Community Engagement Project:
NIMHE Mental Health Programme

Report of the Community Led Research Project Focussing on Mental Health Service Needs of Asian Women undertaken by the Sahara Spotlight Group in Middlesbrough

Researchers

Samaira Mehraj
Raheela Riaz
Shazia Syed
Shazia Tariq

Report prepared by:
Alison Brown, Sarah Cairns, Graduate Mental Health Workers Tees, Esk and Wear Valleys NHS Trust and Saadia Raja, Diversity Manager Social Care Department

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Samaira Mehraj

My name is Samaira Mehraj. I am involved with a few courses ECDL, Drug awareness, CDW, Mentoring and especially Mental Health Research for South Asian Women. I have chosen this research project because I am a south Asian woman and as a South Asian woman I am aware of my cultural and religious needs very well, besides this I speak the languages Urdu, Punjabi and English spoken by the local community which allows me to communicate with a large number of local people. I have done lots of voluntary work already. I always wanted to do something for my self and others with the help of this course my wish came true.

Raheela Riaz

I am a married woman and have three children who are all in higher education. My husband works full time and therefore I found that I have a lot of spare time on my hands.

Over the last 2 years I have been involved in the Sahara Asian women's group where as a volunteer I have regularly attended their classes and helped whenever needed. Through this group I have been forwarded to be a part of a group of four women who are going to be involved in community research and mental health project.

At times I have found this course difficult because although I can read pretty well, my written and spoken English, I feel is somewhat lacking. In time my true strength, which is in written and spoken Urdu and Punjabi, will be a big asset when it comes to communicating with Asian ladies.

I know that I can make anybody feel at ease and comfortable when they are with me and therefore I am sure I will get a very positive response to any questions that I will be asking them.

Shazia Syed

28 years old, work for this project as a co-ordinator. I am married with 2 & 5 years old sons. I had no previous experience of health and social care or research. I joined the group to gain knowledge; want to know and solve the problem of mental health issues of my community. I am really enjoying and getting a lot of information and experience because of this use full research. "

Shazia Tariq

My name is Shazia Tariq. I am married and have three children. I am studying Class room Assistant and ECDL in Computer. I am now involved with mental health community based research. I wanted to help to find out information that how to improve services for women in BME Community. I can speak English, Urdu and Punjabi language spoken by the local community which allows me to communicate with large number of the local people.

Acknowledgements

The researchers would like to take this opportunity to acknowledge and thank the National institute for Mental Health in England (NIMHE), The University of Central Lancashire not only supported our project but also helped researchers to gain qualifications and Sahara Spotlight Group for the opportunity to take part in this research project. Also we would like to thank all of the people who have supported the project. We have received ongoing support from Selina Ullah Race Equality Lead of NorthEast, Yorkshire and Humberside, and Nadia Ahmed our support worker from the University of Central Lancashire. We have had guidance from our steering group, Elaine Shephard, Service Manager Mental Health Services of Middlesbrough Social Care Department and Tees, Esk and Wear Valleys NHS Trust; Deborah Goodchild, Ethnicity and Diversity Officer for Tees, Esk and Wear Valleys NHS Trust, Saadia Raja Diversity Manager Middlesbrough Social care Department, Mrs Rifaat Raja and Zarina Din of the Sahara Women's Group.

We would also like to show our appreciation to Age Concern and their staff. We used their premises as our office base. We would like to give our gratitude to Middlesbrough International Centre, Teaching Learning Centre, Milan Group, Sure Start and their staff who have been very co-operative during our work and allowing us to use their rooms and facilities for conducting interviews. A special thanks to all our South Asian Women who have participated in this research by answering the questionnaire. Their feedback provided us a clearer insight as to why South Asian Women do not access Mental Health Services in Middlesbrough. A graduate mental health worker from the local Primary Mental Health Care Service also worked with the researchers on a weekly basis to help with the research and report writing.

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1. Executive Summary

This project was funded by the National Institute for Mental Health in England and supported by the Central for Ethnicity and Health, University of Central Lancashire (UCLAN). This project is one of 29 projects around the country selected to research in the mental health needs of black and minority ethnic communities. This study was undertaken and managed by Spotlight Sahara Asian Women group (Middlesbrough) an organisation that support Asian women who are older, isolated and disabled. Sahara group engaged, identified and recruited 4 researchers from the local community. The training was provided by Centre for Ethnicity and Health, University of Central Lancashire UCLAN and the project took place between April 2006 and March 2007.

Sahara Group decided to look into the experiences of South Asian women's use of Mental Health Services in Middlesbrough. What services and support they used and if those were appropriate and responsive to their needs, and what recommendations they could give to make mental health services more appropriate, accessible and culturally sensitive. Local Mental Health Services and Local Authority Social Care also supported this Theme. The Group preferred to use questionnaires to gather this information. The researchers carried out 107 face to face interviews with South Asian women.

It is widely recognised that BME communities experience social and material disadvantage and face barriers in their access to statutory support services. Social exclusion is a symptom and product of institutional racism and stereotypes. Within a health context social exclusion and institutional racism have contributed towards significant differences in health outcomes for BME communities including Muslim communities. . The key findings are

- That the participants defined mental wellbeing as being comfortable, relaxed, happy and safe in their environment. They feel that racism poses a threat to their mental wellbeing and that this has increased since the recent terror attacks and 9/11.
- Support of family and friends and those in similar situations is of great comfort.
- A significant proportion of the participants are suffering from mental health related problems and receiving treatment for this.
- Medication is the most frequent form of treatment, yet the women express the need for more therapies such as counselling.

- Awareness of services in the area is relatively low. Awareness of mental health issues could be increased by providing information on the symptoms but also services available. Information can be provided in a number of locations including the GP surgery and local community centres.
- Barriers to accessing services include language problems, lack of awareness, services not being culturally appropriate.

The research grouped the findings into themes some of which are discussed below:

What does mental well being means to you?

> *"I don't have a problem living in Middlesbrough, we have a big community which I enjoy."*

However after 9/11 there has been change in the political situation that has effect ed communities' mental well being.

> *"I don't feel safe walking on the road with my veil on."*
>
> *"After 9/11 I feel living in Middlesbrough has had an effect on my mental state as there is now a certain amount of fear in me".*

> "*Help was inaccessible at the time, I was afraid in case anyone found out. I later sought help when confidentiality was affirmed."*

> *"Didn't feel comfortable talking to a stranger."*

Choices

Some quotes about treatments.

> *"Medication, not appropriate, fear of addiction".*
>
> "*Prescribed antidepressants – helped for a little while but underlying problems were still present."*
>
> *"Medication is not a permanent solution."*

In order to help maintain mental well being women relied on prayers, family and friends support. This shows that future development of services could focus on the spiritual and community side of peoples lives instead of focusing on medicine to make people better.

Beliappa (1991) highlighted the fact that the lack of awareness of existing local support services meant that many coped with their distress by using internal mechanisms such as praying, crying and hard work.

Language barriers/Information/Cultural and Gender Specific

> *"Services should be bilingual as we can't express our feelings"*
> *"More Asian women workers make us more comfortable".".*

> *"If they don't understand my culture they won't know where I am coming from – can't get to the root of the problem."*

Safe Spaces

> *"We want a place people can go to without fear"*
> "*safer places to go to. Drop in centre so you have somewhere to go and meet". "get together for old age people*".

Recommendations

The results of the research suggest the following recommendations. These recommendations are based on key research findings and are targeted at local decision makers. This research has highlighted the gaps in mental health service provision for South Asian women living in Middlesbrough. These recommendations seek to address these gaps in service provision.

1. **To increase awareness of services in the local area for South Asian women with mental health issues**

- Agencies can work together to create this information, a resource directory could be put together to include all the services available, the referral criteria and means of accessing the services.
- The information should be made available in different formats concerning common mental health problems and what services are available and how to access them.
- Leaflets should be available in GP surgeries, Sure Start, community groups like Sahara group, local community centres and places of worship.
- Mental health awareness events should also be run in local community centres to further increase the awareness of mental health issues and service providers.

2. **Members of the South Asian Community are used to provide cultural competency training for health professionals**

- Cultural competency training that looks at the mental health needs of this community and including both cultural and religious aspects needs to be given to mental health professionals.
- 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 from managers to grass root mental health service provision.

3. Employing culturally competent gender specific BME/Bilingual Asian workers and Aalims, Aalimas to meet cultural and religious needs.

- To employ a range of support workers who would work to develop person centred services that promote mental well-being and enable individuals and families to cope with mental health crisis i.e. a relative, partner, parent and or sibling.
- Resources should be made available to employ from local community Aalims/Aalimas (male and female religious scholars) based within the community.
- To employ BME workers so that support is received directly from someone of their own community. This would put the women at ease and ensure they are understood properly.
- Ensure that all those whose first language is not English has a language needs assessment at first appointment. Raise awareness that South Asian women are entitled to ask for an interpreter if the health professional does not speak their language.

4. Ensure that South Asian women suffering mental health problems are offered 'talking therapies' which are culturally sensitive to their needs as alternatives to medication.

- The women should be made aware that they are entitled to a choice of treatments.
- More talking therapies such as counselling would be beneficial as a treatment option of their mental health difficulties.
- Offering choices to BME people in Middlesbrough includes provision of above as well as Faith-based Resources.

5. All services assure confidentiality.

- Addressing the issues of confidentiality in service provision.
- Building the confidence of white workers. Breaking down fear faced by some Asian females.

6. Ensure that South Asian women have access to a female health professional

- The women should be able to request an appointment with a female GP or other appropriate health professional. Support from the south Asian community would help improve understanding and remove the language barrier.
- Provision of competent confidential interpretation service should be provided. The service needs to publicise in the surgery and should be available on request in GP surgery.

7. Drop in services and social support for Asian women

- Community/Day/Drop in Centre Facilities: Safe spaces in both statutory services and in the community should be developed and promoted.
- Working jointly with public, local and community organisation to pool resources could help to achieve this.
- Creating gender specific leisure opportunities e.g. swimming all females including female lifeguards.

8. Strategic Planning and Implementation

- This report and its recommendations be included in the FIS action plan which ought and will cut across all agencies that are interested in enabling people living in mental distress to recover.

Conclusion

This study and the themes that emerge are not new, they reaffirm much of what is known already. “In 1999 and 2002 the Health Survey for England, indicated that in women, depressive episodes were most common among Indian and Pakistani respondents, Pakistani women 6.3 per cent and Indian women 5.7 per cents. Nazroo, J, King M. (2002)”.

In addition, Teesside University has carried out a similar research in 2003 and 2004 and Asian women highlighted almost identical issues concerning language, information gender specific worker etc. The Nisaa Project 2004.

The study will only be of value if the recommendations proposed are taken forward and implemented and a time scale for reporting back the outcome to the community is set in motion.

2. Introduction

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

Background

We often hear the following words or phrases:

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

Sometimes they are used inter-changeably to mean the same thing. Sometimes the same word or phrase is used by different people in the same meeting to mean different things. The Centre for Ethnicity and Health has a very specific notion of Community Engagement, and this paper attempts 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 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 pieces of work. They would be able to use the nine month process to learn about drug related uses 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 understanding 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
- Regeneration
- Higher Education
- Asylum

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

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

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

The Key Ingredients

According to the Centre for Ethnicity and Health model, a Community Engagement project must have the community at its very heart. In order to achieve this, it is essential to work through a host community organisation. This may be an existing community group, but it might also be necessary to set a real or virtual group up where one does not exist already. The key thing is that this host community organisation should have good links to the target community[1] (whoever this is) such that it is able to recruit a number of people from the target community take part in the project and to do the work (see section on task below). It is important that the host community organisation is able to provide a co-ordination and infra-structure (e.g. somewhere to meet; access to phones and computers; financial systems) for the day to day activities that will be undertaken when 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 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, that 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 of 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 t the host organisation. We would expect that the bulk of this money would be used to pay people from the target community as community researchers[2]. We then allocate a named member of staff from our Community Engagement Team as a project support worker. This person will visit the project for at least half a day a fortnight. It is their role to support and guide the host organisation and the researchers through the project. We also provide a package of training – typically in the form of a series of accredited workshops. The accredited workshops give participants in the project a chance to gain a University qualification whilst they undertake the work. The support workers will also assist the group to pull together a steering group for the project[3].The steering group is an essential element of the project: without one, it is difficult to see who the community are engaging with and it is unlikely that anything out of the project will be sustained in the longer term. The group will be doing a needs assessment or a consultation exercise, but for what purpose? It is the role of the steering group to ensure that the work that the group undertakes sits with local priorities and strategies, and that there is a mechanism for picking up the findings and recommendations that the group may make. It is also their role to help to pick up the key individuals who are developed through the project process to help them to make their 'next steps'.

The Community Engagement Team

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

<table>
<tr><td colspan="4">National Programme Directors</td></tr>
<tr><td>Northern Team</td><td>Midlands Team</td><td>Southern Team</td><td rowspan="2">Senior Programme Advisors</td></tr>
<tr><td>Senior Support Worker</td><td>Senior Support Worker</td><td>Senior Support Worker</td></tr>
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X 3</td><td rowspan="3">Support Workers
X 6</td><td>Drug Interventions Programme</td></tr>
<tr><td>Regeneration</td></tr>
<tr><td>Mental Health</td></tr>
<tr><td colspan="4">Teaching And Learning Team</td></tr>
<tr><td colspan="4">Administration Team</td></tr>
<tr><td colspan="4">Communications Officer</td></tr>
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1. The target community may be defined in a number of ways – in many 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. domestic violence, sex workers)

2. This is not always possible, for example, where potential participants are in receipt of state benefits and where to receive payment would leave the participant worse off.
3. Very often we will have helped groups to do this very early on in the process at the point at which they are applying to take part in the project.

Programme Outcomes

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

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

Sahara Spotlight Group was one of 29 community groups who took part in the National Institute for Mental Health in England's Community Engagement Programme in 2006. The objectives of the programme were to deliver and improve equality of access, experience and outcomes for Black, minority and ethnic mental health service users. This supports the plan outlined by the government in their 5 year plan "Delivering Race Equality in Mental Health Care" which plans to put structures into place to improve services for all by involving the people the services are designed for.

The objectives are:

- Building capacity in the non-statutory sector by training members of the community to research and help develop services
- 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 used in the non-statutory sector
- Involving Black and minority ethnic communities in identifying needs and in the design and delivery of more appropriate, effective and responsive services
- Ensuring greater community participation in, and ownership of, mental health services
- Allowing local populations to influence the way services are planned and delivered
- Contributing to workforce development, and specifically the recruitment of 500 Community Development Workers

The focus of our work was the mental health needs of South Asian Women in Middlesbrough and how services could be developed to better meet their needs.

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.

Middlesbrough Community Background Information

The 2001 census shows that there were 134 860 people in Middlesbrough and 6.3% of these are of non-white background. Of the non-white people 0.9% were mixed race, 0.6% were Indian, 3.6% Pakistani and 0.1% Bangladeshi. This shows that Black and ethnic minorities form a significant proportion of the Middlesbrough population and Asian people make up the majority of this proportion. This means we need to ensure that services are available to support these people who have made Middlesbrough their home and have the same rights to high quality services as everyone else. The research results suggested Urdu was the language read and written by majority of participants and it is the language of Middlesbrough's BME (Pakistani) community the largest non-white community (census 2001) in Middlesbrough.

