	0
	African	2	0	2
	Other	0	0	0
Chinese	Chinese	8	9	17

	Other	1	3	4
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Other explanations – c Turkish (5), c Kurdish (1), g Arabic (1), l Arabic (2), l Asian (4), r North African (1), r Arabic (2), r I don't like this question (1)

Q6 Were you born in the UK?

Born in UK	Female	Male	Total	%
Yes	1	1	2	5
No	20	20	40	95

Q6a: If no, how long have you lived here?

	Female	Male	Total	%
Less than a year	0	1	1	3
1- 5 years	5	4	9	21
6- 10 years	7	8	15	36
11 years or more	7	10	17	40

Q7: What type of residency do you have?

Residency	Female	Male	Total	%
British Citizen	11	13	24	57
European Union citizen	0	1	1	3
Foreign National	6	3	9	21
Refugee/asylum seeker	2	4	6	14
Other	0	2	2	5

Q8: What is your first language?

Language	Spoken number	Written number
Arabic	14	14
Bengali	2	1
Cantonese	17	0
Chinese	0	17

English	0	1
Haka	6	0
Kurdish	1	0
Pashtun	1	0
Turkish	6	9

Q9: What languages are you fluent in?

Language	Spoken number	Written number
Arabic	13	13
Bengali	2	2
Cantonese	17	0
Chinese	0	17
English	17	12
French	2	1
Haka	9	0
Hindi	1	1
Kurdish	1	0
Mandarin	1	0
Pashtun	1	0
Swiss	1	1
Turkish	4	4

Q10: How would you describe your religion?

Religion	Female	Male	Total	%
None	3	3	6	14
Christian	4	8	14	34
Buddhist	1	0	1	2
Hindu	0	0	0	0
Jewish	0	0	0	0
Muslim	12	8	20	48

Sikh	0	0	0	0
Other	0	0	1	2

Other explanations – just believe in God, follow no rules (1).

Q11: *How would you describe your sexuality?*

Sexual orientation	Female	Male	Total	%
Heterosexual or straight	18	19	37	88
Homosexual or gay man	0	0	0	0
Lesbian or gay woman	0	0	0	0
Bisexual	1	0	1	2
Do not wish to answer	2	2	4	10
Other	0	0	0	0

Q12. *Do you have a disability that affects your daily living?*

	Female	Male	Total	%
Yes	5	6	11	26
No	14	15	29	69
No answer	2	0	2	5

PROJECT SPECIFIC DATA

Q13: *Are you registered with a GP in Devon?*

	Female	Male	Total	%
Yes	20	19	39	93
No	0	3	3	7

Q14: How easy is it to communicate with your GP? (language)

	Female	Male	Total	%
Easy	1	7	8	20
OK	11	6	17	40
Difficult	9	7	16	38
No answer	0	1	1	2

Q15 Do you feel understood by your GP (sensitivity)?

	Female	Male	Total	%
Always	2	5	7	17
Usually	3	5	8	19
Sometimes	13	7	20	48
Never	3	3	6	14
No answer	0	1	1	2

Q16 If you need one, were you offered an interpreter?

	Female	Male	Total	%
Yes	2	4	6	14
No	18	8	26	62
Didn't need one	1	7	8	19
No answer	0	2	2	5

Q16a Were you offered leaflets translated into your own language?

	Female	Male	Total	%
Yes	1	1	2	5
No	20	18	38	90
No answer	0	2	2	5

Q17 How often has the treatment or advice been helpful?

	Female	Male	Total	%
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Always	0	1	1	2
Usually	8	8	16	38
Sometimes	12	11	23	56
Never	1	0	1	2
No answer	0	1	1	2

Q18 Is there a treatment you could access in your home country that is not available here?

	Female	Male	Total	%
Britain has always been my home country	2	1	3	8
No	10	9	19	45
Yes (please explain)	8	11	19	45
No answer	1	0	1	2

Q19 Do you feel confident in asking for treatment?

	Female	Male	Total	%
Yes	13	14	27	64
No	8	7	15	36

Q20 How would you describe your current state of general well-being on a scale of 1-5 (1 being excellent and 5 being very poor)?

	Female	Male	Total	%
1 excellent	0	3	3	7
2	6	3	9	21
3	9	11	20	48
4	3	4	7	17
5 v. poor	2	0	2	5
No answer	1	0	1	2

Q21 Are you suffering from an acute medical condition (short term)?

	Female	Male	Total	%
Yes	5	2	7	17
No	15	18	33	78
No answer	1	1	2	5

Q21a Are you suffering from a chronic medical condition?

	Female	Male	Total	%
Yes	10	8	18	42
No	10	14	24	56
No answer	1	0	1	2

Q22 How would you describe your current state of mental well-being on a scale of 1-5 (1 being excellent and 5 very poor)

	Female	Male	Total	%
1 excellent	0	4	4	10
2	9	7	16	38
3	8	5	13	31
4	2	4	6	14
5 v. poor	2	0	2	5
No answer	0	1	1	2

Q23 What helps to keep yourself mentally well?

	Female	Male	Total	Rank
Optimistic Attitude	5	6	11	5

Education	4	6	10	6
Drink/drugs	2	1	3	9
Exercise	5	8	13	4
Hobbies	7	8	15	3
Religion	6	5	11	5
Walking	8	7	15	3
Going to the sea or countryside	6	7	13	4
Gardening	4	5	9	7
Reading	9	8	17	1
Work	9	7	16	2
Music	6	7	13	4
Personal development	2	4	6	8
Other (please explain)	4	4	8	-

Other explanations – radio (1), TV (2), relax at home (1), weekly meeting with friends (1), time with the family (2), housework (2), shopping (3), PC (1), time with grandchildren (1).

Q24 Have you experienced any of these events in either your home country or the UK?

	Home country number			UK number		
	Female	Male	Total	Female	Male	Total
Discrimination	2	2	4	11	17	28
Bullying	1	1	2	4	6	10
Migration	1	1	2	2	3	5
War	6	4	10	1	0	1
Torture	1	2	3	1	0	1
Violence	3	4	7	0	0	0
Rape	0	0	0	0	1	1
Sexual assault	1	1	2	0	1	1
Bereavement	4	4	8	3	3	6
Separation from the family	7	3	10	1	3	4
Lived in a refugee camp	0	1	1	2	1	3
Detention/imprisonment	1	0	1	1	0	1
Homelessness	3	1	4	1	2	3
Financial problems	10	12	22	6	6	12
Divorce	2	2	4	1	1	2
Childhood in care	1	1	2	0	0	0
Domestic violence	1	1	1	0	0	0
Serious illness	2	0	2	2	1	3
Psychiatric hospital admission	0	0	0	1	0	1

Racial abuse	2	0	2	7	8	15
Language difficulties	4	0	4	12	11	23
Social isolation	0	1	1	4	3	7
Other persecution (please explain)						

Q24a Do you think any of the following impact on a person's mental health?

	Female	Rank	Male	Rank
Discrimination	12	5	12	6
Bullying	9	7	12	6
Migration	10	6	10	8
War	15	1	17	1
Torture	10	6	15	3
Violence	14	2	14	4
Rape	13	3	16	2
Sexual assault	11	5	17	1
Bereavement	7	9	8	10
Separation from the family	12	4	12	6
Lived in a refugee camp	11	5	10	8
Detention/imprisonment	8	8	10	8
Homelessness	12	4	13	5
Financial problems	5	10	11	7
Divorce	7	9	9	9
Childhood in care	9	7	14	4
Domestic violence	10	6	14	4
Serious illness	9	7	14	4
Psychiatric hospital admission	9	7	11	7
Racial abuse	9	7	14	4
Language difficulties	8	8	9	9
Social isolation	13	3	13	5
Other persecution (please explain)	0		2	

Q25 Have you experienced any of the following in the last 3 years?

	Female	%	Male	%	Total	%
Depression	12	57	12	57	24	57

Anxiety	10	48	7	33	17	40
Guilt	1	5	1	5	2	5
Stress	15	71	18	86	33	79
Sadness (for a long time)	4	19	4	19	8	19
Loneliness (for a long time)	6	29	4	19	10	24
Mood swings	7	33	8	38	13	31
Suicidal thoughts	0	0	0	0	0	0
Suicidal attempts	0	0	0	0	0	0
Flashbacks	1	5	0	0	1	2
Nightmares	2	9	7	33	9	21
Difficulty sleeping	9	43	14	67	23	55
Emotional numbness/ Withdrawal	3	14	3	14	6	14
Loss of appetite	5	24	6	29	11	26
Drinking too much alcohol	0	0	3	14	3	7
Drug misuse	0	0	0	0	0	0
Gambling	1	5	4	19	5	12
Relationship difficulties	2	9	3	14	5	12
Poor concentration	10	48	6	29	13	31
Memory loss	9	43	5	24	12	29
Paranoia	1	5	1	5	2	5
Schizophrenia	2	9	0	0	1	2

Q26 Have you been to any of the following for treatment?

Female

	Yes	Very effective	Quite effective	Not effective
Doctor/GP	13	1	8	4
Hospital	3	0	3	0
Refuge	0	0	0	0
NHS Walk- in Centre	3	0	3	0
Religious leader	5	1	4	0
Counsellor/psychotherapist	2	0	1	1
Psychologist	1	0	1	0
Psychiatrist	1	1	0	0
Telephone helpline	0	0	0	0
Social services	0	0	0	0
Charity/voluntary organisation	0	0	0	0
Family member	11	1	7	3
Work colleague	2	0	2	0
Friend	10	4	5	1
Internet	1	0	0	0
Embassy	0	0	0	0
Other (please explain)	0	0	0	0

Male

	Yes	Very effective	Quite effective	Not effective
Doctor/GP	9	0	6	3
Hospital	3	0	2	1
Refuge	0	0	0	0
NHS Walk- in Centre	2	0	2	0
Religious leader	0	0	0	0
Counsellor/ psychotherapist	2	0	2	0
Psychologist	2	1	1	0
Psychiatrist	1	1	0	0
Telephone helpline	0	0	0	0
Social services	3	1	2	0
Charity/voluntary organisation	0	0	0	0
Family member	8	3	4	1
Work colleague	4	2	0	2
Friend	9	2	5	2
Internet	1	0	0	0
Embassy	1	0	0	0
Other (please explain)	2	1	0	0

Total

	Yes	Very effective	Quite effective	Not effective
Doctor/GP	22	1	14	7
Hospital	6	0	5	1
Refuge	0	0	0	0
NHS Walk- in Centre	3	0	3	0
Religious leader	5	1	4	0
Counsellor/ psychotherapist	4	0	3	1
Psychologist	2	1	1	0
Psychiatrist	2	2	0	0
Telephone helpline	0	0	0	0
Social services	3	1	2	0
Charity/voluntary organisation	0	0	0	0
Family member	19	4	10	5
Work colleague	6	2	1	2
Friend	19	6	10	3
Internet	1	0	0	0
Embassy	1	0	0	0
Other (please explain)	2	1	0	0

Q31 Has the current political climate affected your mental health?

	Female	Male	Total	%
Yes (please explain	9	9	18	43
No	11	12	23	55
No answer	1	0	1	2

Qualitative Responses

Q 6 Were you born here?

33. Yes, but I spent some time in the home country

Q12 Do you have a disability that affects your daily living?

6. Yes, slight memory loss

11. Yes, memory loss

12. Yes, arthritis

13. Yes, arthritis

14. Yes, arthritis

24. Yes, arthritis and very bad memory loss

27. Yes, suffer arthritis but still able to work, retiring soon

28. Yes, bad back

35. Yes, using a wheel-chair

Q14 How easy is it to communicate with your GP?

42. Difficult, possible only when a family member is with me

Q16 If you need one, were you offered an interpreter?

- 4. I didn't know that I can have interpreter
- 19. No, no-one said that I can have an interpreter
- 34. No, and I don't know if it was available or not
- 42. She doesn't know because she has always a family member with
- 43. Didn't need one, because my son or daughter are always with me

Q18 Is there a treatment you could access in your home country that is not available here?

- 2. In my country I hadn't have language problems. If I could explain my matter, communication between me and GP much better
- 3. No, but private consultant more easier in home country
- 4. Yes, private doctor or consultant but expensive
- 5. Don't think so
- 7. Yes, herbal medicine
- 9. Yes, acupuncture
- 10. Yes, herbal Medicine
- 11. Yes, acupuncture
- 12. Yes, herbal medicine
- 13. Yes, herbal medicine
- 14. Yes, herbal medicine
- 15. Yes, acupuncture, herbal medicine
- 18. Yes, some home remedies
- 19. Yes, private consultants and hospitals
- 25. Yes, acupuncture and herbal medicine
- 26. Yes, perhaps herbal medicine
- 28. Yes, Chinese herbal medicine

30. Yes, the private doctor and private health association

33. Yes, some private associations

35. Yes, some herbal treatment

43. The same methods but not efficient

Q19 Do you feel confident in asking for treatment?

4. No, not all the time because I am not sure I will be understood

6. No, GP not understand language very well and feel memory loss not treated as illness

7. No, I do not feel like I am understood, because of my language, not very good spoken English

10. No, language barrier

11. No, nervous

13. No confidence, language not understood

14. No, language barrier

19. No, no-one understands me, no feel that I am in pain and understand what I am suffering from

27. No, language barrier

28. No, language makes seeing GP difficult and embarrassing

24. No, not good English, but daughter is so can come with me to translate

42. No, I know I wouldn't get it

43. Can't ask because I know GP wouldn't give

49. No, because I want my son or daughter-in-law to be with me. I can't go alone

Q27 Would you like to say more about the service/help you received?

3. Its important to find someone who have the ability to hear you and

understand it as it is for you. GP listening but he can't put himself in my situation as it is for me

4. I think the service would be helpful
6. Not much help with very old, not much they can do
7. Have not needed help, mentally OK
10. Average help
13. Very poor
16. It take long, long time until you find one thing quite suitable to your situation
17. The GP have limited time for the patient and some time it is not enough in explaining situations
18. I didn't have any service and if they can't understand my physical pain how come they will understand my psychological pain and my needs
21. I didn't try any of them because in the physical illness he have limited time and many other patients what about when I need to speak and speak and no one have time to me and no cultural understanding.
23. The help received was good, but would not have be able to speak it my daughter couldn't come with me to translate
24. Luckily, very fluent in English, service help received may not have helped me or could not have seeked help and advice
25. Both my wife and I mental health is OK. Have not needed to seek advice but we are both OK in English so no trouble speaking to GP we are understood, but unable to say the same for people not so fluent, expect it can be bad if not understood
26. Was OK if not for language barrier
27. If fluent in English would be OK the help they give
28. Was offered interpreter but English not too bad little misunderstood
29. The feeling as widowed is not easy to be understood all the time by the help provided
31. No
32. I think if I will go to the GP and say I have depression he will say all of us we do

- 33. The problem that when you becoming depressed you don't want to talk to anyone while your GP want you to talk
- 34. They try to help but some points we can't explain and they can't feel it
- 37. Need more help about language and understanding
- 39. It was helpful just talking about it
- 41. I got bad experience with GP because the medicine I got was not good for me
- 48. It take a long time until you get the service
- 49. Give you the feeling that you can get help one day

Q28 If you did NOT choose to go to professional mental health services, why was this?

- 1. It wasn't serious
- 2. I don't know, I thought to go to the GP but I didn't go, I don't know why
- 3. I don't think it is a serious problem I want just someone he can understand and listen to give support
- 4. I was think if I will talk someone understand me I will be OK
- 5. No needed to
- 8. I would approach my GP if needed to
- 10. Didn't think it was a problem
- 12. Not necessary
- 13. Have not needed help
- 14. They would not understand me
- 15. I am mentally well
- 18. don't know how to access to the professionals not though the GP
- 19. Poor communication, and no understanding, he just act that he understand me but I am sure he is not
- 22. How I can go to professional who will refer me, no-one have enough time to hear me

26. Mental health OK
28. Only GP because of language barrier
30. It is not easy to find, its long time in the queue, when you will be there you forget what you want
32. No one offer me that I can go to the professional
33. Because I think that all the people suffer like me
34. I didn't choose
37. I could manage it on my own
38. Because I do not need to
40. I don't feel the need to
42. Because of language and poor cultural understanding (empathy)
43. Language problems – I did think I couldn't get necessary help
45. Trying to help your survey and expecting some possible help
49. I didn't choose
50. I don't think it is serious problem. I want some-one to talk with and he can understand

Q29 Is there anything available in your background culture which was not available here?

1. I don't know really
2. Dentist
3. Understand the problem, he have the same thinking like me
4. The preferable family member who can give support or friend (best friend)
5. Do not think so, available everywhere now such as herbal or Chinese doctors
6. No
7. No
8. No

- 9. Yes
- 10. No
- 11. No
- 12. No
- 13. Yes
- 14. Yes
- 15. No
- 17. More friends, more people can understand your feelings
- 18. Better communication and understanding
- 19. The understanding about feelings
- 21. Don't know about my background but I missed my family through difficult time
- 22. Not much different between both of them, just the friends
- 24. Herbal medicine, acupuncture
- 25. No
- 26. No
- 27. Acupuncture
- 28. Chinese medicine
- 29. No
- 30. Understanding the feeling and the problem
- 32. No
- 33. No
- 34. I don't think
- 35. No
- 37. No
- 40. No

- 42. No
- 43. No
- 44. Lots of things
- 45. No
- 49. I don't think
- 50. The friend and family members

Q30 Is there anything else you would like to tell us about what it is like experiencing mental health problems while living in this area.

- 2. There is no difference for me if I want to talk to anybody about my mental health problems
- 4. Very limited environment because of the cultural difference
- 6. I feel it would be the same in any area
- 7. Feel very isolated. Nobody seems to understand
- 8. No different from home country except for the language barrier
- 9. Very isolated and misunderstood
- 15. I am mentally well, have not needed help
- 17. It takes a long time until you can go to a professional who is more helpful
- 18. If you are feeling lonely you will be very lonely and become extremely bad
- 19. As if someone drop you in a well without help
- 22. Feeling alone in a country you think it is perfect in providing services
- 24. Very lonely due to language barrier. My daughter had to do it all for me
- 25. I have not experienced any mental health problems as yet
- 27. Can be difficult feeling lonely and not understood
- 28. Can be difficult sometimes, a bit isolated but plenty of choice. Friends prevent feeling too lonely.
- 30. Think it take long time until they understood your problem and reasons for it

- 32. I think it is the same
- 33. I think it is like anywhere
- 34. Like suffer in a dark fridge
- 35. No different
- 37. No
- 40. No
- 42. I wish more bme organisations – people who is professional in this area
- 43. No
- 44. No
- 45. No
- 49. Gives you more troubles in your life
- 50. Having pressure on pressure

Q31 Has the current political climate affected this (eg war on terror)?

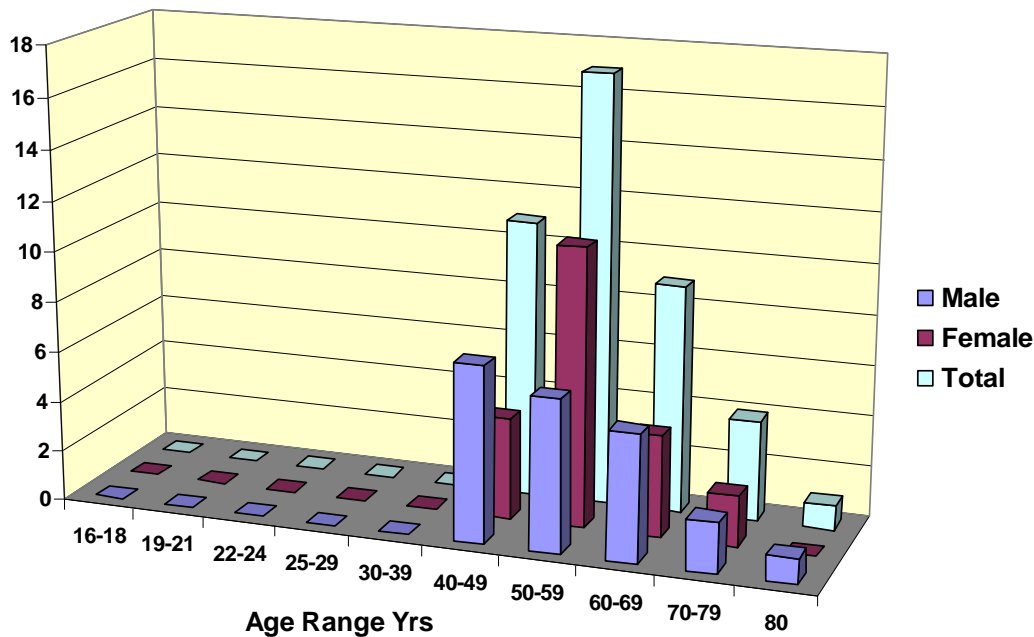
- 1. Yes, afraid of the future and now anxiety and racial isolation
- 2. Yes, last London experience, and the situation in Iraq, affecting directly our lives in the UK. We are not very happy and now with this gives much difficulties
- 3. Yes, it give more troubles
- 4. Yes, because some times, if I want to communicate with the others, they refuse that because I am a Muslim
- 7. Yes, makes me remember the past, and makes me sad
- 18. Yes, it became worse sometimes
- 19. I am not sure because I haven't experience before the terror situation
- 21. Yes, not my personal health but since G W Bush took over I feel depressed by the day. Love to see his backside walking away from public life

- 22. No, there is not a difference between now and before, except the doctor's time limitation
- 30. It make everything harder
- 33. The political climate give more depression
- 34. Give more depression
- 35. Destroying your hope
- 39. Makes the difficult for the forever for living in the society. Makes the other guilty
- 40. General climate against foreigner is much negativer and offensiver. Especially against Muslims, Arabs
- 43. Racial abuse is more intensively (happens often)
- 49. It makes out life more difficult
- 50. It makes it worth life

DISCUSSION

One of the constraints we put on our choice of sample was age. The Hikmat Centre, which is the only commissioned bme service in the area, is orientated towards an older age group. This gave the project an existing pool of potential respondents aged 45 and over who were familiar with some of the researchers and trusted the project managers.