Out of 64 694 males – 60 371 of these were white and 4323 were non-white. Out of 70 156 females – 66 030 were white and 4126 non-white. Non-white women make up the lowest proportion of the population meaning their needs may be forgotten and we need to work to get them recognised.

Non-white females are also the lowest group to have health problems (13.7%) compared with white females (23.1%) and non-white males (14.4%). This means their needs will not stand out and be noticed as much as the highest proportion – white females (23.1%).

Employment is lowest in non-white women (13.6%) compared to 21.3% in white women and 25% in non white males. Unemployment is higher in non-white women (4.5%) than white women (3.5). Unemployment is often linked with poor social conditions and lack of self-esteem. This may mean non-white women need specific type of support tailored to their needs.

In Middlesbrough 76.8% said they were Christians, 4.2% Muslims, 0.3% Hindus, 0.3% Sikhs, 0.3% others, 10.1 % stated no religion and 8% did not answer the question.

Sahara Group background information

Sahara Group for older Asian women was formed in January 2003 and launched in September 2003. The main aim of this group is to enable isolated Asian women from Middlesbrough town centre to maintain health and well being and relieve isolation. This Group has become a focal point for the Asian community in Middlesbrough. The group was initially for older women only but later changed to include women of all ages due to demand.

Membership includes women with physical disability, carers and frail older women, and women with mental health issues. The present membership is 60 and is growing. The group meets every Monday at the Pavilion in Albert Park from 10:30am to 12:30 pm. The future vision for this group is to have a multicultural day centre. Now it is only a drop in Centre.

Sahara is assisting Asian women living in Middlesbrough from the following communities; Pakistani, Indian and Bangladeshi. Women from these backgrounds are amongst the least confident and most socially isolated, many are isolated by their lack of command of English, suffer from depression, low morale and have poor health.

The group arranges different activities for members e.g. information sessions on healthy eating, mental health, social service and food hygiene, etc. And also arranges keep-fit classes for members, weight and blood pressure checks in conjunction with health promotion. It is a social group and provides much needed support to Asian women by mutual understanding of each other culture, religion and language.

Aims and Objectives of Project

The aims and objectives:

- Building capacity in the non-statutory sector by training members of the community to research and help develop services,
- 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 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, and
- Contributing to workforce development, and specifically the recruitment of Community Development Workers.

Methods

This section outlines the steps taken by the group to prepare this report, including setting up a steering group, recruiting the community researchers, selecting the methods and collecting the data.

Recruitment of Community Researchers

The Sahara Group leader advertised and circulated information within the community to recruit women who were interested in developing research skills and who wanted to contribute to the development of services in their own community. Firstly the group co-ordinator was appointed then interested candidates were interviewed and 3 women were made part of the team.

Choosing the Methods

Sahara Group decided to look into the experiences of South Asian women relating to the use of Mental Health Services in Middlesbrough. What services and support they used and what recommendations they could give to make mental health services more appropriate,

accessible and culturally sensitive. Local Mental Health Services and Local Authority Social Care also supported this Theme.

The researchers chose a semi-structured questionnaire (see Appendix 2) as the research tool to gather both quantitative and qualitative data during one-to-one interviews. They felt this would be the most effective way of gathering as much information as possible from each participant and was the method they felt most comfortable using in their first experience of research.

They decided general information would be needed about each participant to find out the type of person they are e.g. gender, ethnicity. They felt it necessary to find out women's experiences of mental health in order to see how well people understand it and how they interpret it. Information was also needed to find out what services people are aware of and what they already use to allow the researchers to see where the gaps in knowledge of services are. If the research shows that services are not available, the main part of the project is to find out what support people feel they need and how their needs could be better met. The different types of information required formed the sections of the questionnaire which ends by asking participants to make three recommendations they feel would ensure mental health services meet their needs. Each participant completed a consent (appendix 3) form agreeing that the information they gave could be used for research purposes.

Establishment of a Steering Group.

A local steering group was established to support and guide the project and to help take the recommendations forward. Membership of the steering group comprised of representatives from:

Middlesbrough Borough Council,

National institute for mental health in England (NIMHE),

Tees, Esk and Wear Valleys NHS Trust,

Sahara Asian Women Group Middlesbrough, and

University of Central Lancashire.

The researchers received ongoing support from the Steering Group which consisted of the University support worker, a Service Manager of Middlesbrough Community Mental Health Service, the Mental Health Trust Diversity Officer, the leader of the Sahara Group and

Diversity Manager from Council Social Care Department. Presence of managers from the local mental health services and Social Care Department means that the results of the project and the recommendations following it can be taken directly to the people who are putting them into practice. The role of the Steering Group was to manage the project, to help organise meeting rooms and access to equipment, to organise the budget and payment of the researchers, to outline the aims and expectations of the project and to listen to and help resolve problems faced by the researchers. Regular meetings were held with the Steering Group to monitor the progress of the project.

The researchers in the group attended workshops in York run by the University of Central Lancashire to gain knowledge of mental health and relevant skills in carrying out a research project. An understanding of mental health was essential in order to recognise what problems people might face and to know what they are able to do about it. Research skills were developed so the women could design, run and analyse an effective research project to ensure the results are valid and can be used as support to make genuine recommendations to local services. The researchers completed coursework around the workshops and gained certificates from the University. The researchers also attended Network Meetings with their counterparts engaged in other projects to share information and ideas.

The group was allocated a support worker from the University of Central Lancashire who attended fortnightly meetings with the researchers to advise them on the running of the project, its design, the collation of the data and the analysis. The support worker was also the link with the University to ensure the researchers followed their regulations and met their expectations.

Collecting the data

The researchers piloted the questionnaire with 8 participants initially to test its suitability before collecting data from the sample. Following the pilot the questionnaire was amended to aid understanding of certain questions. (For questionnaire see appendix 2).

Participants were found from local community groups and community networks. The researchers attended group meetings or made appointments with individuals to conduct the questionnaires. The questionnaires were completed face to face by one participant and a

pair of researchers. The information given was written down on a questionnaire form and stored in a locked filing cabinet for confidentiality.

Analysing the data

The questionnaire yielded both qualitative and quantitative data. Quantitative data was entered on to a spreadsheet so that graphs and tables could be drawn up. Qualitative data was transcribed so that emerging themes could be detected. Direct quotes were also used to illustrate the key points.

Results

This section presents the findings from the research project. A total of 107 participants completed the questionnaire. The results are presented in sections. The first section contains demographic data presented as numerical data in graphical format for each of the questions asked. The second section pertains to the participants personal experiences which contains quantitative data presented in graphs and qualitative data presented in themes. Section 3 pertains to the awareness the participants have of local services and whether the services meet the needs of the community. The final section is concentrated on recommendations from the participants as to how improvements to local mental health services can be made to better meet the needs of South Asian women with mental health problems.

A copy of the raw data from the questionnaire can be found in appendix 1.

Section 1- Demographic Data

Figure 1- Age distribution of participants (N=107)

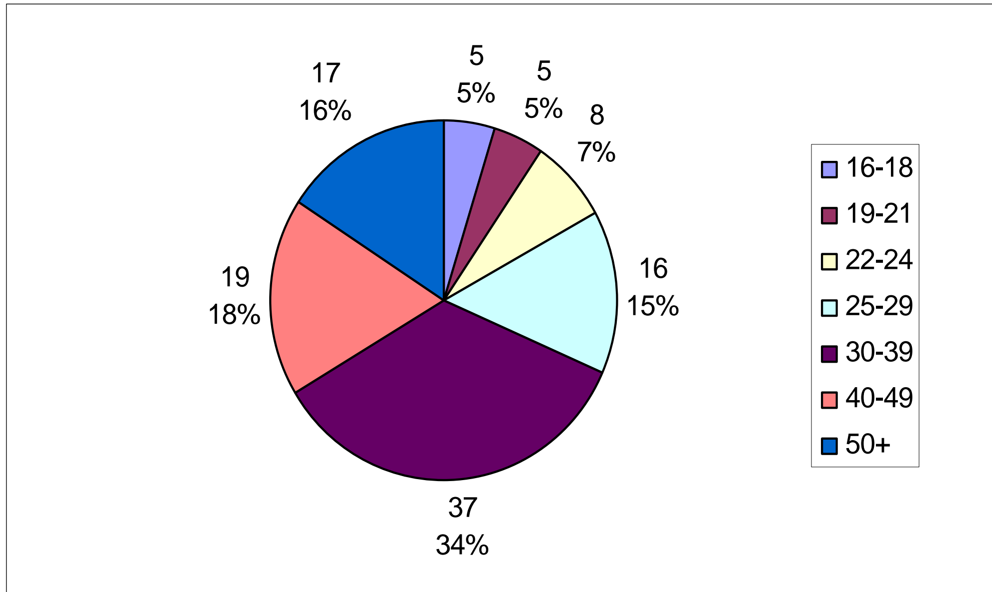


Figure 2 Ethnicity of participants (N=107)

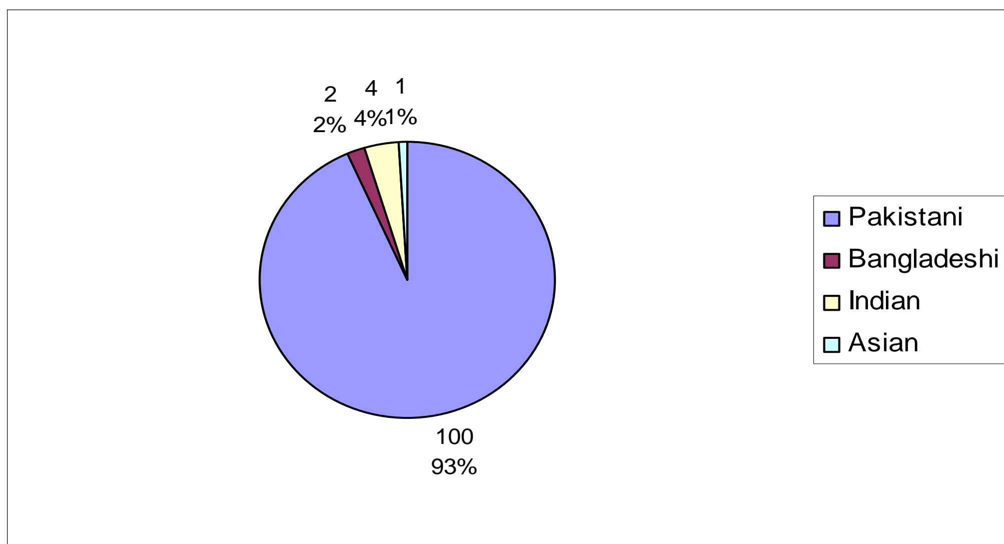
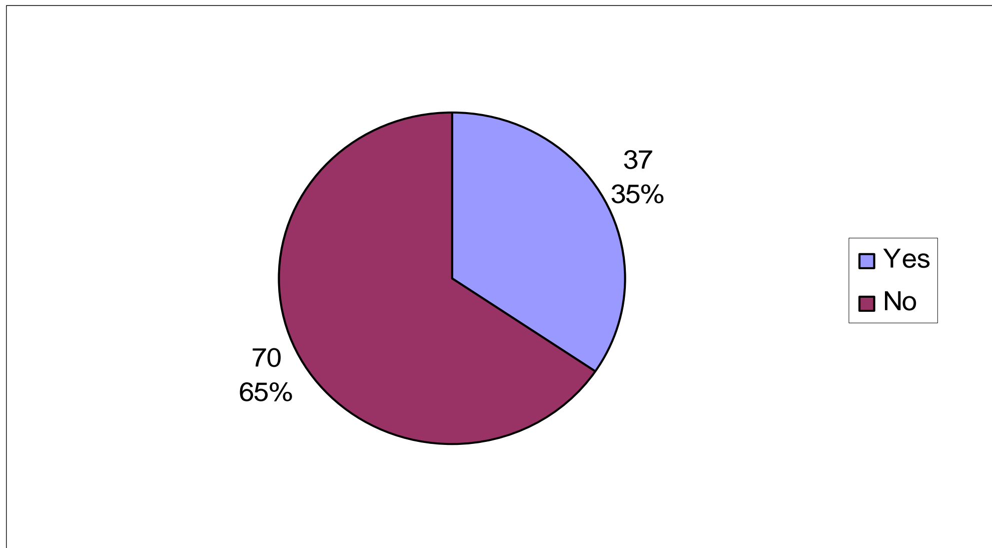


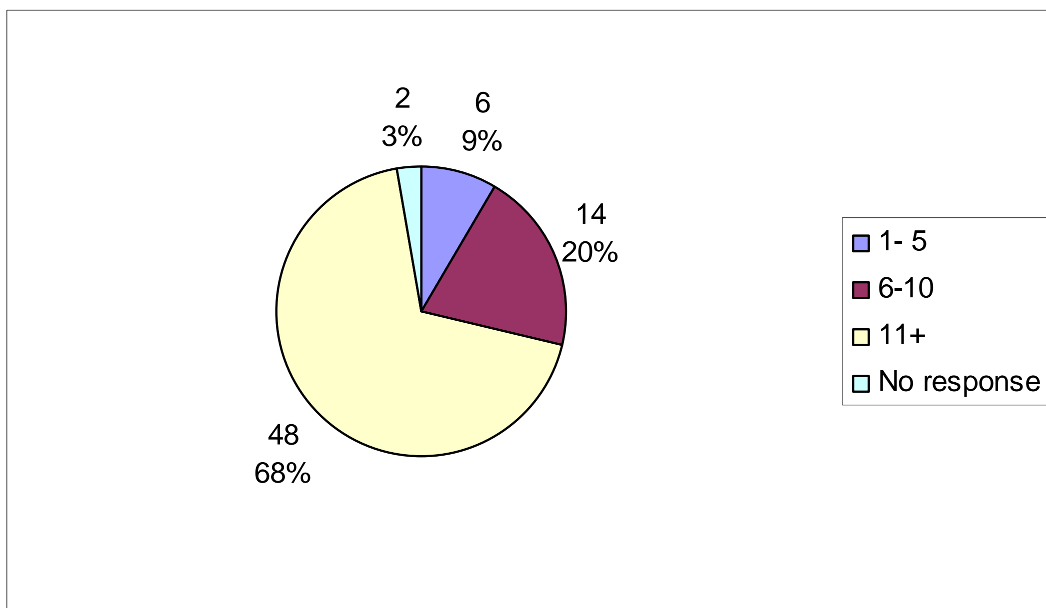
Figure 3 Percentage of participants born in the UK (N=107)



65% (70) were not born in the UK.

35% (37) were born in the UK.