Q1 How old are you?



Gender

The project was lucky in that respondents were divided equally by gender. Significant differentiation on the grounds of gender is, therefore, much easier to see in the data. All the women, for example, were registered with a Devon GP, whereas almost a quarter of the men were not.

Conversely, where there is no differentiation in choice or experience, for example in ease of communication with GPs, this is also clear.

Significant variation on the grounds of gender was indicated across a range of fields: GP registration; communication and professional sensitivity; self-diagnosis of mental health status and general well-being; exercise; education; separation from family; anxiety; loneliness; nightmares; difficulty sleeping; alcohol miss-use; gambling; poor concentration and memory loss; and support preferences. All these issues are considered individually within the discussion.

Domestic Status

Only one respondent had never been married, a smaller percentage than would be expected in a control group of Anglo-Celtic antecedents. The researchers understood

why immediately, and explained that it was considered a personal and civic responsibility in many cultures to marry and produce children.

Ethnicity

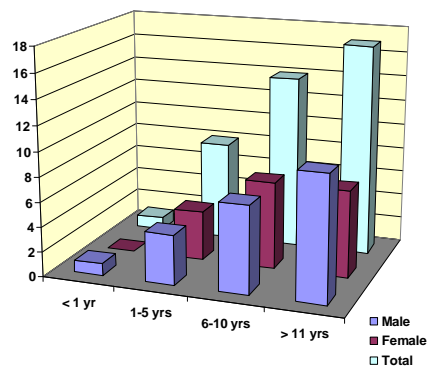
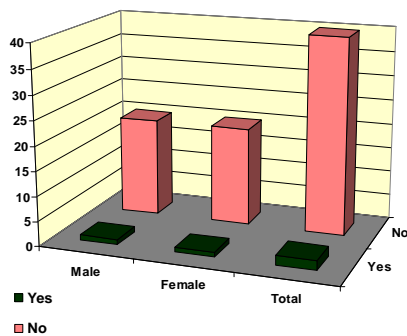
The ethnic monitoring system proscribed by UCLan complies with widely used Government guidelines. Our quantitative data would naturally lead one to assume a wide cross-section of cultures was represented among the respondents, who ethnically identified themselves across nine different classificatory fields.

This is far from the truth, however. The seemingly broad cross-section of ethnic groups represented is actually only two or three, all of whom perceive themselves very differently. For example of the eleven who described themselves as 'Arabic', one ticked Mixed Other, two Asian or Asian British Other, two British or British Black African, one Other Group North African, and two Other Group Arabic. The group therefore concludes that no useful inferences can be drawn from this data.

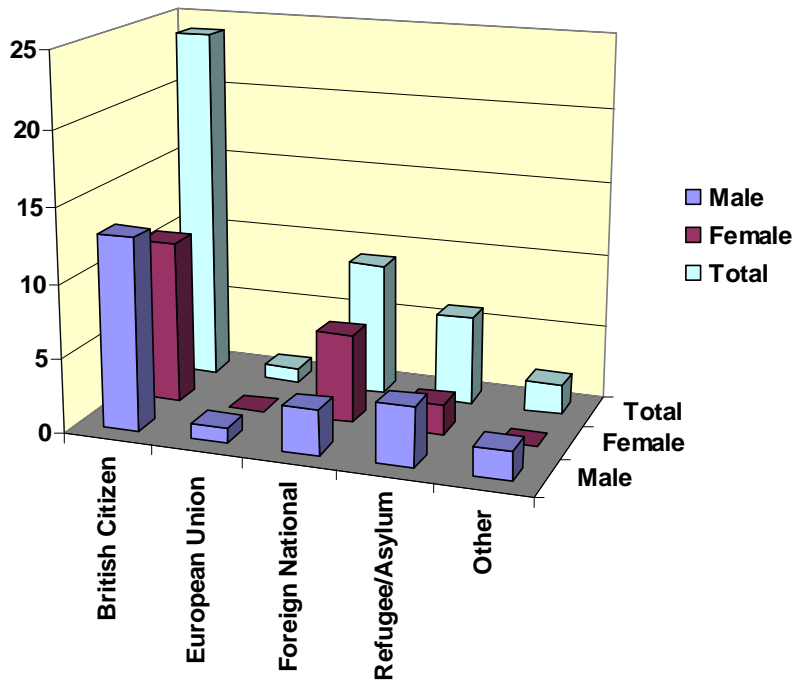
Residency

What we *can* be sure about is that 95% of participants were born overseas. We also know that 78% have been living in the UK for at least six years, and that over half are British Citizens

Q6 Were you born in the UK? Q6a If no, how long have you lived here?

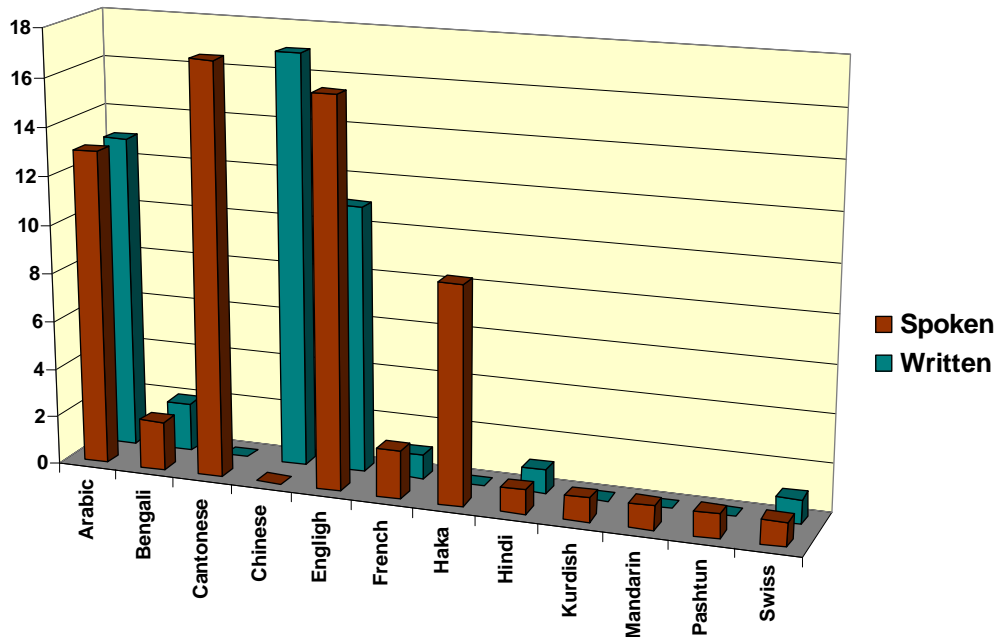


Q7 What type of residency do you have?



Despite the comparatively long periods of residency for almost four out of five participants, only 28% were comfortable with **written** English, and 40% judge themselves fluent in **spoken** English.

Q9 What languages are you fluent in?



This theme is picked out throughout the questionnaires, as respondents repeatedly try to qualify their statements by explaining, in various ways:

“Was OK if not for language barrier.”

Improving communication is central to the recommendations of this report. There has been no aspect of the project that has escaped communication challenges and we expected an emphasis to appear in the data, in part because several questions were dedicated to the topic. It will be returned to later.

Religion

We had predicted that most of our respondents would practice a religion, and 84% of them did. What surprised us was that religion ranked lower than hobbies, walking, reading and work, and equal to music, as a method of maintaining good mental health.

We had also expected rather more than 13% to go to a religious leader for help, particularly after the problems reported by the Imam. This discrepancy could be caused by a bias in the sample, or by the Imam's time becoming ever more scarce, or by inter-generational difference in behaviour.

Sexuality

There had been controversy and disagreement among the research group about including this question and it was anticipated that respondents would object to answering it. However, only four respondents preferred not to answer, suggesting reference, at least, to alternative expressions of sexuality could be becoming more acceptable among bme communities, including among older, devout members.

Disability

Monitoring for disabilities was part of the core questioning and so, strictly speaking, should be included in this first section. The significance of the data, however, is enhanced when considered in the context of respondents' self-diagnosed health status, and will therefore appear in the following section.

PROJECT SPECIFIC DATA – GENERAL HEALTH

GP Services

Credit should go to somebody, perhaps the old Exeter PCT, for a 93% Devon GP registration rate among this group of bme older people. Respondents seemed generally satisfied with their GPs. Of those who had gone to a GP for help with a mental health problem, 65% thought his treatment had been “quite effective” although rather less, 25% only, considered more general treatment or advice “usually helpful”. No-body thought their GP was always helpful.

Apparently, it is communication difficulty that compromises the healing relationship between health professional and bme service user; almost all the relevant qualitative data cites poor communication as the reason for poor outcomes; in both access and experience.

At one end of the planned care pathway, the system is failing when potential users of mental health services don't even **try** to access available help, despite knowing it is there, because of perceived communication problems. When asked why they had decided **not** to approach a medical agency when realising something was wrong, a respondent told us,

“Language problems. I did think I couldn't get necessary help.”

And another, simply,

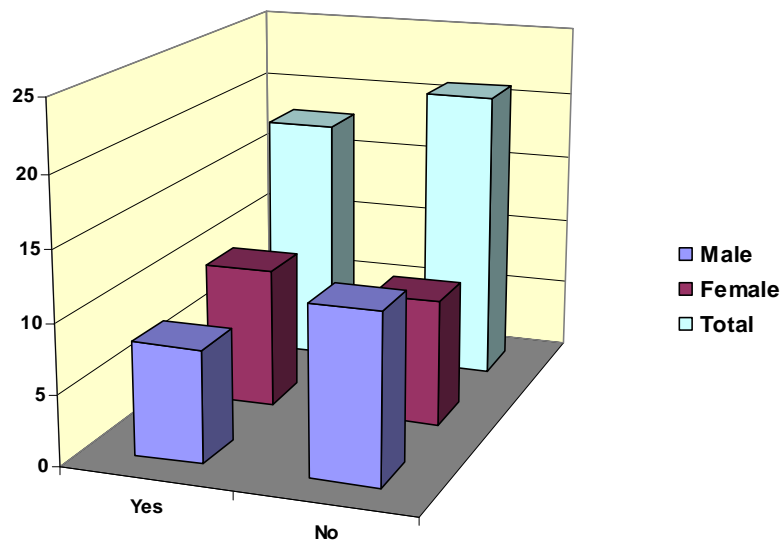
“They would not understand me.”

Later in the questionnaire, when the developing relationship between respondent and researcher encouraged a more intimate approach to the consultation, we asked respondents directly if they felt confident about requesting treatment. More than one in

three did not. All fourteen of the respondents who answered “No”, qualified their statement, and ten of them identified communication as both pivotal and distressing, for example,

“language makes seeing GP difficult and embarrassing”.

Q19 Do you feel confident in asking for treatment?



Two participants, when asked this question, were convinced their requests for treatment would be rejected, replying,

“No. I know I wouldn’t get it.”

And,

“Can’t ask because I know GP wouldn’t give.”

Having succeeded in making an appointment, some respondents found they still couldn’t guarantee their concerns would be understood. One or two acknowledged this was not for want of trying on the part of the GP,

“They try to help, but some points we can’t explain and they can’t feel it.”

And, similarly,

“GP listening but he can’t put himself in my situation, as it is for me.”

It was generally understood that GP appointments are restricted to a few minutes only, but some thought this makes cross-cultural understanding impossible,

“The GP have limited time for the patient, and sometimes it is not enough in explaining situations.”

How many think it, we don't know, but one participant at least asked us to record a more cynical justification for not going for treatment,

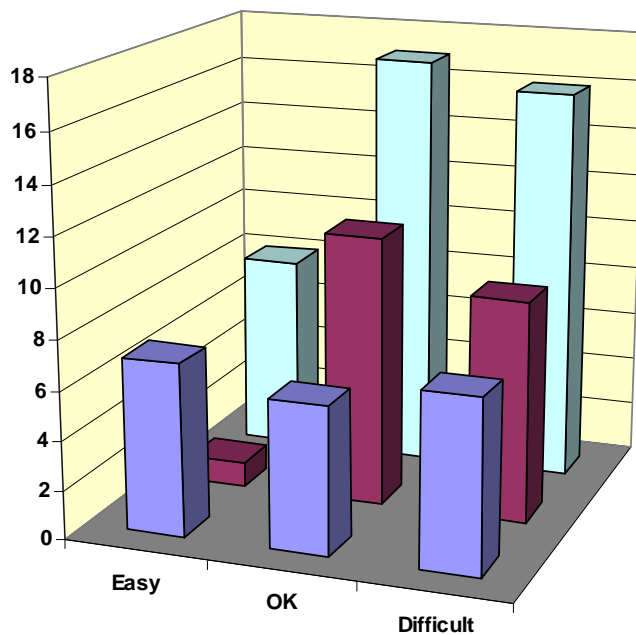
“Poor communication, and no understanding. He just act that he understand me, but I am sure he is not.”

All in all, 38% described communication with their GP as 'difficult', with only one in five finding it 'easy'.

“Difficult. Possible only when a family member is with me”,

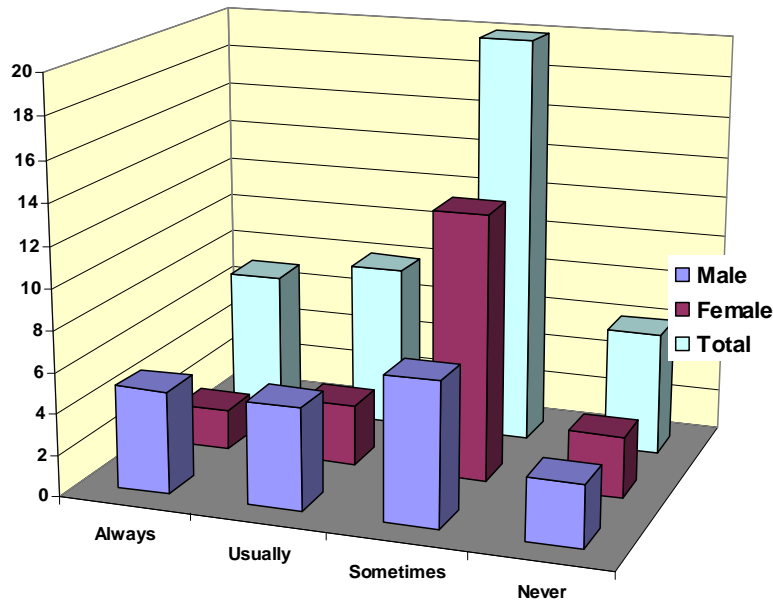
was a common position. The remainder described the experience as 'ok'.

Q14 How easy is it to communicate with your GP? (language)



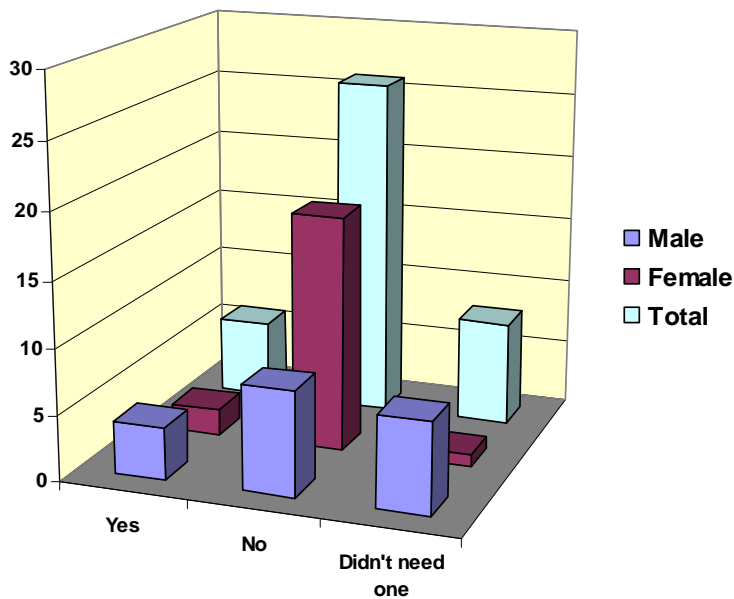
We also asked respondents how often they felt their GP understood their **cultural** sensitivities and feelings. An encouraging 18% 'always' felt understood and the same number 'usually'. Six people recorded 'never' having felt understood at all, but the common experience seems to be that older bme people in and around Exeter feel their GPs are sensitive to their cultural *habitus* some of the time.

Q15 Do you feel understood by your GP (sensitivity)



The Steering Group, as well as the Research Team, were interested in what interpreting and translation services were being used to support consultations, so the questionnaire asked about both. We asked respondents whether or not they considered they needed such support and, if they did, whether they were offered either.

Q16 If you need one, were you offered an interpreter?

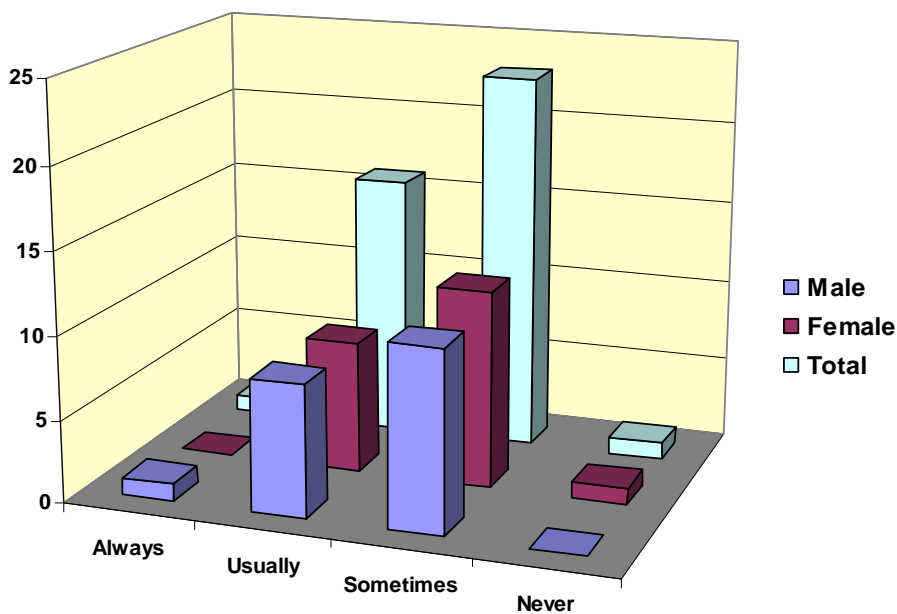


The answer was a resounding 'no' for the women, 85% of whom considered they needed, yet were not offered, an interpreter (including Language Line) at their consultation. The men fared rather better with 35%, partly because a further 35% felt confident enough in their English not to need one.

Only two of the participants had ever been offered a leaflet in their own language by anyone other than the Hikmat Centre.

Communication problems notwithstanding, a good many interventions **are** perceived as successful. Over 40% of respondents acknowledged the treatment or advice they received from their GP was 'usually' helpful, and only one complained that it 'never' was. The majority, again, had to be satisfied with receiving helpful treatment or advice 'sometimes'.

Q17 How often has the treatment or advice been helpful?



Culturally Specific Treatments

The Hikmat Centre has, almost since its inception, provided an opportunity for service users to access treatments other than the Euro-centric biomedical range offered by most surgeries. In fact, the service users requested this facility, so take up has always been good and we intentionally included question 18, expecting a positive response.

As predicted, over half identified treatment that is available to them in their country of origin, but not here. Semantics confuses the picture, however. Discussion confirmed that some respondents interpreted 'not available' as not available through **circumstances** rather than not available because **something doesn't exist**. This was because they had enjoyed comprehensive and reliable medical insurances and access to good quality private treatments in their country of origin, which were non-transferable, or they had defaulted on because of displacement.

So, in principal, such services **are** available here, but not now available to a refugee or asylum seeker, where they were at home.

Twenty-one respondents elaborated on what they felt is missing from their current range of treatments, falling into three main categories: private health insurance and treatments, herbal medicines and acupuncture. The researchers were told anecdotally that herbal and other culturally approved naturopathic remedies are routinely brought back from overseas trips.

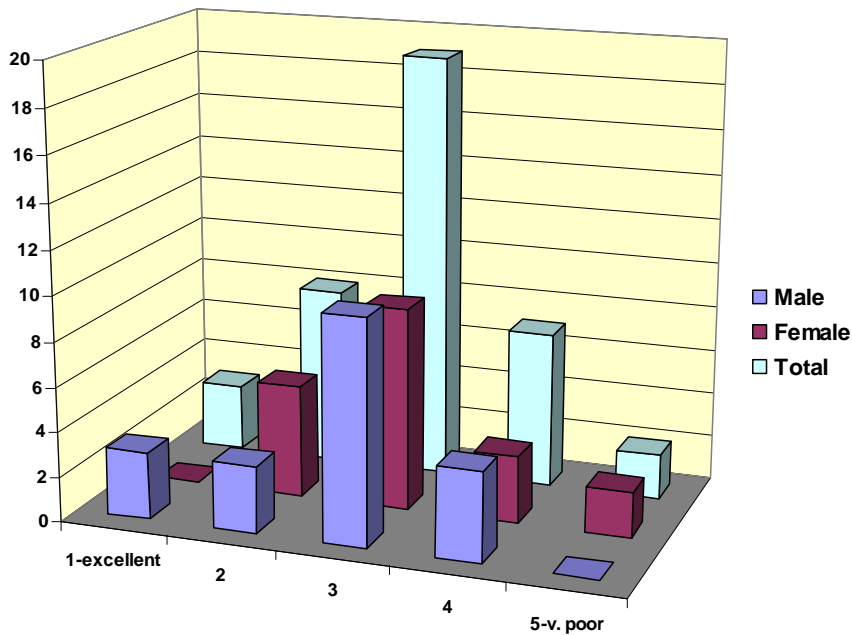
Self-diagnosed Health Status

The Research Team considered long and hard how to overcome the reticence of most bme people to talk about mental ill-health. One option that was rejected was to 'water down' the language; using terms such 'emotional well-being' and 'mood', or the colloquial terms used by the ethnic groups themselves (which usually refer to an organ of the body used in an analogous sense).