Figure 4 Length of time the participants not born in the UK have lived in the country (N=70)

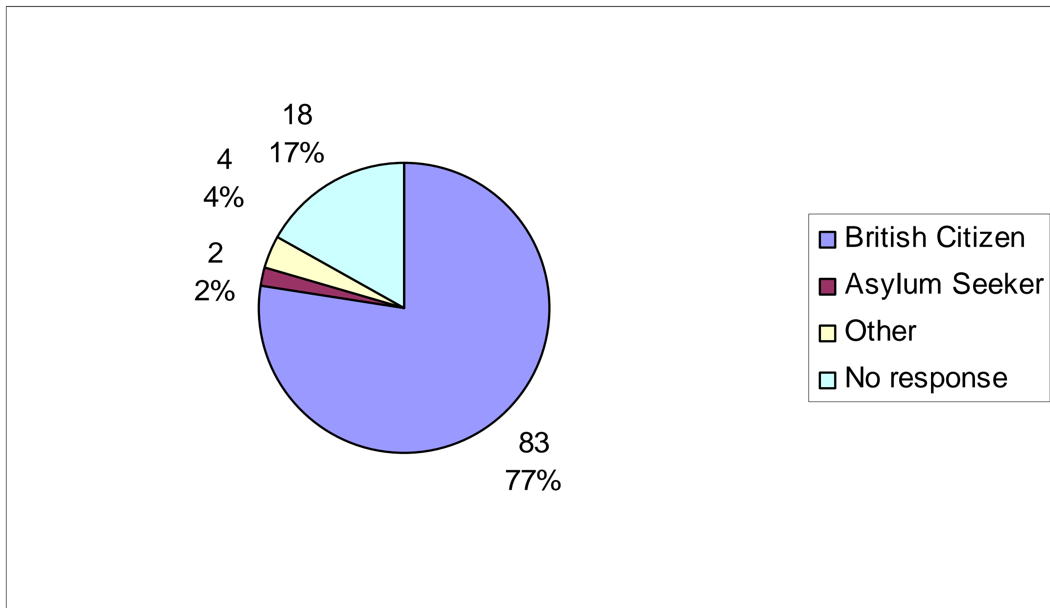


Lived in UK -11+ 68% (48),

6-10 years- 20% (14),

1-5 years- 9% (6) , No response 3% (2).

Figure 5 Citizenship of the participants (N=107)



Participants were asked to state their first spoken language. However most of them gave multiple responses to the question.

Figure 6 Percentage of participants using different spoken languages (N=107)

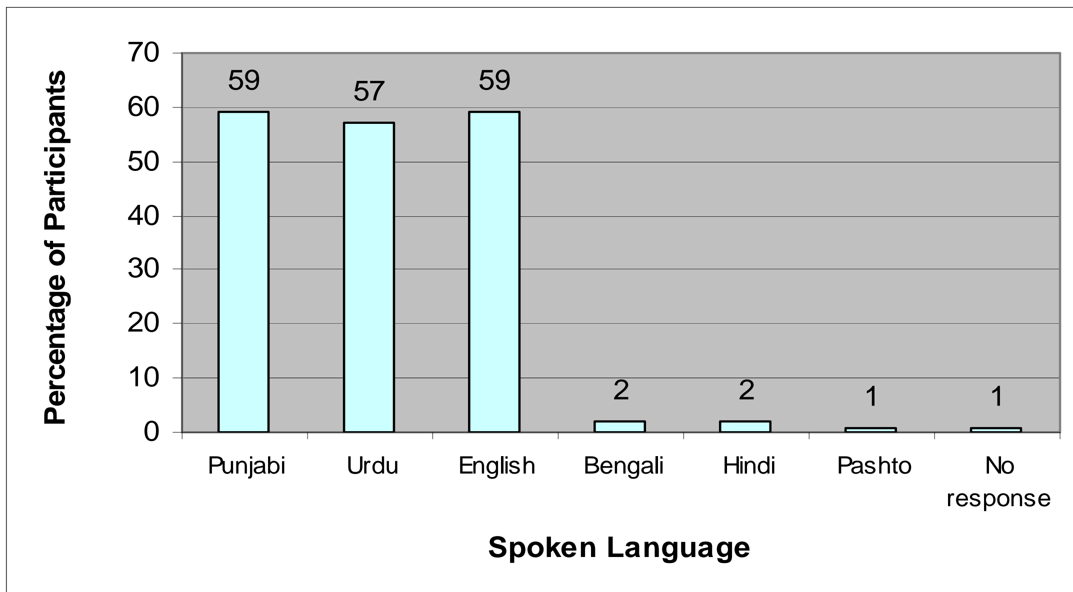
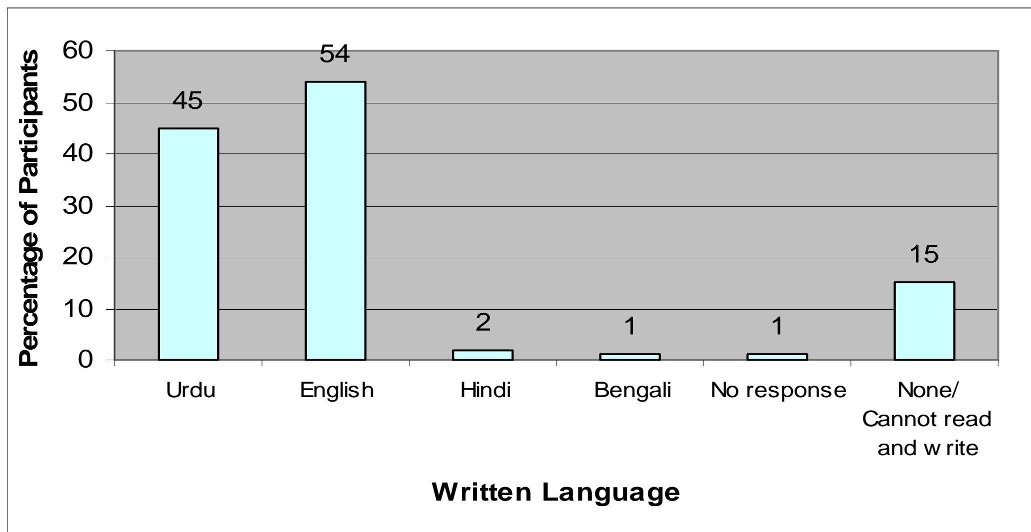


Figure 6 English and Punjabi 59% (63), Urdu 57% (61) Bengali 2, Hindi 2, Pashto 1, and no response 1.

Participants were then asked what their first written language was.

Figure 7 Percentage of participants using different written languages (N=107)



54% (58) English

45% (48) Urdu

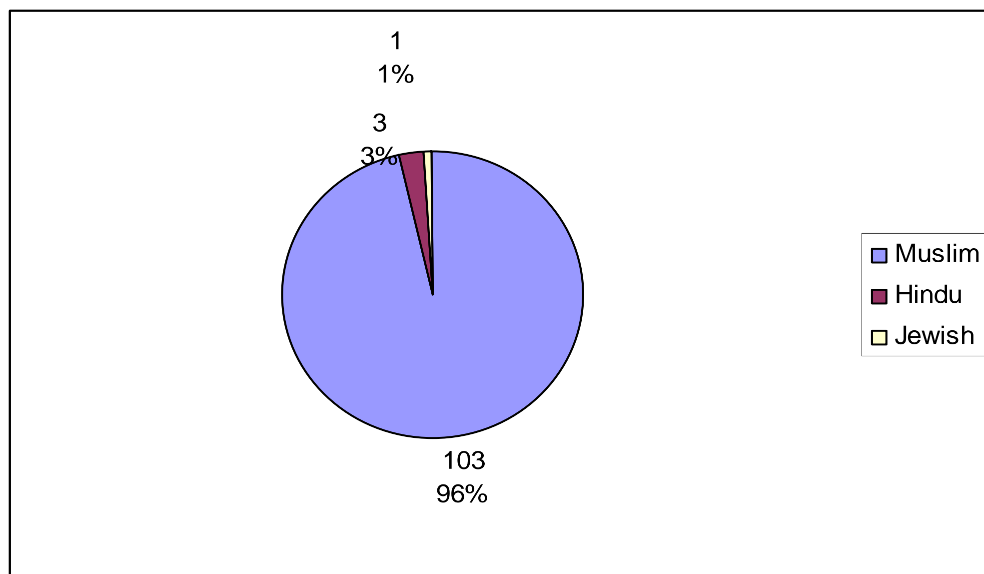
15 % (16) unable to read or write

2 participants (2%) Hindi written language,

1 (1%) participant used Bengali.

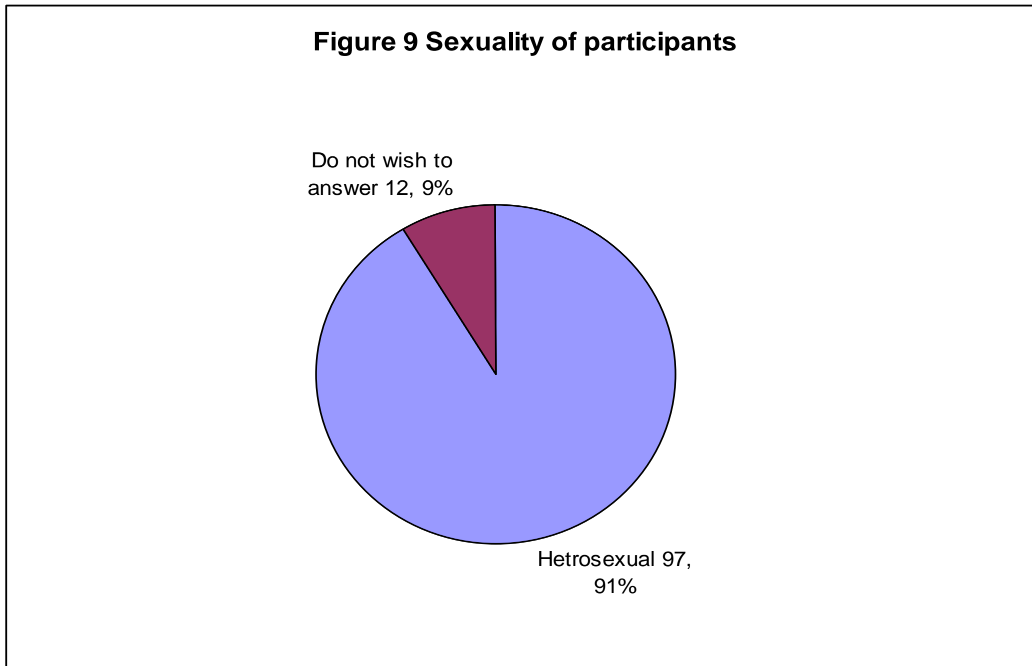
1 (1%) did not respond to the question.

Figure 8 Religious beliefs of participants



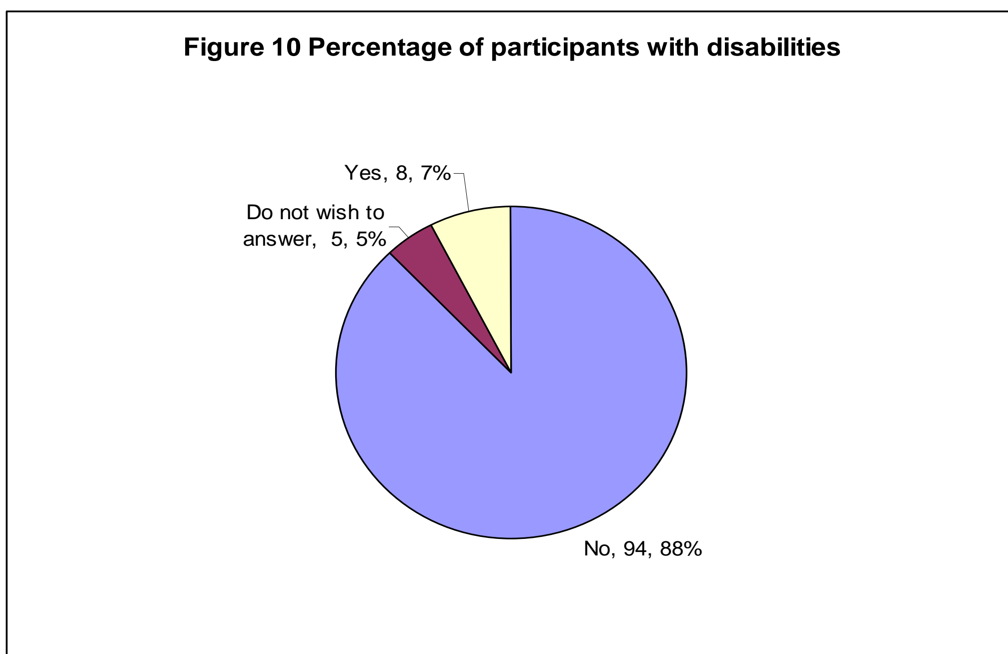
(96%/103) Muslim. 3% (3) Hindu, 1% (1 respondent) Jewish.

Figure 9 Sexuality of participants



91% (97) heterosexual/straight, (9%/ 12 participants) did not wish to answer the question.

Figure 10 Percentage of participants with disabilities

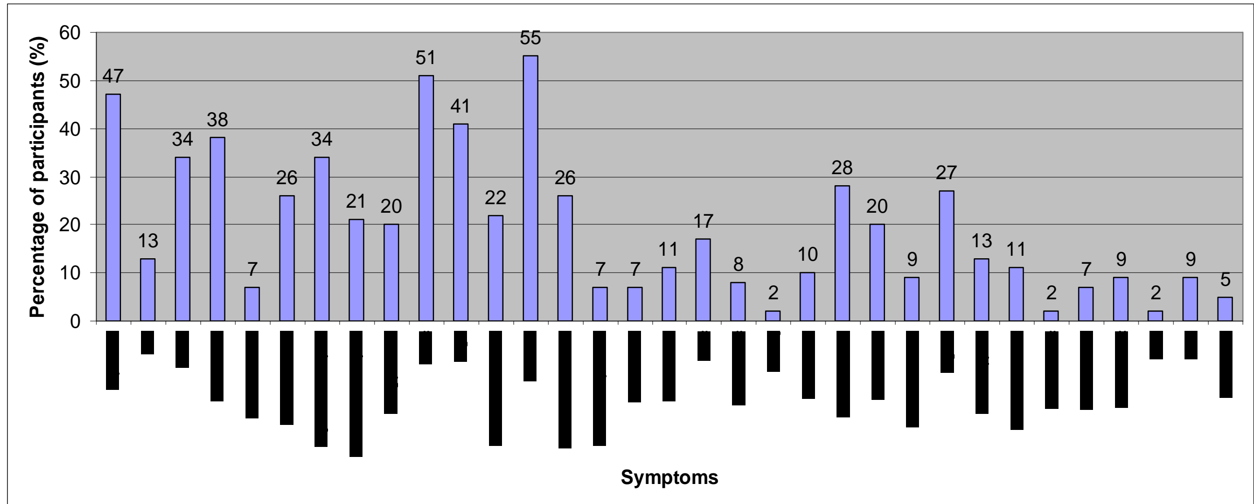


(88%/94 participants) no disability, 7% (8) have disability only one participant gave a description of their disability. This lady described her disability as being partially blind and deaf. 5% (5) of participants did not answer this question.