The Steering Group, whose creative contribution was needs-led as well as project-focused, suggested we lead participants into more sensitive areas of inquiry through a generalised medical section. We therefore offered an opportunity for people to report acute, as well as chronic, medical conditions and to rate their general well-being before we asked **anything** about their mental health.

As might be expected, the mode for general well-being on a scale of one to five was three for both genders. Gender differences were visible at either end of the scale; no women reported excellent health and no men reported very poor health.

Q20 How would you describe your current state of general well-being on a scale of one to five (1 being excellent and 5 being very poor)?

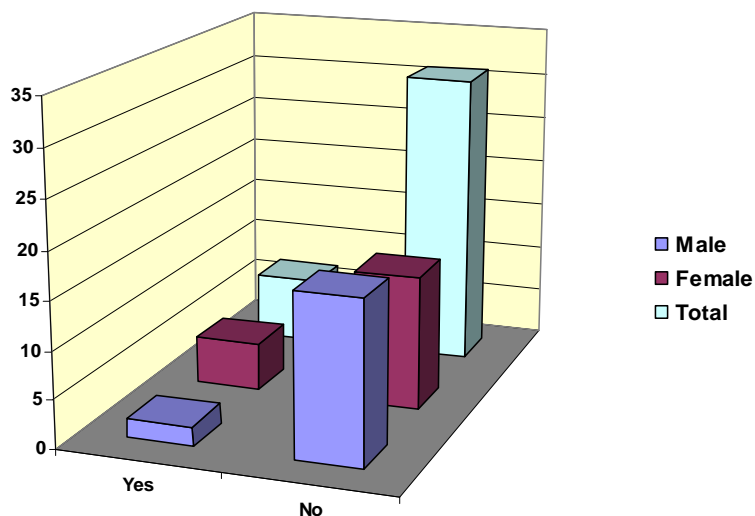


A quarter of the women diagnosed themselves as having poor or very poor general health.

Just **over** a quarter of the total sample considered themselves in good or excellent health, and just **under** a quarter in poor or very poor health.

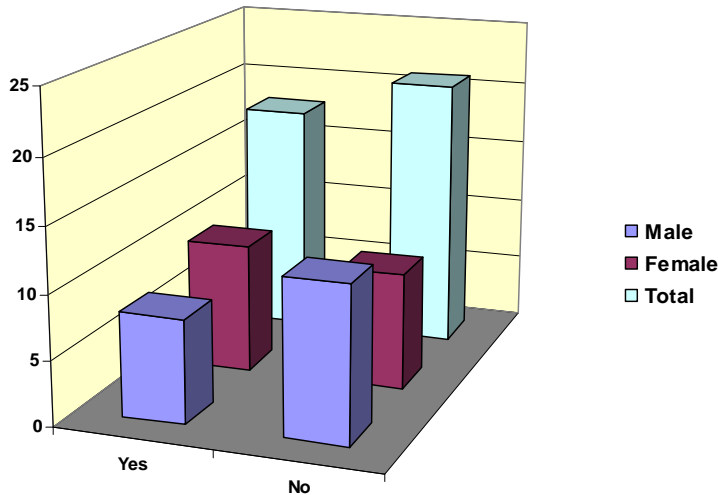
Very few respondents (18%) considered themselves to be suffering from acute medical conditions, although of these 71% were women.

Q21 Are you suffering from an acute medical condition?



Chronic medical conditions were far more prevalent, and far more evenly distributed. Almost half the respondents answered “yes” to the question, “Are you suffering from a chronic medical condition?”, 56% of them women.

Q21a Are you suffering from a chronic medical condition?



There is a noticeable discrepancy between the number self-reporting chronic ill-health and those who identified themselves as ‘disabled’ when asked the earlier core question. The team believes this statistical difference is the mathematical expression of a pervasive ignorance among some people about what constitutes ‘disabled’ and consequently, what benefits and allowances are available for both service users and carers.

PROJECT SPECIFIC DATA – MENTAL HEALTH

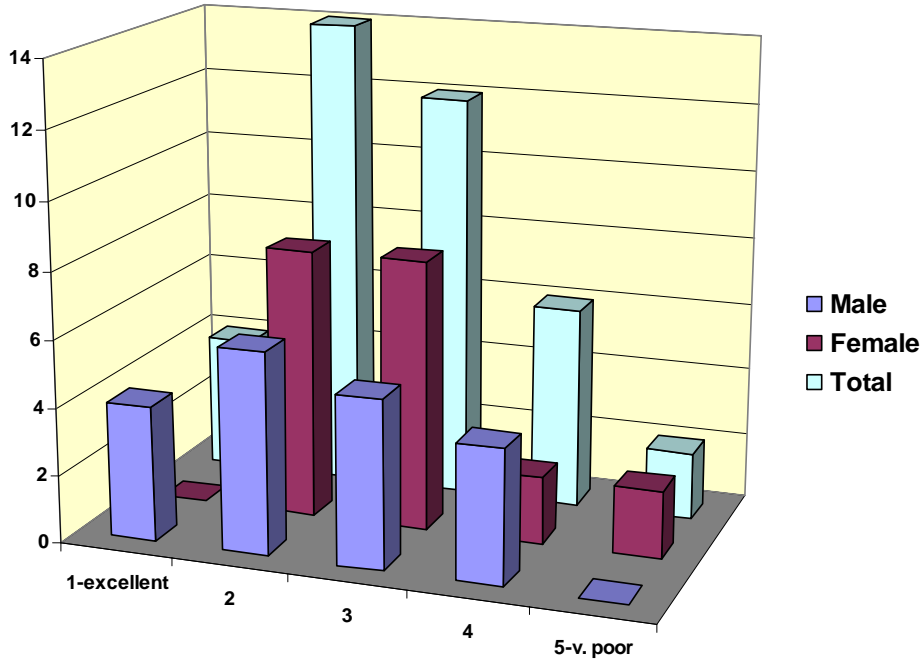
The questions now become mental-health focused, the first asks respondents for a reflexive appraisal of their current state of mental well-being.

The quantitative data from this question shows a sharp contrast to earlier perceptions of general health, where the mode (48%) was three on a scale of five. Here, 68% of respondents were divided almost equally between two and three on the scale, leading us to infer better mental health among participants than general health.

However, as will be discussed below, a degree of denial is suspected among the Chinese community who, not infrequently, insisted they had never had any mental health problem. The Chinese speaking researcher confirmed this may be influenced by cultural expectations and stigma.

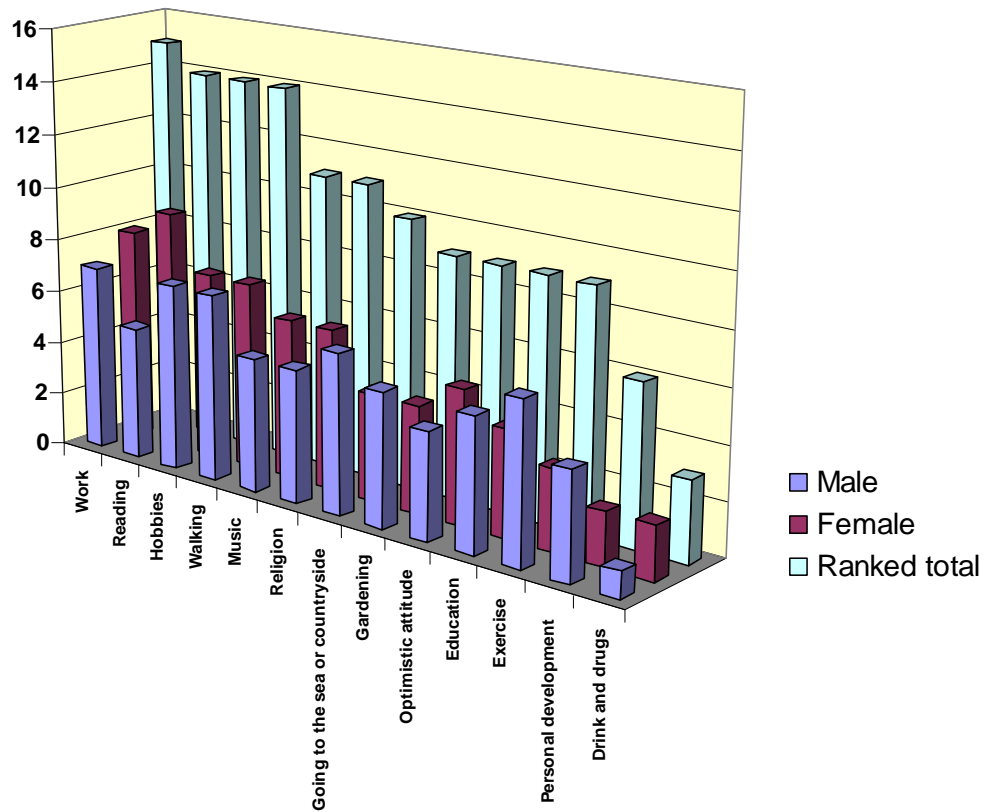
Again, no women reported ‘excellent’ mental well-being and no men ‘very poor’.

Q22 How would you describe your current state of mental well-being on a scale of one to five (1 being excellent and 5 being very poor)?



Staff and managers at the Hikmat Centre were anxious to capitalise on the opportunity the research offered, to find out what helps service users keep mentally buoyant. The intention was to use such information to improve the range of activities on offer and increase the impact of the centre on the mental well-being of its client group. A category question was agreed, listing suggestions and asking respondents to add others.

Q23 What helps to keep yourself mentally well?



Every activity suggested was included in the lists of more than one respondent. Eight additional choices were included in the ‘other’ category, including listening to radio, TV, relaxing at home, weekly meeting with friends, time with the family, housework, shopping, PC and time with grandchildren.

The most popular form of relaxation was reading and 43% of participants included it in their list of activities. The Hikmat Centre is committed to continuing early work with Devon County Library Services to develop and distribute culture-bound collections. It is continually working to increase its range of newspapers and periodicals in hard copy.

Work came second, supporting current arguments that the perception of ‘contributing to society’ is vital to mental well-being. Joint third were hobbies and walking, corroborating the evidence from the earlier enquiry into Muslim elders’ health²⁰.

²⁰ A *Question of Fairness* (2004) reported 83% of its sample walked as their primary, or very often only, form of exercise.

The importance of music, walking and going to the sea or country-side, which all came fourth and were chosen by a third of participants, should encourage optimism among those whose desire is to increase bme people’s access to the region’s natural and civic resources.

More ethereal, ‘an optimistic attitude’ and ‘religion’ shared fifth place. Although it does not show in the data, optimistic attitude was particularly popular as a self-help support amongst the Chinese community. The project’s Chinese researcher identified ‘optimistic attitude’ as a cultural injunction, expected of people in good times and bad. We had expected ‘religion’ to feature more strongly, both here and as a ‘treatment’ option in question 26.