Section 2- Personal Experience

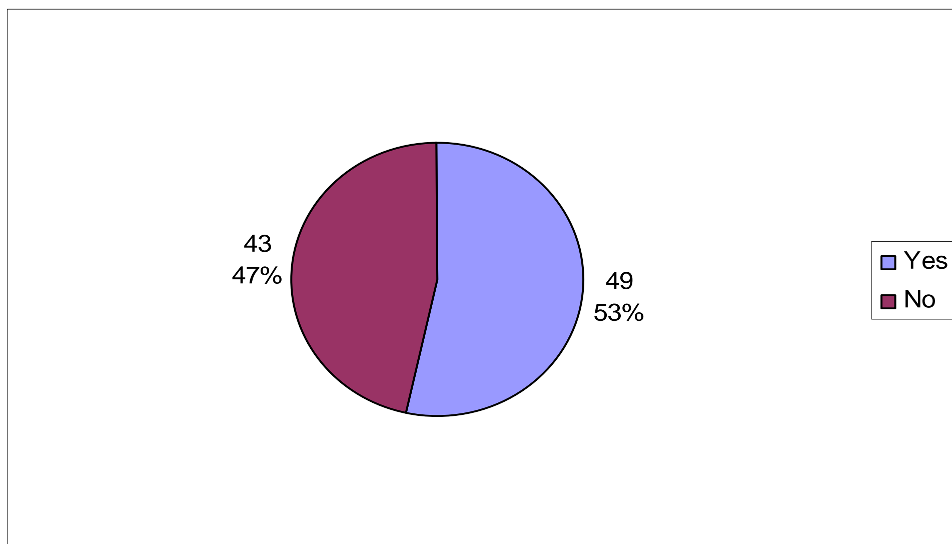
What does mental health well being mean to you?

Figure 11 Symptoms experienced by participants (N=107)



Tiredness' (55%) 'Stress' (51%) and 'Depression' (47%). 38% of participants said they had suffered with Mood Swings and 34% said they had suffered symptoms of Anxiety. 9% (10 participants) had not suffered any of the symptoms listed, with a further 5% (5 participants) giving no response to this question.

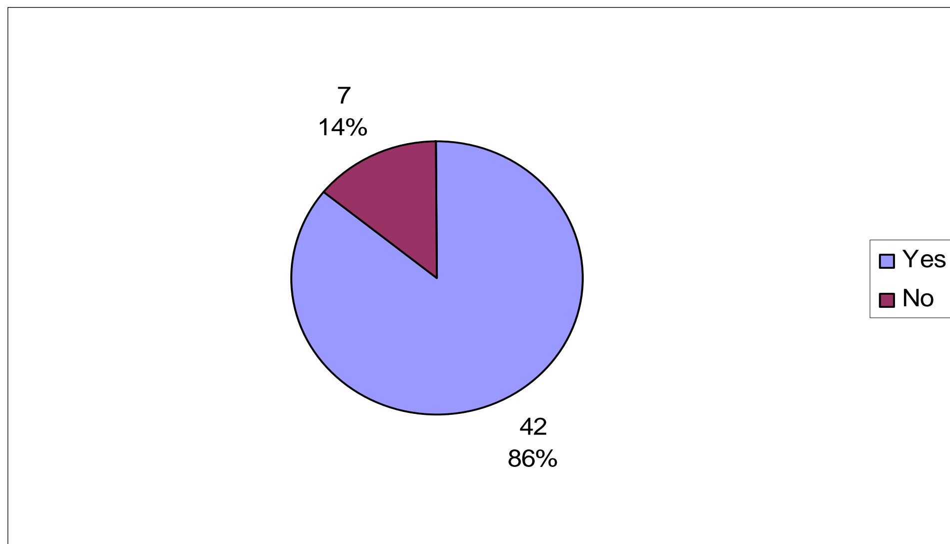
Participants were asked whether any of the symptoms experienced had an effect on their mental health. 92 people said their mental health have effected who were asked further questions. Figure 12 Percentage of respondents whose mental health was affected by the symptoms. (N=92)



53% (49 people) affected their mental health. 47% (43 participants) not had an effect on their mental health.

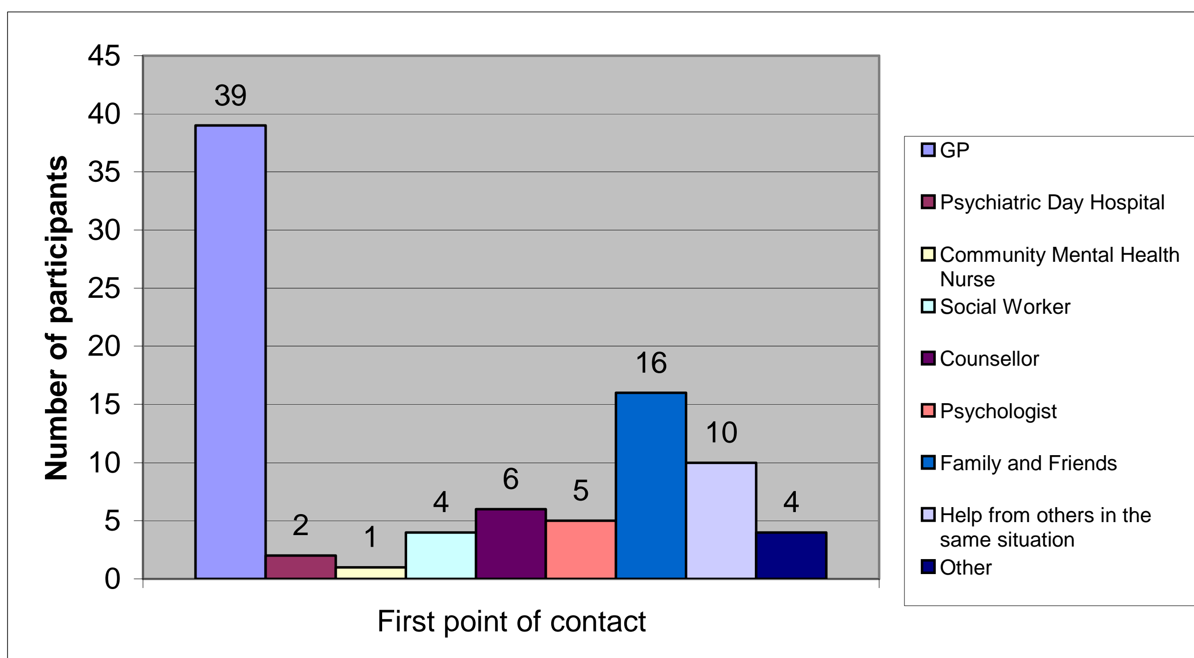
The 49 participants who said their symptoms had affected their mental health were then asked whether they sought help.

Figure 13 Percentage of participants who sought help for their symptoms.



It can be seen from figure 13 that the majority of participants (86% / 42 participants) did seek help for their symptoms. 14% (7 participants said no).

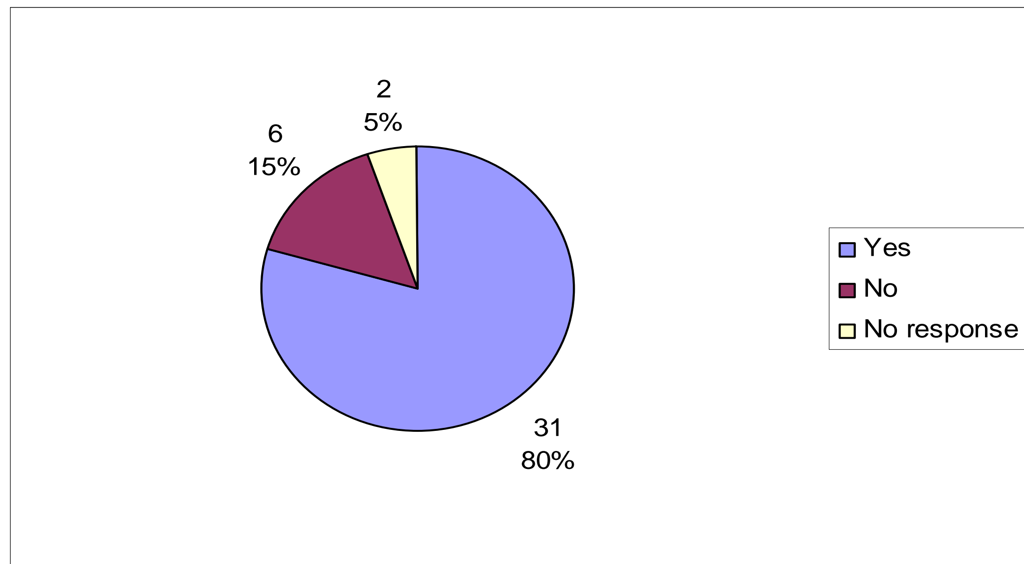
The 42 participants who felt their symptoms had an effect on their mental health and sought help for their difficulties were asked who they sought help from at the first point of contact. Figure 14 First point of contact for seeking help



GP. 39 out of the 42 (93%), Family and friends 16 (38%), 10 participants (24%) stating they used them as a first point of contact.

Of the participants who sought help from the GP as a first point of contact were asked whether they were given any choice of treatment? (N=39)

Figure 15 Percentage of respondents who were given a choice of treatment.



(80%/ 31) were offered a choice of treatments by their GP. 15%(6 participants) stated that they were not given a treatment choice and 5% (2 participants) gave no response to this question.

Of the participants (32) who stated they were offered a choice, they described the treatment offered as:

Medication (15 / 47%)

Relaxation (2 / 6%)

Counselling (7 / 22%)

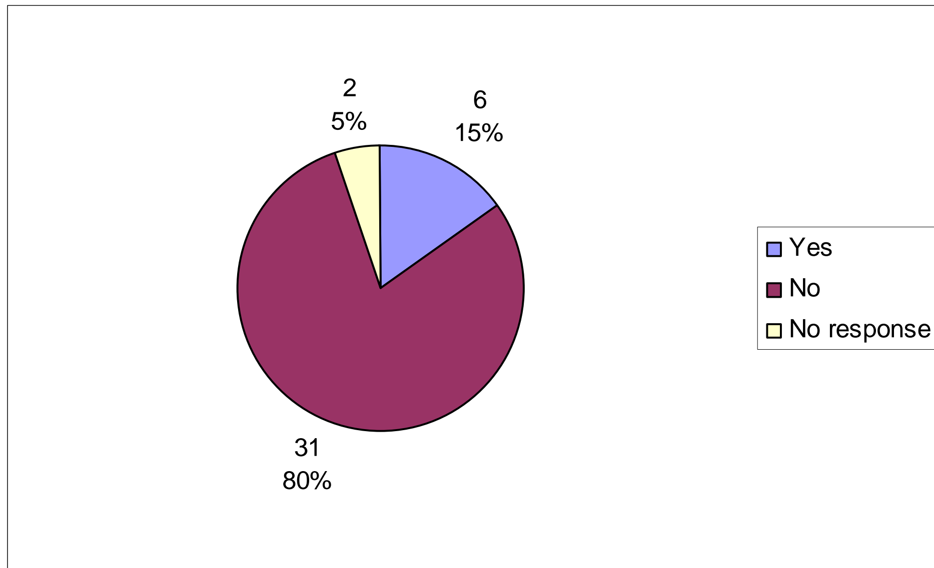
Referral to a Psychologist (2/ 6%)

Referral to a specialist (1 / 3%)

Exercise (1/ 3%)

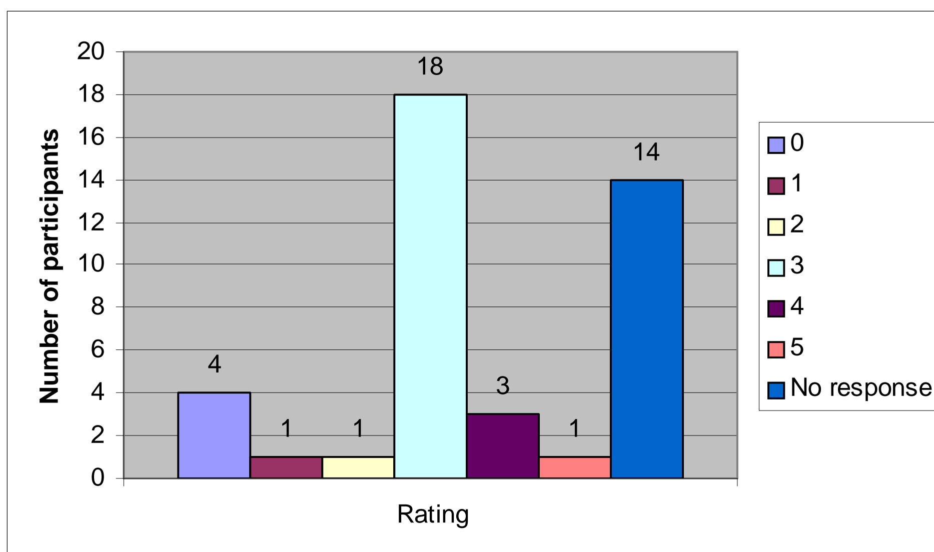
Specialist Mental Health Services

Figure 16 The percentage of participants seeking help from the GP who were referred to specialist mental health services.



Of the 42 participants who sought help for their symptoms were asked how effective the treatment they received was. The participants had to rate how helpful the treatment was on a scale of 0-5 with 0 being 'not at all' and 5 being 'very much'. Figure 17 below shows the responses given.

Figure 17 Extent of how helpful participants feel the treatment they received was.

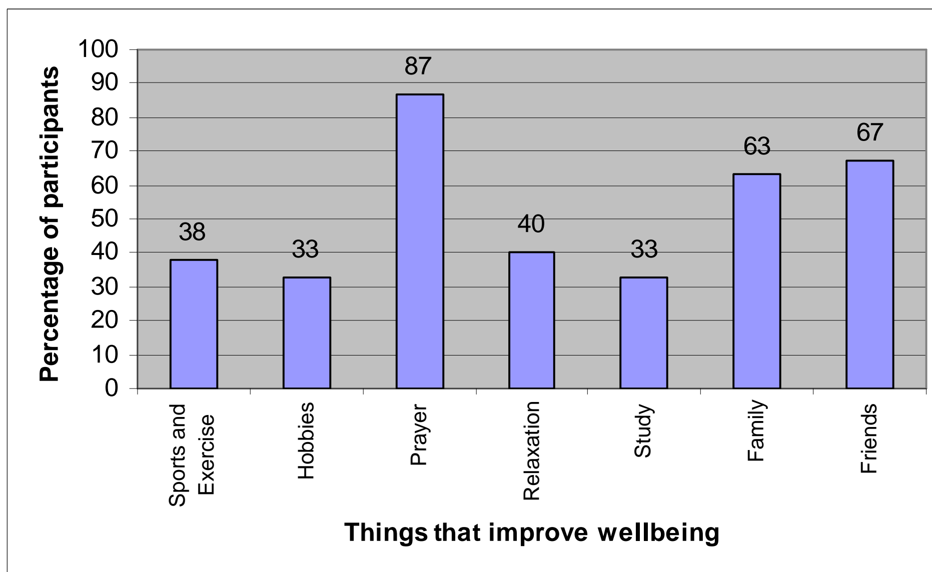


(18 / 43%) rated the helpfulness of the treatment they received as 3 on a scale of 0-5, 5 being most helpful. 6 (14%) participants felt that the service was not very helpful as indicated by them awarding scores of 0-2. 4 participants (9%) found the help that they

received to be good or very good as indicated by them awarding scores of 4-5. 14 (33%) participants gave no response to this question.

Activities contributing to mental wellbeing Figure 18

Participants were asked what keeps them happy and contributes to their well-being.



87% (94) prayers, 63% (68) family and 67% (72) friends did. Only 33% (36) of participants stated that hobbies contributed to their happiness however many responses given in the 'other' category could be classified as hobbies.

There were 34 responses that were given in the other category which have been classified into the following categories:

Shopping (8)

TV (5)

Music (4)

Films (2)

Children (2)

Keeping occupied (3)

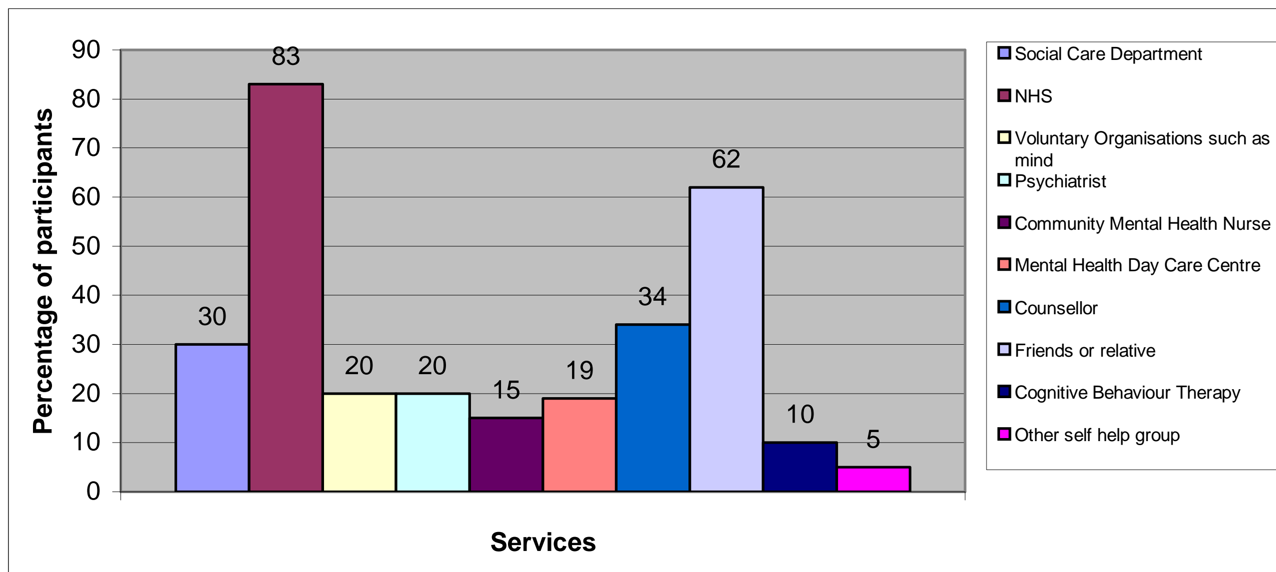
Housework (4)

Sewing (3)

Section 3- Awareness

Participants were asked which services they were aware of.

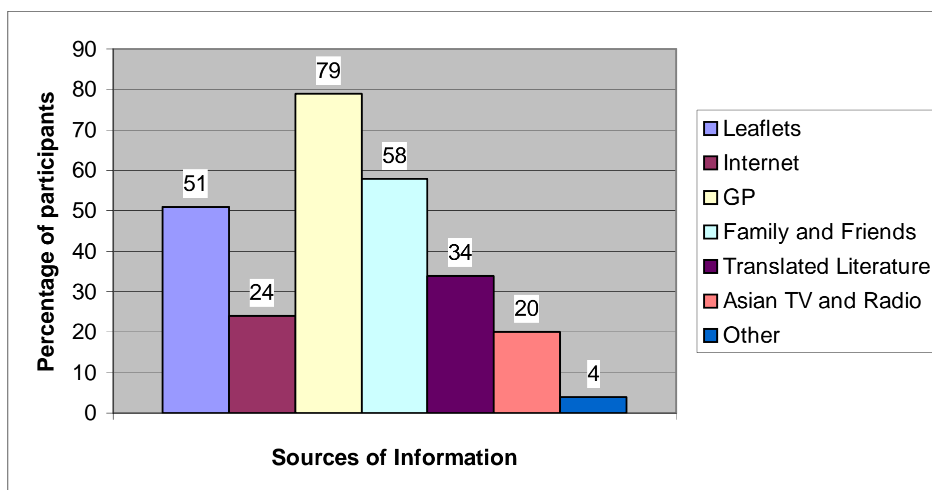
Figure 19 Percentage of participants aware of local services



NHS 83% (89),relatives with 62% (67),social services 30% (32) and voluntary organisations 20% (22), counsellors (34% / 37), Psychiatrists (20% / 21 participants) and community mental health nurses (15% /16).

Sources of Information

Participants were asked where they find out information about service providers. Figure 20



Respondents use more than one source to get information. Responses that were given in the 'other' category included Sure Start, the Yellow pages and local community centres. GP 76% (79)

Family and Friends 54% (58)

Leaflets 47% (51)

Translated Literature 33% (34)

Internet 20% (22)

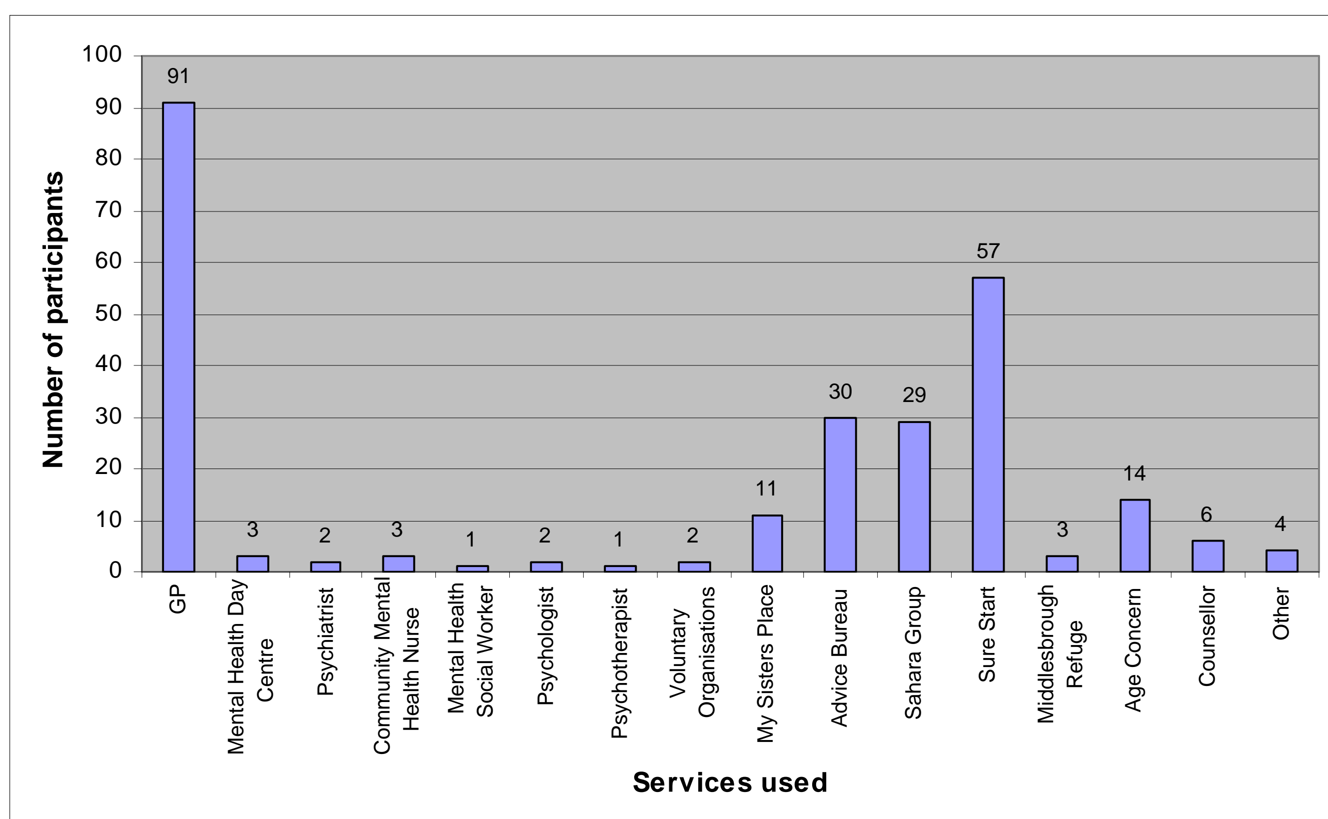
Asian TV and Radio 18% (20)

Other 4% (5)

Services Attended-

Participants were asked about the services they had attended and been referred to.

Figure 21 below shows the number of participants that had attended each service.

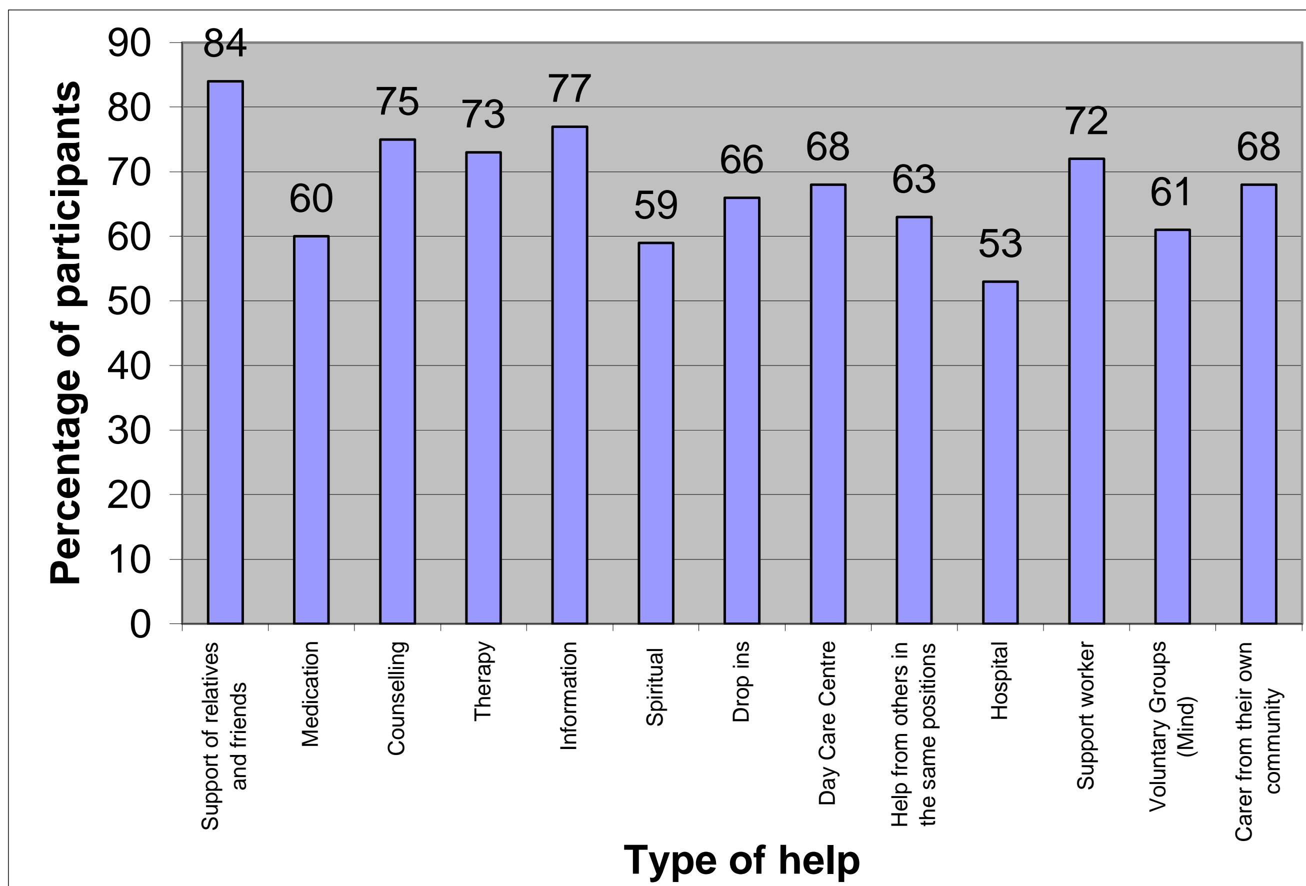


GP 85% (91), Sure Start 53% (57), Advice Bureau 28% (30), Sahara Group 27% (29) Age Concerns 13% (12), Responses in the other category were – Islamic classes (4 participants / 4%), International Centre, Women support Group and Reed House.

Section 4

Recommendations.

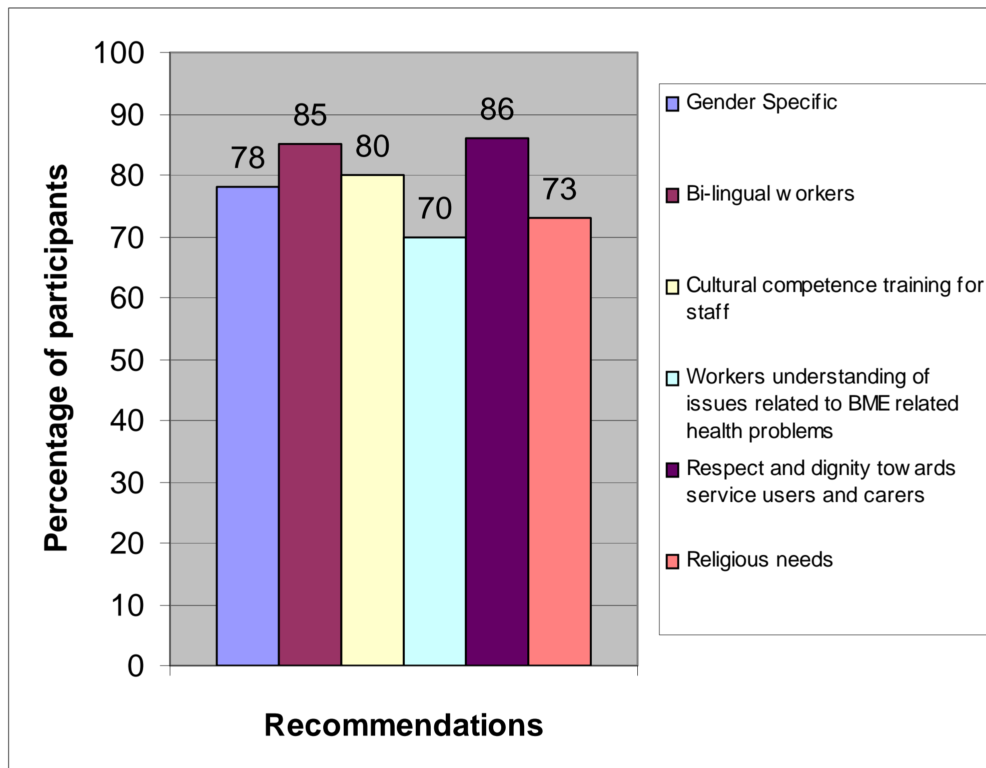
Figure 22 Recommend help for South Asian women with mental health problems in Middlesbrough



Support of relatives and friends 84% (89), Therapy 73% (78), Information 77% (82) ,Counselling 75% (80),Support workers 71% (76), Drop in 66% (71), Day Care Centre 68% (73), Carers from their own community 68% (73), Help from others in the same positions 62% (66), Volunteer group (Mind) 60% (64), Medication 60% (64),Spiritual 59% (63), and Hospital 52% (55).