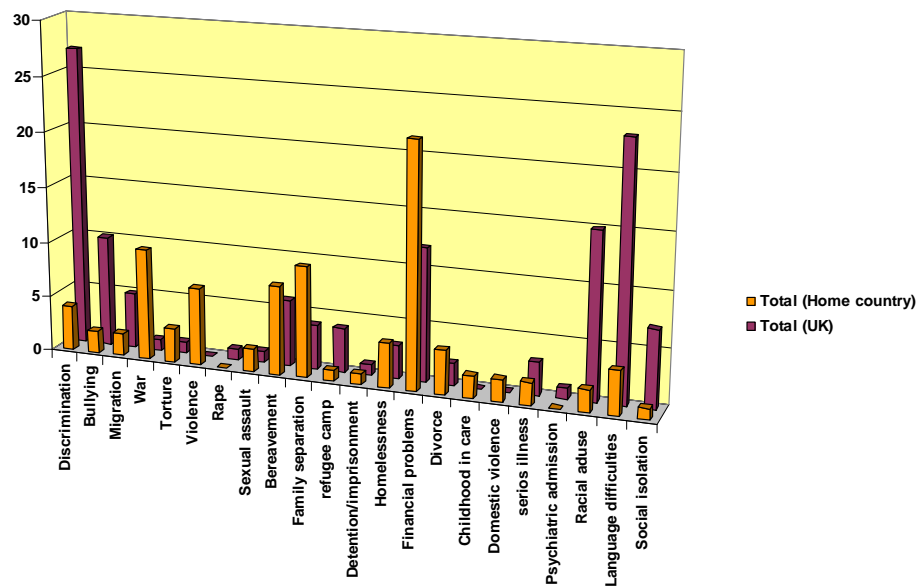
Traumatic Life Experiences

In question 24 we made no further concessions to the respondent’s sensitivities and asked **directly** about traumatic life experiences. Every event we included except imprisonment was affirmed by at least one respondent.

Almost two-thirds of respondents reported having financial difficulties in their home countries, with a third suffering separation from family and another third, bereavement. Just under a quarter had experienced war.

In the UK, discrimination was a universal experience with racial abuse and language difficulties reported by almost half, followed by financial problems (more than a third) and bullying (a third).

Q24 Have you experienced any of these events in either your home country or the UK?



We were surprised by the small number (8) who reported experiencing social isolation, but this could have been because a mistake in aligning the tables resulted in this option slipping onto a new page. When asked what experiences they thought impact on our mental health, social isolation ranked very high amongst the women. This would imply an attachment to the question generated by personal experience.

Many different attitudes to personal trauma are expressed by service users at Hikmat, despite much similarity in the suffering. The team wondered if these imprecise and subjective impressions could be distilled into quantifiable distinctions. We were also interested in whether the potential for post traumatic stress disorders was acknowledged among the communities, given the stigma attached to mental illness. Question 24a is an attempt to do this.

Perceived Causes of Mental Ill-health

Unfortunately, the sample sheet cannot distinguish cultural differences in perception, but it can distinguish gender ones.

We were unsurprised to find that more respondents, of both genders, thought 'war' impacts negatively on mental health than any other category. After this, however, there is a divergence of values.

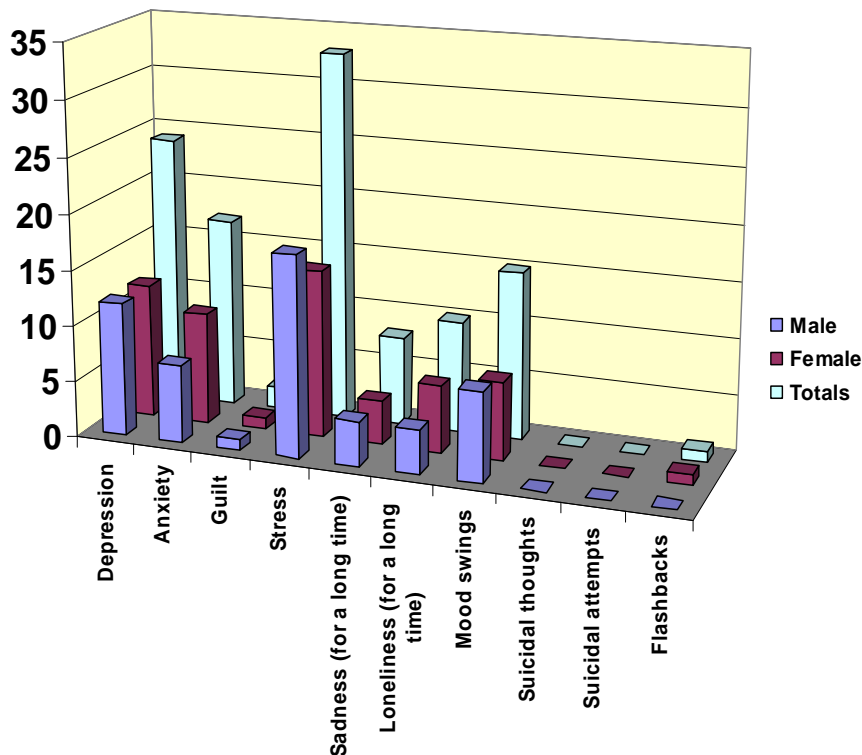
'Sexual assault' was chosen by the same number of men as 'war', while it only appeared fifth on the women's list. By contrast, the women ranked 'social isolation' second, while the men ranked it fifth.

'Discrimination', 'migration', 'separation from the family', and 'living in a refugee camp' were all in the women's top five list but not in the men's. The men were more concerned about 'bullying', 'childhood in care', and 'racial abuse', none of which appeared in the women's top five.

We inferred from this that experiences around displacement impact more on the women from our target communities, while belligerence and personal assault are the challenges the men fear. The team considers it probable that the importance afforded 'sexual assault' is, in part at least, a reflection of its power to destroy family honour and was considered by the men as a threat to their women rather than themselves, although it was noted that one man reported being sexually assaulted in his home country and one in the UK, and one had also been raped in the UK.

Having acknowledged the traumatic events experienced by members of the sample group, and the impact they could have on a person's mental well-being, it was hoped the participants would have developed trust in the researchers, and the process, enough to divulge in more detail their own mental health difficulties and problems over the last three years.

Q25 Have you experienced any of the following in the last three years?

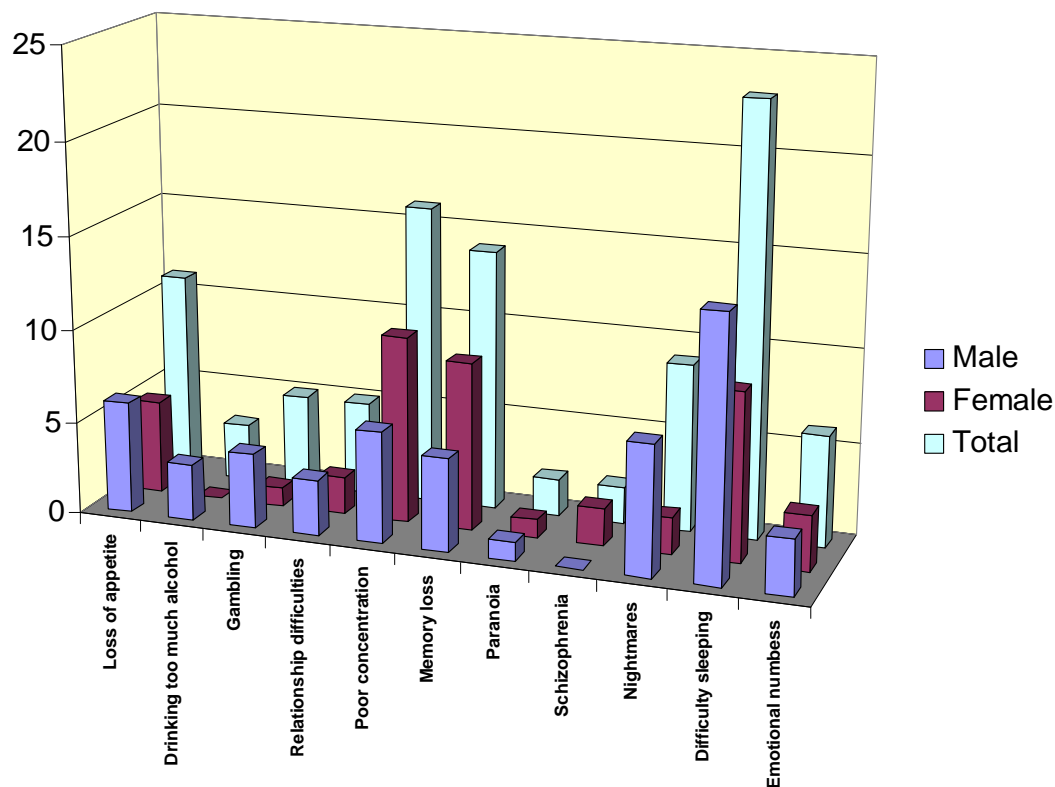


Stress seems almost universal (79%), although the team thinks it likely this is a common experience for many in the UK at present.

Rather more worrying is that more than half the participants think they have clinical depression. This can be compared with a general rate for older people of 12-15%.²¹ A third, mostly men, describe themselves as anxious.

Around one in five have experienced long periods of sadness, slightly more long periods of loneliness, particularly the men. Twenty percent of respondents also suffer from nightmares.

²¹ Care Services Improvement Partnership, 2006. *Everybody's business. Integrated mental health services for older adults: a service development guide*



We expected mood swings to be relatively prevalent, which they were at more than one in three, but were surprised by the high incidence of appetite loss (over a quarter), poor concentration (38%), and memory loss (one in three).

The team tried to find a concept to distinguish the feeling of total disengagement and decided to describe the state as 'emotional numbness or withdrawal'. Three men and three women acknowledged they had felt like this at least once over the last three years.

Treatment Choice and Effectiveness

We then asked, in question 26, what treatments had been tried and how effective they were. It is encouraging to see that, of the twelve individuals who accessed statutory mental health services, only one thought it had not been effective, and three thought the treatment had been very effective.

The total number receiving a service from psychiatry, psychology, psychotherapy or counselling, however, was significantly lower than the number who went to family members or friends. Even though not considered particularly effective, they were jointly the second most popular source of help in an emotional crisis, beaten only by GPs who, even then, were only consulted by a quarter of the respondents.

The figures in this table are conspicuous by their absence. The team offered eighteen options for treatment of which only three had been accessed by more than six of the

projects participants, and only one of those was a health care specialist, leading us to understand that most bme older people manage their emotional difficulties alone.

Questions 27 to 30 are qualitative and offer the respondent an opportunity to talk more about any service they may have accessed, or about why they did not access any. We also gave people a further opportunity here to tell us about treatments or support they can access within their background culture, and anything else about their experience of having poor mental health while living in and around Exeter.

These statements are reproduced in full at the end of the Results section.

Some of the responses make particularly dismal reading. One or two seemed to have given up all together, for example,

“If they can’t understand my physical pain how come they will understand my psychological pain and my needs?” and,

“I think, if I will go to the GP and say I have depression he will say, ‘All of us we do’.”

Some, however, were more optimistic,

“Give you the feeling that you can get help one day.”

Or even,

“It was helpful just talking about it.”

Question 30, asking people to tell us anything else about what it is like experiencing mental health problems in the area, produced some graphic answers, of which perhaps the most shocking became the title of this report,

“Like suffer in a dark fridge”,

although there were others, such as,

“As if someone drop you in a well without help”.

Many answers to this question involved loneliness, isolation and feeling misunderstood.

Political climate

The final question was to ask whether the current political climate is affecting people’s health and their relationship to health services. Almost half thought it is, either because it directly contributes to feelings of stress and depression, or because it is perceived as affecting people’s willingness to interact with bme individuals.

CONCLUSIONS

Unfortunately, what is beyond the scope of this report is providing a context of general and mental health status among the population of the area as a whole. The results can only be presented as a stand-alone picture of a particular demographic sample; in space, time and ethnic heritage, without comparitors. Further study is a recommendation.

However, the project provided a platform for some older people, whose only common experience was varying degrees of alienation from statutory health and social care support, to describe that experience, and participants contributed with unexpected enthusiasm and candour.

The impression left with the project team is of a hidden community of older adults, from a variety of cultures, who are dealing with the emotional consequences of a range of traumas by resorting almost entirely to personal determination.

War, violence, and family separation are not uncommon memories for Devon's black and ethnic minority residents. For many, financial difficulties in the country of origin have persisted here, now compounded by language problems, racial abuse and discrimination.

Our respondents are not pretending that life with their originating communities was trouble free. They honestly acknowledge the challenges left behind. But here, they are experiencing additional disadvantages, including differential statutory support, as well as racism and discrimination, whilst relinquishing the medical insurances, traditional treatments and family comfort they had enjoyed in the home country. Significant proportions are suffering untreated depression, stress, mood swings, sleep disturbance, memory and other psychological problems.

In 2004, Sainsbury's Centre for Mental Health researched services for Devon's older people²² and noted widespread dissatisfactions with existing arrangements for planning and commissioning services. People thought them "fragmented, hidden and inconsistent".²³

Amongst our sample, few had sufficient confidence to access the system, so there is little data on mental health service experiences or outcomes. For those that did, satisfaction levels are encouraging.

But both our quantitative and qualitative data strongly support the hypothesis that acceptance onto a mental health care pathway for older black and minority residents of Exeter is rare, despite a high level of self-diagnosed psychological distress. And the

²² Devon Strategic Older People's Partnership.....

²³ Devon Older People's Mental Health Development Programme, 2005. *OPMH News No 1*

picture seems to have changed little in the three years since the Sainsbury Centre's report, which referred its readers to Professor Appleby's²⁴ assertion that the needs of bme communities is the area of mental health care where there is the **greatest need** and **yet the least has been done**.

The South West Peninsular Strategic Health Authority have made the heart of their 2015 vision the development of services,

"that increase choice for users and carers, providing an increasing range of community based services within a 'Whole Life' recovery model of support²⁵."

In the Autumn of 2005, the Devon Older People's Mental Health Development Programme advocated following the government's guidelines²⁶ in its newsletter, including the development of,

"culturally aware staff, community engagement, better information."

Every one at policy level, then, seems to have been in agreement for some time with the project's objective to focus attention on two, at least, of the national priorities articulated in *Delivering Race Equality in Mental Health*, namely:

- increasing the range of therapies available to bme people, and
- developing a culturally competent workforce by including a more active role for bme communities and service users.

Pressure is mounting (and the project team take responsibility for stimulating demand through its research) for a more effective approach to improving take up of services. How might this be accomplished?

The *Race for Health* programme²⁷ is led by Primary Care Trusts and acknowledges,

"some capacity building of BME voluntary sector organisations may be required".

"But we can't afford to invest", cry the cash-strapped PCTs. Dr Sam Thompson, writing in *Update*, the newsletter of the National Institute of Mental Health in England and Care

Services Improvement Partnership, suggests they can't afford **not** to invest and refers to recent research which,

²⁴ Professor Appleby, National Director for Mental Health

²⁵ Developing a Mental Health and Well-being Strategic Framework, attachment E

²⁶ *Everybody's Business – Integrated Mental Health Services for Older Adults: a Service Development Guide*, Department of Health and Care Services Improvement Partnership

²⁷ *Race for Health, Towards Race Equality In Health: a guide to policy and good practice for commissioning services*, 2006.

“strongly suggests that interventions designed to raise levels of mental well-being across the population would have a very large pay-off in terms of physical health outcomes in later life”.

It is worth remembering here the comparative 2001 *Census* statistics on Limiting Long Term Illnesses among local bme older people aged between 50 and 64.

There is a new duty placed on commissioners to respond to patients and the public. Section 11 of the Health and Social Care Act 2001 places a duty on trusts and PCTs to involve and consult patients and public in planning and development of health services.²⁸ The PCT representatives on the Steering Group made clear their desire to maintain regular contact with the researchers, and through them the communities who had contributed to the project, thus capitalising on the trust and expertise developed over its ten month life-span.

New ways of funding health projects are being rolled out across the sector. Commissioning by individual surgeries and GPs opens the way for new configurations of service provision. Direct payments received in lieu of mental health services across the country increased by 78% between 31 March 2005 and 31 March 2006.²⁹

The voluntary sector itself is enjoying an increase of opportunity through the Government’s social enterprise funding streams and community cohesion initiatives. Sharing responsibility for funding, administering and providing services can only increase our options.

According to a recent article in the journal *Community Psychology*, none of these will succeed, however, without the pivotal ingredient,

“political will – the commitment to persist and to advocate publicly on behalf of an approach in the face of opposition – is essential to sustain interdisciplinary projects and to enable them to address inequalities and improve community quality of life”³⁰.

Bme individuals and communities in and around Exeter are suffering and are committed to reducing that suffering. They are equipping themselves with the skills, funding and strategic support necessary to accomplish that. What is missing is partnership; the team’s ultimate dream, which it fervently hopes to achieve through this contribution.

²⁸ *A Stronger Local Voice: a framework for creating a stronger local voice in the development of health and social care services*, 2006.

²⁹ National Social Inclusion Programme, second annual report

³⁰ Jean J Schensul, et all in *Community Psychology* (2006)

Recommendations

1. That the full report is made available to lead executives in the Devon PCT, Devon County Council and Devon Partnership Trust.

2. That Devon PCT, possibly through their Public Health Directorate, are invited to:

build on the skills and experience of the UCLAN trained researchers,

further develop systemic links and communication flows with the local bme populations,

consider further research into the needs of the bme populations.

3. That Devon PCT and Partnership Trust are invited to:

support the development and evaluation of culturally distinct interventions, linked as appropriate to –

a) the Improving Access to Psychological Therapies initiative,

b) identified surgeries, or clusters of surgeries,

improve access to current services, with particular focus on GPs and primary care.

support the creation of learning and development programmes for both people who may use service and staff that provide services

enable extended appointment time with GPs and practice staff.

APPENDICES

Appendix 1 – Invitation to potential Steering Group member

Dear

Re. National Institute of Mental Health in England/University of Central Lancashire BME Programme

Further to our brief conversation last November regarding the above scheme, I am pleased to be able to tell you that our submission has been successful.

The Olive Tree Association will administer the project, one of only four such projects within the South West Region. Management and supervision will be provided by the Hikmat Centre Management Group in conjunction with UCLAN.

The grant is dependent upon the project conforming to the UCLAN model of Community Engagement, one component of which is the development of a multi-disciplinary network designed to both inform service providers and commissioners of clients' needs and encourage take-up of services among target groups.

In November you expressed an interest in your team being represented on the project steering group. We are now in a position to schedule steering group meetings and release project information and would be glad if you could forward contact details for your nomination.

The commitment is expected to be a two-hour meeting bi-monthly with monthly electronic updates to which members may be required to respond.

The project will run from June 2006 to March 2007.

I look forward to hearing from you.

With best wishes

Fiona Hutton
for Hikmat Centre Management Group

Appendix 2 – Invitation to potential project researchers

16th May 2006

Dear Diane, Sevil, Ghania, Justin, Fakhira and Moes,

Re. NIMHE/UCLAN Project

Further to our meeting on Wednesday 10th May I am writing to give you some more details about the Nimhe/Uclan project as promised.

I met with Joanna on Thursday evening and she was very enthusiastic about our proposal. She will be asking her supervisor whether we can add children and young people to our research and getting back to me over the next few days. She thinks this will be agreed.

She confirmed that there is a certificated course of study that runs alongside the research project. What is expected to complete the course will be discussed at the first training day and participants will be encouraged to apply. Joanna will support those who do it with proper academic supervision.

The training days run in pairs, the first two being 13th and 14th June (Tuesday and Wednesday), 11.00 to 4.00 on 13th and 10.00 to 3.00 on 15th. The venue has yet to be arranged but it will be in Exeter. The second pair will be in July and the third pair in November with a single session after this for those registered on the academic programme.

As we discussed at the meeting, the rate of pay will be £12.00 per hour for research time and we are also able to pay 6.00 per hour for training time. The research hours, however, will vary from month to month as the project develops. As little will be going on for the first couple of months, while you complete your training and design your questionnaires, etc, less hours will be expected of you. During the middle section of the project, there will be more work while it will tail off again towards the end.

I expect to have drawn up a work schedule by the time of our first group meeting with Joanna, which I have just heard will be on Monday 5th June and NOT tomorrow 16th May. It is likely to be at St Sidwells but I will confirm that with you.

Could you let me know that you have received this, and whether or not you will be coming to the 5th June meeting please?

I look forward very much to hearing from you and hope to see you on 5th when we can formalise your participation and start to look in more depth at your specific contribution to this exiting opportunity.

With very best wishes
Fiona Hutton
Project Co-ordinator

Tel: 01392 860985
Mobile: 07791 857824
e-mail kulini@msn.com

Appendix 3 – Ethics pro- forma

Pro-forma Ethics Form – Exeter Group

Section 1

<u>Name of group</u>	Hikmat/Olive Tree Mental Health Group
<u>Address</u>	St Sidwell's Community Centre, Sidwell Street, Exeter EX 64 6NN
<u>Name of Support Worker</u>	Joanna Hicks
<u>Date</u>	31 st August 2006

Section 2

What kind of work does the group intend to do?	The group intends to carry out research into the experiences of older mental health users and carers from bme communities in and around Exeter. It also intends to discover the extent of service provision awareness within bme communities and the reasons some potential service users and their carers do not access existing services.
How do they intend to do <u>this</u> ?	The group intends to develop a questionnaire to use with 70 older people and their carers, most of whom currently use the Hikmat BME Elders Centre in Exeter. They also intend to conduct three focus groups, each consisting of eight older bme individuals and their carers.
Who will the respondents <u>be</u> ?	People from bme communities aged 45 and over who are currently using a social contact centre in Exeter, or who are known to centre staff and outreach workers, and their carers. The majority of potential respondents are from China, North Africa, South Asia and the Middle East.

Who will they get to do the work?