The participants were then asked how mental health services could become more responsive and aware of their needs.

Figure 23 Recommendations for how mental health services could become more responsive and aware of cultural needs.



Respect and dignity towards service users and carers 86% (92)

Bi-lingual workers 85% (90)

Cultural Competence training for staff 80% (85)

Gender Specific 78% (83)

Religious needs 72% (77)

Workers understanding of issues related to BME health problems 70% (75)

The participants were asked to list three things that could be done to improve mental health service provision for south Asian women. (N=84)

- Day centres with activities and support, Asian women only – 60 people (71.43%).
- Leisure centre and swimming baths for ladies only, leisure activities, female only session in pool, Asian women only – 36 people (42.86%).
- Community Centres, trips, classes etc – 32 people (38.10%).
- Bilingual workers, better interpretation – 31 people (36.90%).
- Transport – 22 people (26.19%)
- Improve cultural competence of staff, more appropriate staff – 15 people (17.86%).
- Raise awareness of services, information – 11 people (13.10%).
- BME workers – 10 people (11.90%).
- Support groups – 5 people (5.95%).
- Confidentiality assured – 4 people (4.76%).

Discussion

The aim of this research was to focus on the mental health needs of south Asian women in Middlesbrough. The report explored the women's personal experiences of mental health symptoms, accessibility of services and whether services available met their cultural needs.

Sample

The sample of women used for this research was predominately Pakistani (93%) in ethnic origin and the majority (65%) had not been born in the UK. This is a significant finding in terms of the cultural understanding of services in the UK and language barriers. However of those who were not born in the UK, 88% had lived in the UK for over 5 years and therefore should have the opportunity to settle in the UK and gather experiences of services available. In addition 59% of the sample stated they could use English as a spoken language with 54% stating they could use English as a written language. However Punjabi and Urdu are spoken equally as often and Urdu is used as a written language. There are therefore issues regarding communication with English speaking professionals for some of the sample.

Section One Demographic data

The core questions showed that the correct population has been targeted for the collection of the data. 93% (100) Pakistani and Muslim (96% 103) which means they should have had similar experiences living in Middlesbrough Figure 8. The highest proportion of women were in the 30-39 age bracket (34% 37) but there was an equal spread of women in the 40-50+ and 22-29 categories with fewer in the younger age ranges. This is good as if the participants had been too young they may not have had the experiences the older women may have had. (Figure 1)

65% of the participants were not born in the UK (graph 3) which benefits this research as it means they have not grown up knowing the UK health services so would not necessarily be aware of everything. Most (68% 48) have lived in the UK for more than 11 years (graph 4) meaning they have had chance to gather experiences and to get to know what services are available and what would be needed. If they are not aware in this amount of time it is likely that the services do not exist for them.

The majority 83 (77%) of the participants were British Citizens with (2%) 2 describing their status as asylum seekers. (17%) 18 did not respond to this question. The remaining (4%) 4

of participants selected the ‘other’ category and made comments such as ‘resident’ and ‘not claimed yet’.

Figure 6 shows that the most widely spoken languages were English and Punjabi with 59% (63) of the participants speaking these languages in both cases. Urdu was the next most widely spoken language with 57% (61) of people questioned speaking it. 2% (2 participants) of those questioned spoke Bengali and 2% (2 participants) spoke Hindi. 1 (1%) participant spoke Pashto with the remaining 1 (1%) participant not giving any response to the question.

Section Two Personal Experience

Defining Mental Well-being

The participants were asked what mental wellbeing meant to them as a South Asian Woman living in Middlesbrough. The responses could be divided into the following broad themes:

- **Feeling happy, comfortable and relaxed in the environment**
  (40 comments)
  “I am 100% comfortable”
  “I am happy to live in Middlesbrough, feeling relaxed”
  “I feel confident in my environment”
  “I feel very happy”
  “Really relaxed to live here”
- **Feeling afraid to go out alone because of racism, youths and drug dealers (27 comments)**
  “I am only afraid to go out alone because of drug dealers around the town”
  “I don’t feel safe walking on the road with my veil on”
  “Feel afraid to go out alone because of racism and mischievous teenagers”

One major sub-theme within this was the increased fear since 9/11

“ 9/11 has had an effect on my mental state as there is now a certain amount of fear in me”
“We feel scared after the 9/11 attacks as we seem to be targeted more and looked at in a disgusted way”
“ I have not felt as good after 9/11”

“We want a place people can go without fear”

”*safer places to go to. Drop in centre so you have something to go and meet”. “get together for old age people*”.

Staff needs to be aware of social/political issues effecting mental well being of local service users e.g. after tragedies of 9/11, 7/7/2006 and most recent failed attempted suicide attacks involving may be Muslim NHS saff. Staff working with MH patients needs to have briefings about how it could effect their thinking towards Muslim patients and support needs to be provided to staff with appropriate training if needed. It is a fact that every time after such incidents racial tension increases in Middlesbrough community as well as elsewhere.

- **Well balanced emotionally and in state of mind. (8 comments)**

  “Psychological and emotional state of mind”

  “Well balanced state of mind”

  “If I am happy and mentally well then this has so many positives ie. Bringing up children, peaceful household and overall a healthy and more contented lifestyle”

Thirty two of those questioned did not give any response to this question.

One major finding from the research was concerned with how Asian women in Middlesbrough define mental well-being. Mental wellbeing was defined as feeling happy comfortable and relaxed in the environment. The result showed that the women often feel afraid to go out alone because of racism, youths and drug dealers and this poses a threat to the wellbeing of the women. Comments were made with particular reference to 9/11 and how it has had an effect on the mental and emotional wellbeing of the Asian women. This is an important finding, in particular in the light of recent ‘terror attacks’ and health professionals should be mindful of this.

The participants reported a variety of social problems such as financial difficulties (11%) racism (10%) and unemployment (10%) which appear to affect their mental wellbeing. It is worth mental health professionals bearing this in mind as problem solving approaches and signposting to other relevant agencies may have a beneficial effect.

The research clearly highlighted that the South Asian women feel that social support is beneficial to their mental wellbeing. Specific comments were concerned with not feeling

alone and that it was comforting to know others in the community were suffering in the same way. Friends and family were identified as having a major impact on mental well-being and were most often the people the ladies turned to when they had difficulties. 84% of the women questioned said that they feel South Asian women in Middlesbrough with mental health difficulties would benefit from having the support of their friends and family. 68% said that they would benefit from day centres and 66% said that a drop in service would be beneficial. Specific recommendations made by the women were that they would like more access to leisure facilities such as trips, classes and sports that were for Asian women only. *“One stop shop for all Asian women’s needs*”.

87% of the women identified that prayers create positive effects on their wellbeing and happiness. Family and friends were also rated as having a positive impact on well-being. This has implications for mental health services in terms of their focus for treatment. It may be more beneficial to some women that their care is focused around practical activities they can become involved in or spiritual support rather than the traditional medication or therapeutic interventions that are traditionally offered as treatment for emotional problems.

This may be worthwhile for the local community and the Sahara group to consider looking at how they may organise such events with the help of funding from different sources.

The high percentage (53%) of participants who did feel their symptoms had an effect on their mental health may have in part been accounted for by those who have been born and raised in the UK or those respondents who have spent many years living here. However further in- depth research would need to be carried out to ascertain the reasons why women did not associate the symptoms they were suffering with psychological and emotional difficulties.

Recognising the symptoms of mental health problems

The participants were asked about various symptoms they had experienced.

It can be seen from Figure 11 that the symptoms most frequently reported were ‘tiredness’ (55%), ‘stress’ (51%), and ‘depression’ (47%) and anger (41%). 38% of participants said they had suffered from mood swings and 34% said they had suffered symptoms of anxiety.

9% (10 participants) had not suffered any of the symptoms listed, with a further 5% (5 participants) giving no response to this question.

The high incidences of stress, depression and anxiety reported in this research suggests that mental health problems in the population sampled are greater than the 1 in 4 people experiencing similar mental health problems in the general population (Office of National Statistics 2001).

The figures from the research are relatively high but there is the chance that there was also under reporting of mental health problems from the participants considering the stigma associated with this in their culture and faith. This suggests that raising awareness of mental health issues in the South Asian population may have some benefit as to reducing stigma but also informing them of where and how to get help in the hope of reducing the number of women suffering from emotional difficulties.

Of the participants who had experienced one or more symptom 53% stated that these symptoms had an effect on their mental health. Considering the high numbers of symptoms reported this seems a small amount of people who felt that their mental health had been affected.

This may be a reflection that Asian culture does not recognise 'mental health problems' in the way that White British western culture does assume? In the South Asian culture symptoms are more often experienced as 'feeling unwell' in general rather than causing 'mental distress'. In fact there is no direct translation of 'mental health problems' in Punjabi or Urdu. It may be also reflective of the stigma surrounding mental health problems and the reluctance of the women to admit they are suffering from mental health problems. The women may feel that they do not wish to share their problems with others outside their family, a theme that is reflected through the research.

Participants were asked whether any of the symptoms experienced had an effect on their mental health. Figure 12 shows that from the 92 participants who reported one or more symptoms the percentage who felt the symptoms affected their mental health, 53% (49 people) felt that the symptoms they had experienced did affect their mental health. 47% (43

participants) stated that the symptoms they suffered had not had an affect on their mental health.

The 49 participants who said their symptoms had affected their mental health were then asked whether they sought help.

Seeking Help- difficulties and barriers

Of those participants who did feel that the symptoms they experienced had an effect on their mental health the majority (86%) sought help for these symptoms. The first point of access for those seeking help was the GP in 93% of the cases which is congruent with the fact that this is the most well known service within the sample. Other popular first point of contact for those suffering with mental health difficulties was family and friends, with one participant stating, ' I didn't feel comfortable talking to a stranger'. Of those who did not seek help felt they wanted to manage their problems themselves, did not want to share their problems due to trust and confidentiality issues or felt that services were inaccessible.

The majority of participants (86% / 42 participants) did seek help for their symptoms. 14% (7 participants) of those who reported that the symptoms they had suffered affected their mental health did not seek help for their problems.

The 14% (7 participants) who did not seek help were asked to give reasons why they did not seek help. The qualitative comments were.

- "*Appointments could not be made at a suitable time,*
- *Did not want to share problems, wanted to deal with it on my own,*
- *Nobody to turn to- tried to talk to husband but he said it was all in my head,*
- *Help was inaccessible at the time,*
- *I was afraid anyone would find out,*
- *Language problems,*
- *Cant trust anyone I don't know, and*
- *Stigma attached."*

The 42 participants who felt their symptoms had an effect on their mental health and sought help for their difficulties were asked who they sought help from at the first point of contact.

Figure 14 shows that the most frequent first point of contact for participants suffering with symptoms affecting their mental health is the GP. 39 out of the 42 (93%) respondents stated that they went to the GP for help. Family and friends were also a frequently used first point of contact with 16 (38%) respondents stating they used them for help as were others in the same situation with 10 participants (24%) stating they used them as a first point of contact. Participants were asked to give qualitative comments as to whether the help they received from the first point of contact was appropriate or inappropriate for their needs and why. Participants were positive about the help they received and stated that the treatment they received was effective. They found it particularly helpful talking to someone about their problems and feeling of being listened to. However other comments included difficulties making appointments, feeling there was a lack of confidentiality and that there were language, cultural and religious barriers.

Themes as to why the help was appropriate for their needs were:

- **Treatment was effective**
  "The medication helped calm me down and give my feelings a boost"
  "My GP was able to help me and refer me to a specialist who could help me further"
- **Talking about my problems**
  "Talking about my problems helped me"
  *"I was able to say everything I wanted to***"**
- **Being listened to**
  "GP listened to the problem and helped"

Themes as to why the help was inappropriate for their needs were:

- **Feeling there was a lack of confidentiality**
  "I didn't feel comfortable talking to a stranger"
- **Medication was given which doesn't deal with the underlying problems**
  "The GP gave me tablets that put me to sleep but this did nor eliminate the problem"
  "Antidepressants helped for a little while but underlying problems were still present"
  "Hard to get an appointment "

- **Language barriers Language** (15 comments)
  "*Language barriers we need translators*"

The first point of access for those seeking help was the GP in 93% of the cases which is congruent with the fact that this is the most well known service within the sample. Other popular first point of contact for those suffering with mental health difficulties was family and friends 38%, with one participant stating, ' I didn't feel comfortable talking to a stranger'. Of those who did not seek help felt they wanted to manage their problems themselves, did not want to share their problems due to trust and confidentiality issues or felt that services were inaccessible.

If participants are more comfortable talking to their friends and family then it could be suggested that mental health professionals should be providing awareness training to the women in the community by women trained from the community. This ensures that they have the knowledge to be able to help and support each other emotionally. Awareness workshops run in the community by mental health professionals is one suggestion of how this can be achieved.

Of the participants who sought help from the GP as a first point of contact were asked whether they were given any choice of treatment?

Figure 15 shows that the majority of participants (80%/ 32 out of 39) were offered a choice of treatments by their GP. 15% (6 participants) stated that they were not given a treatment choice and 5% (2 participants) gave no response to this question.

Of the participants (32) who stated they were offered a choice, they described the treatment offered as:

Medication (15 / 47%),
Relaxation (2 / 6%),
Counselling (7 / 22%),
Referral to a Psychologist (2/ 6%),
Referral to a specialist (1 / 3%), and
Exercise (1/ 3%).

It can be clearly seen that the treatment of choice offered to the participants was medication. Many respondents did not specify which medication or tablets they were prescribed but some responses included antidepressants, anxiety tablets and sleeping tablets. Counselling was offered to 7 of the 32 women (22%) who needed help not enough choices were offered as women wanted to talk more and discuss about what they were experiencing. 4 participants (13%) gave no response as to what treatment options they were given.

Of the participants who sought help from the GP 80% stated that they were given a choice of treatment. However on closer inspection of the qualitative comments it seemed that the question may have been interpreted in a way that was not intended. Many respondents only stated one form of treatment and did not give the other that they were offered. It may be that these people were only offered a single form of treatment and the choice they had to make was whether to accept it or decline.

Of the 28 participants who stated which treatment options they were given, they were further asked whether the treatment was appropriate and why. 15 (54%) participants stated that the treatment they had received was appropriate and the remaining 13 (46%) felt that the treatment they received was inappropriate for their needs.

Qualitative comments made by those who felt the treatment they received was appropriate fell into the following two categories:

- **Treatment was effective/helpful** (15 responses)
  "*Depression, stress and other problems finished after the treatment*"
  "I was better after this treatment"
  "*I was able to express my feelings and understand why I felt so anxious and worried. It improved my mental state*."
- *Felt at ease talking to someone from my own culture who understood my problems* (2 responses)
- **Realising I was not alone**
  " It allowed me to discuss my problems openly and confidently, also allowing me to realise that I was not alone in feeling how I did"

"When I realised that others were in the same position it made me feel normal and relieved as I was scared that there was something wrong with me"
"The medication helped calm me down and give my feelings a boost"
"My GP was able to help me and refer me to a specialist who could help me further"
"Talking about my problems helped me"

Participants were positive about the help they received and stated that the treatment they received was effective. They found it particularly helpful talking to someone about their problems and feeling being listened to. However, other comments included difficulties making appointments, feeling there was a lack of confidentiality and that there were language barriers. *"I didn't feel comfortable talking to a stranger"*

However, although many people said they were effective, there were common a concern of fearing addiction to medication and that medication does not eliminate the underlying problems. One suggestion could be that information is provided to all patients receiving medication with regards to addiction and side effects and the opportunity is given to the patient to discuss their concerns. This would have to be done in a way meaningful to the individual patient, in a language they could understand and could be given in oral or written form depending on the needs of the individual.

Of the 13 that felt the treatment they received was inappropriate for their need the qualitative comments fell into the following themes.

- **Fear of becoming addicted to medication** (4 comments)
  "They worked for a little while but later I became reliant on them. I was afraid of addiction"
- **Treatment did not help symptoms** *(4 comments)*
  "*I don't feel they eliminated the stress and depression"*
  "I don't feel the tablets were helpful they didn't make me feel better"
- **Adverse side effects from medication** (2 *comments)*
  "The tablets made me drowsy"
  "They increased my weight"
  "Effects were temporary" (1)

Other interesting comments were:

Should have been referred to psychologist

"It didn't suit my lifestyle and the initial lack of understanding contributed to the lack of suitability of the treatment"

Specialist Mental Health Services

Of the 107 participants that were involved in the research only 6 stated that hey had been referred to specialist mental health service. This may be a true reflection of the numbers accessing such services or may be a reflection of the reluctance to admit this due to the associated stigma. There were only 4 comments made with regards to how helpful and appropriate the participants felt the service they received was which were all themed around the effectiveness of the treatment. As this number is so small no firm conclusions can be made with regards to the appropriateness of the services these participants received.

Figure 16 the percentage of participants seeking help from the GP who were referred to specialist mental health services. (N-42)

80% (31) of the respondents who sought help from the GP were not referred on to specialist mental health services. 15% (6 participants) of the respondents attending the GP practice as a first point of contact were felt to have needed specialist treatment and referred on to the mental health team. 5% (2 participants) did not give a response to this question.

The findings show that only 7 participants were offered counselling session, however only 6 participants stated they attended counselling. No information is available for why this participant did not attend counselling. This is a very small number of women accessing counselling services despite the themes of what was most beneficial about the treatment they received being identified as 'having someone to talk to about problems' and 'being listened to. 75% of the women questioned recommended that counselling should be offered as a treatment for mental health problems.

Of the 6 participants who got referred to specialist mental health teams by the GP, 4 felt that the referral was appropriate and the subsequent treatment effective for their difficulties. There was no response from the other 2 participants.

Of the 42 participants who sought help for their symptoms they were asked how effective the treatment they received was. The participants had to rate how helpful the treatment was on a scale of 0-5 with 0 being 'not at all' and 5 being 'very much'.

Figure 17 shows that the majority of respondents (18 / 43%) rated the helpfulness of the treatment they received as 3 on a scale of 0-5. 6 (14%) participants felt that the service was not very helpful as indicated by them awarding scores of 0-2. 4 participants (9%) found the help that they received to be good or very good as indicated by them awarding scores of 4-5. 14 (33%) participants gave no response to this question.

Most GP surgeries should have access to counselling provisions. However it appears that the participants in this research have not been offered this service and only 34% of the women are aware of counselling services locally. If services are available and women are agreeable to this kind of therapy then there must be a reason why GPs are not referring women for 'talking therapies'. This may be because they are assuming that women would not want to access it or may be that if there are no bilingual counsellors that some of the ladies may not be able to fully utilise the service provided. Establishing the reasons why the participants did not access to 'talking therapies' is beyond the scope of this research, however, this may be something worth considering for future research. The women suggested that they find having someone to discuss their problems and someone to listen to them of great benefit. The women also expressed concerns with regards to medication especially fears of becoming addicted.

Activities contributing to mental wellbeing

Participants were asked what keeps them happy and contributes to their well-being.

Figure 18 shows that 87% (94) of the participants questioned find prayers do create a positive effect on their wellbeing and happiness. 63% (68) of participants stated that family contributed to their wellbeing and 67% (72) of respondents stated that friends did. Only 33% (36) of participants stated that hobbies contributed to their happiness, however many responses given in the 'other' category could be classified as hobbies.

There were 34 responses that were given in the other category which have been classified into the following categories:

Shopping (8),

TV (5),

Music (4),

Films (2),

Children (2),

Keeping occupied (3),

Housework (4), and

Sewing (3) .

Other comments made were hair dressing and makeup, driving and socialising.

Section 3- Awareness

Participants were asked which services they were aware of. Figure 19 shows the percentage of respondents who were aware of each of the listed services.

The majority of participants are aware of the NHS with 83% of participants (89 participants) stating they are aware of it. The next most well-known service is that of friends and relatives with 62% of respondents (67 participants) stating they know they can turn to them for help. Awareness of other services such as social services and voluntary organisations are relatively low with 30% (32 participants) and 20% of participants (22 participants) respectively being aware of these services. Awareness of counsellors (34% / 37 participants) is higher than Psychiatrists (20% / 21 participants) and community mental health nurses (15% /16 participants).

Sources of Information

Participants were asked where they find out information about service providers. Figure 20 shows the percentage of respondents using the various sources of information.

The source of information about local services that was most frequently used was the GP surgery (85 participants / 79%). Respondents also used family and friends (62 participants / 58%) and leaflets (56 participants / 51%) as frequent sources of information. Responses that were given in the 'other' category (4 participants/4%) included Sure Start, the Yellow pages and local community centres.

Services Attended

Participants were asked about the services they had attended and been referred to.

Figure 21 shows that the service that is attended the most by the participants is the GP (91 participants / 85%). Sure Start (57 participants / 53%), the Advice Bureau (30 participants / 28%) and Sahara Group (29 participants/ 27%) are used by many of the women.

Responses in the other category (4 participants / 4%) were – Islamic classes, International Centre, Women support Group and Reed House.

The participants were asked what they found most and least helpful about the support they received from the services they accessed.

Most Helpful

The 28 qualitative comments regarding what participants found most helpful about the support they received were grouped into the following themes:

- **Social support and the opportunity to meet others (**7 comments)
  "Mixing with like-minded people with similar social needs"
  "Seeing I'm not alone and that others in my community are suffering in the same way"
  "Talking to those in the same position as me who have a similar problem"
- **The helpful advice they gave** (7 comments**)**
  "*Good advice and leaflets"*
  " I was happy with the advice I was given"
- **They understood my concerns (**4 comments)
  "*They understand"*
  "Understanding my problems and concerns"
- **The courses they offered/ learning English** (3 comments)
  "Learning English and computer studies helped me get a job"
- **Staff spoke my language** (2 comments)
  "*The people who work there speak my language"*
- **Easy to talk to and feeling listened to** (4 comments)
  "The GP listened to me"
  "Talking in confidence with another woman"

A further comment was made about the appointments being on time.

Least Helpful

34 comments were made with regards to what participants found least helpful about the support they received. The emerging themes were as follows:

- **Unavailability of suitably timed appointments** (9 comments)
  "GP appointments not available"
  "I work and have no time for appointments"
  "Hard to get an appointment on the same day"

- **Language barriers** (7 comments)
  " No interpreter or Asian doctor who can understand me"
  "GP cannot speak my language"
  "Not very helpful my daughter has to translate for me"
- **Lack of respect / attitude of staff** (5 comments)
  "*We asked for help to fill the forms-being told why don't you ask you children to fill them in was not acceptable. I was unsatisfied with their help"*
  "They don't respect me"
- **No female GPs** (2 comments)
  "No lady doctor in the practice**"**
- **Lack of understanding of problems** (2 comments)
  "No real analysis and distinction of the root of the problem"
- **Lack of organisation** (2 comments)
  "Not properly organised"
  "No proper structure"
- **Little time to discuss problems/ rushed** (2 comments)
  "*GP had little time to discuss my problems"*
  "GP rushed everything and didn't seem to care"

Other responses were lack of Asian doctors, lack of information, no crèche for children, no services for older people and more staff needed.

Cultural needs

Participants were asked whether the services met their cultural needs.

Of those who gave responses that suggested their cultural needs were met the following themes emerged:

- **Access to female GP or nurse** (10 comments)
  "Lady doctor who I can speak with"
  "GP surgery has a nurse who I see so my cultural needs are met"
  "I can see a lady doctor when I want"
- **Understood my problems** (3 comments)
  "Very understanding approach and they're easy to talk to"
- **Understood and respected my culture** (4 comments)
  "*They were aware that I could not eat various foods and catered for this"*

“The psychologist understood my culture a little bit but it involved a lot of effort on my and his part. I felt a lot of time may have been wasted due to this”

“Spoke to an Asian woman, which was helpful because she understands my cultural society”

- **Asian /bilingual staff- no language problems** (3 comments)

  “*Asian GP- no language barriers”*

- **Same cultural background** (2 comments)

  “*From the same cultural background”*

Other responses were that the services try their best to meet cultural needs and that there is starting to be more awareness. One respondent stated that she feels that she had not been dealt with differently because she was Asian.

Of those who gave responses that suggested that their cultural needs were not met the following themes emerged:

- **Lack of understanding of the culture and religion** (8 comments)

  “They don’t know about your culture and you have to explain it to them”

  “Don’t understand the culture and don’t understand where I’m coming from therefore can’t get to the root of my problem”

  “They sometime treat people in stereotypes”

  “They don’t consider our culture”

  “If I had followed the advice they gave me it would have brought shame in my culture”

- **No female GPs/ difficulty getting appointments with female GP** (6 comments)

  “When I wish to make an appointment with a lady doctor she is not available”

  “Hard to tell male doctors about ‘ladies problems’”

  “I want to see a lady doctor because of my culture”

- **Language problems** (3 comments)

  “*Language problem but they do respect and treat me well”*

  “Doctor could not speak Urdu so I could not explain my problems”

  “Should be an Asian doctor or interpreter”

Appropriate Staff

Participants were asked whether the services had appropriate staff to deal with their needs.

The majority of participants who responded to this question suggested that the staff were appropriate as they were respectful and kind, friendly, willing to help and other comments were made about bilingual staff and staff of the same culture.

Comments with regards to inappropriate staff were centred around them being rude, lacking respect not understanding the culture and only speaking English.

Barriers to Accessing Services

Participants were asked what makes it hard to access services.

The research suggested that there were numerous practical and emotional reasons why the participants were not accessing available services. The following part of the discussion centres around the main barriers to South Asian women in Middlesbrough accessing services and suggested improvements that could be made to address these.

One practical issue the ladies identified was that they had no appropriate transport to take them from home to the services they had to access. This could be resolved by having a community bus although this would require funding. The local south Asian community may want to look at ways of raising funds and practical implications of this or other transportation modes. Lack of independence as they are afraid to use public transport has direct impact on mental well being and self-confidence. There are number of incidences of Asian women being attacked while travelling via public transport. (reported to Sahara Group)

The main themes were as follows:

- **Transport** (20 comments)
  "No appropriate access to transport"
- **Language** (15 comments)
  "*Language barriers we need translators*"
- **Confidentiality and trust** (6 comments)
  "Trusting people and having confidence in them"
- **Lack of information and awareness of services** (5)
  "I don't feel I am fully aware of services or their use"
- **Difficulties with appointment times** (4)
  "Can't get appointments when you need them"
- **Lack of parking facilities** (2)

"Parking problems"

- **Language barriers Language**

  "*Language barriers we need translators*"

Other responses were fear of family, not having permission to leave the house, lack of culturally competent staff, lack of motivation, no child care, disabilities, embarrassment and not knowing what to expect.

Section 4

In this section of the questionnaire the participants were asked what services and support they think South Asian women in the Middlesbrough community with mental health problems should receive. They were asked how mental health services could become more responsive to their needs and to suggest improvements to mental health services.

Figure 22 - 84% of the participants (90 participants) feel that women with mental health problems should receive the support of relatives and friends. 77% (83 participants) of those questioned felt that more information was needed for women with mental health problems in Middlesbrough. 73% (78 participants) felt that therapy would benefit these ladies and 75% (81 participants) stated that counselling would be a suitable form of help. Drop in 66% (71), Day Care Centre 68% (73), The least recommended help was hospital with 53% (57 participants) stating this was a suitable treatment and medication with 60%(64 participants).

The participants were then asked how mental health services could become more responsive and aware of their needs.

Figure 23 shows that the participants feel that showing respect and dignity towards service users and carers is the most important way to improve mental health services to become more responsive of South Asian women's cultural needs (86% or 90 participants). 85% of those questioned (91 participants) feel that a bi-lingual worker is required and 80 % (86 participants) feel that there should be more cultural competence training for staff.

The participants were asked to list three things that could be done to improve mental health service provision for south Asian women.

Many of the ladies stated that they would like more access to leisure activities including trips, classes and sports which were for Asian women only (60 participants/ 56%). 22 (21

participants) of those questioned also stated that they would like increased access to transport.

The specific recommendations for mental health services were:

- **Bilingual workers and better interpretation** (31 comments)

  "Interpreter in every service"

  "Interpretation in surgeries"

  "Someone there to translate and interpret"

  "Bilingual workers with mental health knowledge"

  "Bilingual counsellors with cultural knowledge"
- **Improve the cultural competence of staff and the employment of more appropriate staff** (15 comments)

  "*Give respect"*

  "Staff should be friendly and helpful"

  "Cultural competence training for staff"

  "Staff should be more aware of cultural issues"

  "More female staff"

  "GPs should ask the right questions"
- **Provide more information about services raising awareness of what is available in the local community** (11 comments)

  "*Information should be given"*

  "Leaflets printed in Urdu and Punjabi about services"

  "More information and leaflets for mental health services"

  "Advertisements in the local paper about these services"

  "Raise awareness of the services available"

  "Leaflet drops in Asian communities"

  "Information given at Friday Prayers"

  "Notices put in Asian shops in different languages"
- **Employ BME workers** (10 comments)

  "Helpers of the same cultural background"
- **To provide support groups** (5 comments)

  "*Support groups and one to one confidential discussions"*
- **To assure confidentiality** (4 comments)

“Assured confidentiality”

“Ensure all information is confidential”

“Confidentiality should be respected”

- **Increased availability and accessibility** (3 comments)

  “Increased availability and easier accessibility”

  “Service centres should be accessible 24 hours a day”

  “One stop shop for all Asian women’s needs”
- **Alternative therapies** (2 comments)

  “*Availability of alternative therapies that women can relate to”*

  “Expressive art therapy”

Awareness of services

83% of the participants stated that they were aware of the NHS. Awareness of specific mental health provisions was considerably lower. 34% of participants were aware of counselling services, 20% were aware of psychiatrist and 15% were aware of community mental health nurses. The number of participants who had accessed any kind of mental health service was lower. Only 3% had attended a mental health day service, 3% had been referred to a community mental health nurse, 2% had been referred to a psychologist, 2% to a psychiatrist and 1% to a psychotherapist. The lack of awareness may be reflective of the fact that very few of the ladies questioned had need to access specialist mental health services and therefore may not be reflection of the awareness of the female South Asian population in Middlesbrough as a whole.