A team of 6 researchers has been recruited from local North African, Chinese, South Asian and Middle Eastern communities. Four members of the team currently work at the Hikmat Centre, one with refugees and asylum seekers, and one with a Muslim women's association. The co-ordinator is a medical anthropologist with a background in older people's mental health who is known to many of the target communities.

Where will they undertake the work?

Most of the work will be conducted at the Hikmat Centre, although it is anticipated that some questionnaires will be conducted in respondents' homes, at their request. The Hikmat Centre has use of larger community rooms for focus groups and small private rooms for interviews and the completion of questionnaires. Risk assessments on the use of all rooms by older people have been completed. All smaller rooms have 'in use' options on the doors to ensure privacy. In accordance with Hikmat's Outreach Work policy, questionnaires conducted in respondents' homes will be undertaken by pairs of researchers.

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

The six Researchers will all work with the Co-ordinator who is the named lead for this project. She will have oversight of the project on a day-to-day basis. The Co-ordinator will meet with the team fortnightly, and provide interim support through e-mail, telephone, texts and individual supervision as required.

The Researchers and the Co-ordinator will all be attending the training workshops that the University is providing.

The Support Worker will also be visiting on a fortnightly basis, as well as being available by telephone or e-mail for support around any issues group members are uncertain about.

How will they ensure that participants in the project have given consent?

An information sheet about the project has been prepared (see attached). The interviewers will read this to potential respondents before they begin completing the questionnaire. Respondents will be asked whether they are happy to proceed with the questionnaire based on the information they have been given.

How will the project ensure confidentiality?

Names will not be recorded on questionnaires. Completed questionnaires will be stored in a locked filing cabinet in an office used by the Olive Tree Association, who are administering the project.

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 responses to any particular individual.

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

Participants will be asked if they would like a copy of the final report. Those who say they would will be asked to give their name and address but these will be recorded separately from the questionnaires (ie a list of people who want more information).

Participants in the focus group will be requested to keep what was said within the group and asked not to talk about it outside. However, we know that we cannot guarantee that people won't talk about what is said outside the group. Focus group participants will be told confidentiality cannot be guaranteed therefore and reminded that they should therefore think about what they say in the group, and that they should not reveal anything that they would not feel comfortable disclosing outside the group.

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

Completed questionnaires and notes from focus groups will be stored in a locked filing cabinet as described. Only staff working on the project will have access to them.

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

It is anticipated that the subject matter and intimate nature of the interviews may open up feelings for the respondents beyond the scope of the researchers or the project. There is also concern that respondents will think the project is there to offer help. Researchers will therefore have available a sheet signposting a range of appropriate services in the main languages of the

target groups and will be encouraged to clearly distinguish the research parameters.

Cultural perceptions of the subject matter may cause friction within families. In order to minimise this respondents will be supplied with information about the project in advance of consultation to allow time for discussion.

Respondents will receive basic counselling training to maintain boundaries, sensitivity and self-awareness.

A culturally competent Community Psychiatric Nurse will be available through the Hikmat Centre for immediate referral if necessary.

Please confirm the make-up of the steering group.

The Steering Group is made up of the Project Co-ordinator, Fiona Hutton; Brenda Laker, Management Group of the Hikmat BME Elders' Centre; David Wright, joint Chair of the Olive Tree Association; Lynne Bradshaw, Equality and Diversity Lead, Exeter and East Devon PCT; Dr Rob Kidney, Assistant Clinical Psychologist, Older People; David Evans, Exeter Older People's (Mental Health) Integrated Team; Dr Susan Bedford, Older People's Psychiatric Services; Nichola Weate, Services Manager, Age Concern Exeter; Lynn McClellan, Clinical Tutor, Dept of Doctorate, Clinical and Community Psychology, University of Exeter; Lindsay Stewart, Approved Social Work Training Co-ordinator, Ian Pearson, LIT Lead, Devon PCT, and Joanna Hicks, University of Central Lancashire Regional Support Worker.

How often does the Steering group meet?

It meets every two months.

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 4 – Respondents’ Consent Form

(Printed on headed paper)

Hikmat and Olive Tree Association BME Mental Health Project

Information for prospective respondents - Questionnaires

Hikmat and The Olive Tree Association are conducting research into the mental health service needs and experiences of BME older people from in and around Exeter. The research will explore any experiences BME older people and their cares have of using mental health services. The research also aims to discover the extent of services provision awareness within BME communities and to identify whether there are barriers which prevent some potential service users and their carers from accessing existing services.

The research is funded by the Care Services Improvement Partnership and supported by the Centre for Ethnicity and Health at the University of Central Lancashire.

When all the information is collected, a report will be written which will be used by local services and, when combined with 39 other reports from round the country, the Government, to make changes to services on offer to BME citizens. In particular we hope to:

- Increase the range of therapies that are culturally appropriate and effective
- Encourage a more active role for bme communities in training the workforce and developing policy and provision
- Increase the proportion of bme service users who feel they have recovered from their emotional distress after treatment.

By taking part in the project you will be contributing to improving the situation in the future. Completing the questionnaire is voluntary but we will offer you a voucher to thank you for your time and effort.

You don't have to answer any questions you don't want to and you can stop the interview at any time.

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.

When we have completed all the questionnaires we will be inviting people to hear the results and discuss the most common themes in more detail in small focus groups. If you would be prepared to contribute to one of these sessions, please let your researcher know and they will contact you when the dates have been set. The report will be available for everyone to see.

The information you give us is anonymous and will be treated confidentially. 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.

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

Do you have any questions?

Are you happy to undertake the questionnaire?

Who can help with emotional distress if you live in Exeter?

One out of every four of us who live in Exeter will need help with overcoming emotional distress at some time. That is a lot of people, who will not want exactly the same sort of help.

This leaflet gives a brief description of what is available in Exeter to help with **stress, sadness, anxiety, anger, loss of confidence, fear, depression**, or any other emotional problems. If you need help understanding or making contact with any service mentioned on this leaflet you can ask the person who gave it to you or ask to speak to the ***Hikmat BME Elder's Centre Mental Health Worker***.

Self-help

Some will want to work through their difficulties at home on their own, or with family and friends, with minimal support from other agencies (***Self-Help Sessions, NHS Walk-In Centre, 01392 208630 or Stress Control Course, The Victory Centre, 01392 383788***).

Hospital Care

However, some may prefer to get right away from everyday life and stay in hospital for a while to sort things out (***Emergency Duty social Service, 0845 6000388, Wonford House Hospital, 01392 403433***).

A broad range of services fall between these two.

GP Surgeries

A GP (General Practitioner) is a local doctor (contact **NHS Direct, 0845 46 47** for a list of GPs in your area and details of how to register). He can offer some advice and/or medication to help your problem and he can refer you to more specialised help. GP's surgeries often have nurses, therapists and counsellors who offer practical support if we are trying to make life-style changes to improve our mental health.

Psychology Services

You or your GP could refer you to a psychologist, psychotherapist or counsellor (what are often called 'talking therapies') (**Meadow House, 01392 208900, Psychological Services 01392 403170**) or psychiatric services (which are more medication and hospital-based treatments and accessed through your GP).

Or you can ask to be referred to a Care Co-ordinator who will help you develop a Care Plan. This makes sure we have what we need in accommodation (**Community Mental Health Team Accommodation Officer, 01392 20890**), benefits (**Citizens Advice Bureau, 01392 201210**), employment, education and activities (**WorkWAYS, 01392 208833, Exeter Council for Voluntary Service, 01392 202055**), therapy and support (see above). Care Co-ordinators have an enormous range of services they can access on our behalf, such as sheltered accommodation schemes, benefits experts, rehabilitation services, help with drugs or alcohol (**Addaction, 01392 255151, Exeter Drugs Project, 01392 666711**), art, drama and music therapies, education and training opportunities, a drop-in café and individual support through an "enabler" (**Community Mental Health Team, Meadow House, 01392 208900**).

For accident and emergency dial 999 and ask for an ambulance or go to Accident and Emergency at the Royal Devon and Exeter (R D and E) Hospital, Barrack Road, Exeter.

BIBLIOGRAPHY

- Acheson, D. 1998. *Independent Inquiry into Inequalities in Health Report*
- Age Concern and the Commission for Race Equality, November 1998. *Age and Race: Double Discrimination,*
- Care Services Improvement Partnership and the National Institute for Mental Health in England, 2006. *National Social Inclusion Programme, Second annual report.* DoH, London.
- Care Services Improvement Partnership and the National Institute for Mental Health in England, 2006. *Update7269,* DoH, London.
- Care Services Improvement Partnership, 2006. *Everybody's business: integrated mental health services for older adults, a service development guide.* DoH, London.
- Department of Health, 2005. *Delivering Race Equality in mental health care.* DoH, London.
- Department of Health, 2006. *Race for Health, Towards Race Equality in Health: a guide to policy and good practice for commissioning services.* DoH, London.
- Department of Health, 2006. *A Stronger Local Voice: a framework for creating a stronger voice in the development of health and social care services.* Doh, London.
- Department of Health and Care Services Improvement Partnership, 2005. *Everybody's Business – Integrated Mental Health Services for Older Adults: a Service Development Guide,* London.
- Devon Older People's Mental Health Programme, 2005. *News No 1,* The Devon Implementation Group
- Devon Older People's Mental Health Programme, 2005. *News No 2,* The Devon Implementation Group
- Evandrou, M. 2000. *Ethnic inequalities in health in later life* in Health Statistics Quarterly, 8 HMSO
- Gross, R. D. 1987. *Psychology: the Science of Mind and behaviour,* Hodder and Stoughton, London
- Healthcare Commission, 2006. *Health watchdog highlights gaps in community mental health care*

- Hutton, F. 2004. *A Question of Fairness: an enquiry into the health and social care needs of Muslim elders in Exeter*, Age Concern Exeter and Devon County Council, Exeter
- Lee, M, 2006. *Inquiry into Mental Health and Well-Being in Later Life*, Age Concern England.
- MacPherson, W. Sir. 1999. *The Stephen Lawrence Inquiry*
- Magne, S. 2003. *Multi-ethnic Devon: a Rural Handbook*, Devon and Exeter Race Equality Council, Exeter
- National Social Inclusion Programme, 2006. *Second annual report*, Care Services Improvement Partnership, National Institute for Mental Health in England
- Pharoah, C. 1995. *Primary Health Care for Elderly People from Black and Minority Ethnic Communities*, Age Concern Institute of Gerontology, HMSO
- Seward, D, Quraishi, M, & Vernon, H, 2005. *Future development of mental health services for older people*, The Sainsbury Centre for Mental Health, Devon Older People's Strategic Partnership
- Schensul, J J, Robinson J, et al, 2006. *Building Interdisciplinary/Intersectoral Research Partnerships for Community-Based Mental Health Research with Older Minority Adults*, in *Community Psychology* 38:79-93
- South West Peninsular Strategic Health Authority, 2005. *Developing a Mental Health and Wellbeing Strategic Framework*
- South West Peninsular Strategic Health Authority, 2005. *Ensuring a Patient-led NHS*
- Thompson, S, 2006. *The science of subjective well-being* in Update 7269. Care Services Improvement Partnership and the National Institute for Mental Health in England. DoH, London.