Information

“I don’t feel I am fully aware of services or their use”

“*Information should be given”*

“Leaflets printed in Urdu and Punjabi about services”

“More information and leaflets for mental health services”

“Advertisements in the local paper about these services”

“Raise awareness of the services available”

“Leaflet drops in Asian communities”

“Information given at Friday Prayers”

“Notices put in Asian shops in different languages”

The participants identified that the main source of information about service providers was the GP, family and friends and leaflets. A lack of information and awareness of services was highlighted as a barrier to accessing services. 77% of participants recommended that more information would be helpful to South Asian women with mental health issues in Middlesbrough.

“More information and leaflets for mental health services.”
Raise awareness of services, a programme of introduction to any procedure.”
“Leaflet drops in Asian communities, information given at Friday prayers, notices in Asian shops in different languages.”
“Leaflets in Urdu and Punjabi about services.”

Information could be aimed on two levels, the first being around mental health conditions including the signs and symptoms so that those who are not currently associating the symptoms they are having with a ‘mental health issue’ may become more aware and may be able to access treatment. The second is providing information of services available, how to access them, referral routes, what to expect etc.

The information needs to be provided in various languages especially Urdu as it was identified as the second most widely used written language after English. GP surgeries should have information provided already and do have access to leaflets around mental health issues in other languages that are available from reputable sources such as MIND and the Royal College of Psychiatrist.

Information is often available in GP surgeries however it appears that from this research this information may not be accessible to the participants. A review of the information that is currently been provided within GP surgery is needed. Information leaflets are available in languages other than English from reputable sources such as MIND and Royal College of Psychiatrists however the extent to which these are being utilised in daily practice is unknown.

By providing information in GP surgeries should increase the awareness of mental health issues and services available as the majority of participants attend the GP surgery. However to maximise awareness of the South Asian population of mental health issues, information can be also provided in other locations the participants use frequently such as Sure Start, Sahara Group, places of worship and social venues such as community centres. The participants also suggested leaflet drops in Asian communities and notices being displayed in Asian shops.

This will still exclude those who 15% of the participants questioned who cannot read or write in any language. However the participants suggested that they gain information about services by word of mouth from friends and family so increased general awareness in the community should benefit those who cannot read or write.

Language Barriers

- **Language** (15 comments)

  "*Language barriers we need translators*"

- **Language problems** (3 comments)

  "*Language problem but they do respect and treat me well"*

  "Doctor could no not speak Urdu so I could not explain my problems"

  "Should be an Asian doctor or interpreter"

- **Language barriers** (7 comments)

  " No interpreter or Asian doctor who can understand me"

  "GP cannot speak my language"

"Not very helpful my daughter has to translate for me"

Language barriers and the shortage of translation services was a major theme that ran throughout the research. Not being able to speak to a professional in their own language was the second most common barrier the participants identified to accessing services. Being able to speak with someone of the same language was identified as one of the most helpful aspect of accessing services. The perception of mental health in South Asian culture, as discussed before, is very different to that in white British culture. Having no interpretation makes it increasingly difficult for the ladies to convey the symptoms and

emotional difficulties they are experiencing in a way that is truly reflective of the way they are feeling but in a way that is also meaningful to the GP.

85% of the participants recommended employing more bilingual workers. Bilingual workers have a dual purpose of being able speaking the languages but also have the cultural knowledge of the community. This is probably why such a high percentage of women recommended them as a way of mental health services becoming more responsive and aware of their needs. However other staff could meet similar needs if they have sufficient cultural awareness and have access to interpretation services.

Tees, Esk and Wear Valleys NHS Trust have an interpretation policy that states that services users whose language preference is other than English should have access to a translator. Language needs assessments should be carried out at the first meeting and service users should be informed about the availability of this service.

The research finding suggest that there may be problems accessing such services although the reasons why are unclear. A review of this maybe needed.

One important comment made in the research was one lady stated that her daughter had to translate for her at appointments. However it is worth noting that some service users may not wish to do this due to confidentiality issues. There may be some private issues that they do not want that family member to know and should have some way of communicating with the health professional without doing so.

Cultural and Religious needs

68% of the participants said the employment of gender specific workers would ensure that services are responsive to their needs. Comments were made around the cultural needs of having a female GP to examine them and discuss ‘ladies problems’ with. However women are still accessing the GP surgery for help with their difficulties accessing appointments with female staff. In order to meet the cultural needs of this population there needs to be access to female GPs or other health professionals such as practice nurses when required.

Figure 18 shows that the activity that 87% of the participants questioned find has a positive effect on their wellbeing and happiness is prayers. Family contributed for 63% of

participants' wellbeing and 67% of respondents stated that friends did. Only 36% of participants stated that hobbies contributed to their happiness however many responses given in the 'other' category could be classified as hobbies.

Mental Health and Islam in Muslim world

As Islam spread to many different lands one of the first psychiatric hospitals arose in Baghdad in 705ce followed by Cairo in 800ce and Damascus in 1270ce. The first specific specialist psychiatric ward was built adjoining general hospitals in Turkey in 1555. (This even experimented with music therapy and sound vibrations/resonance).

Some of the great Muslim physicians include al-Razi (d.925) who wrote a 24 volume encyclopaedia of medicine and ibn Sina (Avicenna; d 1037) who wrote the 14 volume "*The Cannons of Medicine*", which was used in the west for 700 years. Both worked with psychiatric patients, with ibn Sina rejecting the notion that mental illness was caused by evil spirits (Jinns)". However Al-Ghazali criticised ibn Sina's view on the notion of mental illness and Jinns[1], who believed Jinns and other spiritual factors did contribute towards mental illness.

From the above it becomes apparent that Islam has a fully developed system in place that sees faith and spiritual works as central to promoting the well-being. Crucially important is that in Islam there is no gender imbalance and the above is equally valid to Muslim women as it is to men. Women want to seek help on mental health issues but would like to use Islamic ways.

"For Muslim men and women, for believing men and women, for devout men and women, for true men and women, for men an women who are patient and constant, for men and women who humble themselves, for men and women who give in charity, for men and women who fast (and deny themselves), for men and women who deny guard there chastity and for men and women who engage much in Allah's praise-for them has Allah prepared forgiveness and great reward" (33:35 Al Quran)

[1] The Jinn are beings created with free will, living on earth in a world parallel to mankind. The Arabic word Jinn is from the verb '*Janna*' which means to hide or conceal. Thus, they are physically invisible from man as their description suggests (*http://www.islamawareness.net/Jinn/world.html).*

“There is a desire held by sizeable proportion of Muslims for the retention and resuscitation of traditional teachings and the core values of compassion, justice and benevolence that characterise all world faiths, including Islam”. *(Psychiatry and Religion, 2004)*

It becomes apparent from the above that Islam as a faith tradition of Muslims is full of depth that promotes individual and societal well-being, Muslims see their well being symbiotically linked to faith and practice of their ‘way of life’, Islam.

Cultural Competence

The participants felt like some of their cultural needs were not met due to the professionals they were involved with not having appropriate cultural knowledge. Where staff did have cultural knowledge or were of the same cultural background (*“Spoke to an Asian woman, which was helpful because she understands my cultural society”),* participants were satisfied with the service they received. For example one lady was happy with the service received because she had special dietary requirements which were catered for. Participants felt that if staff were not from the same cultural backgrounds as themselves that they either did not understand their concerns or that they had to spend a lot of time explaining their culture to them. One participant was given advice that was unhelpful as what she was advised to do would have been shameful in her culture.

It is clear from this that staff need cultural awareness training in order to provide service users with the most effective, helpful service for their needs. Cultural awareness training would ensure that staff could show respect and dignity towards service users. Showing respect and dignity towards service users and carers was recommended by 86% of participants as a way of improving mental health services. Generally comments from the participants suggested that staff were respectful, kind, friendly and willing to help. Only a small number of respondents said that the staff were rude and lacking in respect however this may be a reflection of the lack of cultural knowledge and not intentional disrespectful behaviour and attitudes. It could be suggested that health professionals undergo cultural competency training that is led by a member of the local South Asian community so that the knowledge they gain from doing so is both accurate and useful.

Confidentiality and trust

Confidentiality and trust were key themes that ran throughout the research. A general lack of trust for health professionals was evident with participants stating that it was hard to trust people they did not know and that they feared others finding out. Confidentiality and Trust were identified as major themes of what makes it hard for the ladies to access services. Many of the participants said they would get support for their difficulties from family and friends. However many women find it equally hard to trust others from their own community again from a lack of trust in confidentiality and a fear that living within a close knit community that others will talk about their problems. It appears that the issue of trust is different for different people with some preferring to confide in professionals and others in their family and friends. As confidentiality has been identified as a key barrier to accessing services this needs to be addressed. It could be suggested that in order to address this we first need to establish what would assure the women that confidentiality would be respected.

Care must be taken to assure confidentiality for the South Asian women accessing the Services. This was identified as a major barrier for not accessing services. Further research is suggested in order to establish how health professionals can better assure confidentiality for these women.

Reflection

After the initial work of getting the questionnaire ready the research, started at its full swing. The interviewees were identified and questionnaires were completed in February and March 2007. The four researchers used their language skills and interacted with Asian women with full confidence.

Although the researchers were not seeking answers from Mental Health service users but by sheer chance and luck they have came into contact with users of Mental Health services. That gave them valuable information about the local services and the benefits and experience of those who used the services from Asian perceptive.

The questionnaire itself does not ask any particular questions about Islam but it was identified in the responses that 83% people use prayers as one of coping mechanism when feeling indisposed. As there is no word in Urdu/Punjabi languages equal to Mental Health most people would simply say they are not feeling well or feeling tired etc. That is why cultural awareness training by Asian service users is necessary.

The project has equipped the researchers with skills such as listening, supporting, building individual confidence and self esteem while being non-judgemental, but above all to believe in someone's ability and help them achieve their goal whatever that maybe. The team of researchers and workers expressed commitment to the project and would like to see the report being implemented within the policy framework and practise of the primary services, NHS and PCT's. It was hoped by the research team that a year long project and the wealth of information obtained, the time and effort they have put in should not go to waste and for this to become yet "another project report". Finally the researchers have expressed that they willing to remain as volunteers and would like to provide cultural awareness training to NHS and PCT staff and learn more about the ethos and framework that these organisations work with.
Overall what was unanimous was the belief and passion in which the research was conducted and carried out in order to improve services for the betterment of one particular community. However, findings show the importance of one community based approaches which could result in the betterment for other community and faith groups.

Towards the final stages of the project, whilst writing up the themes the researchers highlighted the need for the NHS to change its framework and not solely to rely upon and work with the medical model. This was also illustrated via the semi-structured interviews which again reaffirmed the need for choice and for this to be made available at first point of contact and not an add-on.

Conclusions

The Department of Health feel that services could be far more appropriate if developed using the ideas and opinions of the communities they are aimed at. They want to give people in the community the skills they need to research their own ideas to give and to give them the voice to put these forward to service commissioners. This study focuses on the self defined mental health needs of the BME community and provides local BME people the opportunity to define and describe their own perceptions of their identities and what they see as key components of a mental health service which has 'choice' as a central and guiding principle.

“What we do know is that the treatment received by service users should be tailored to their individual needs and not to be affected by other factors”. Louis Appleby, 2007.

This research project has revealed some key findings about the mental health needs of South Asian Women in Middlesbrough. The key findings are

- That the participants defined mental wellbeing as being comfortable, relaxed, happy and safe in their environment. They feel that racism poses a threat to their mental wellbeing and that this has increased since the recent terror attacks and 9/11.
- Support of family and friends and those in similar situations is of great comfort.
- A significant proportion of the participants are suffering from mental health related problems and receiving treatment for this.
- Medication is the most frequent form of treatment, yet the women express the need for more therapies such as counselling.
- Awareness of services in the area is relatively low. Awareness of mental health issues could be increased by providing information on the symptoms but also services available. Information can be provided in a number of locations including the GP surgery and local community centres.
- Barriers to accessing services include language problems, lack of awareness, services not being culturally appropriate.

Language is a contributor to incidences of mis-diagnosis, as well as low referral for psychotherapy and counselling. This is not because they do not believe in such therapy, but because of the difficulty they encounter in making their views or feelings known to mental health professionals schooled in a European ethnocentric tradition, which is often alien and alienating.

Asian cultural traditions and religious beliefs sometimes prohibit certain practices, such as drug taking, conception of children outside marriage and relationships before marriage. This can lead to conflict in families. This creates rift between older and younger generation and contributory factor to mental health suffering. The situation can sometimes be exacerbated by a lack of communication within a family and, also by the lack of available, and appropriate, support from services in the community. Older people feel they have no respect from younger generation and younger think no one care about them.

In the Pakistani Muslim community, for example, the Masjid (mosque) is central to the community's lives, and people turn to it for informal psychological support, often visiting their religious leaders first. Mental health problems may often go undetected, as Asian people may not see the medical practitioner as the appropriate person to contact. Asian women in particular may be at risk as there is a fear that their GPs or workers in a surgery may breach confidentiality. There is a family in Middlesbrough where most not all people (Muslim) go for emotional and religious support. Mental Health awareness training for community Aalims, Aalimas and community leaders from both men and women.

It is clear that people have and continue to experience social exclusion and live with stigma, racism and Islamaphobia and have clear personal and social identities that are informed by their faith and beliefs. That have direct impact on their mental wellbeing.

“Every person, whatever their background, should expect to receive the same standard of care from mental health services”. (Department of Health, 2007).

They are also certain and articulate and suggest to service providers responses that would be congruent with their needs and which crucially offer ‘choice’ and thus increase the possibilities of recovery and non medical interventions.
Many of the ladies stated that they would like more access to leisure activities including trips, classes and sports which were for Asian women only (60 participants) 22 participants also stated that they would like transport.
The specific recommendations for mental health services were:

Recommendations

The results of the research suggest the following recommendations. These recommendations are based on key research findings and are targeted at local decision makers. This research has highlighted the gaps in service provision for South Asian women living in Middlesbrough experiencing mental health problems. These recommendations seek to address these gaps in service provision.

These recommendations show that services need to become more culturally aware, people need to know more about the services and the focus needs to be on the community to ensure the mental well being of the population.

Recommendation 1

To increase awareness of services in the local area for South Asian women with mental health issues

"Didn't know of any services as GP didn't recommend any."

The participants are not aware of local services and do not know how to access them due to poor local advertising. Information empowers people, if they know what is available they can ask for it. It builds confidence to access services if they know how and what to expect. Agencies can work together to create this information, a resource directory could be put together to include all the services available, the referral criteria and means of accessing the services.

Information could be given in the form of leaflets with regards to common mental health problems and what services are available and how to access them. Leaflets should be provided in a variety of languages to ensure that everyone has access to the information. Leaflets should be available in GP surgeries, Sure Start, Sahara group, local community centres and places of worship. Mental health awareness events should also be run in local community centres to further increase the awareness of mental health issues and service providers. Use of video, audiotapes, CD and other new ways of communication with service users with the use of new technology should be explored. Braille and other formats of communications to give information to people who have sight problems and for community members who are deaf or hard of hearing or illiterate.

Recommendation 2

Members of the South Asian Community are used to provide cultural competency training for health professionals

Perceptions of mental health and mental wellbeing for South Asian women is centred around feeling comfortable and relaxed in their own environment. This is different to the White British perception of mental health and wellbeing. Mental health staff need to be mindful of this. Cultural competency training that looks at the mental health needs of this community and including both cultural and religious aspects needs to be given to mental health professionals. Members of the South Asian community could be involved in both designing and providing this training to staff to ensure that it is accurate and realistic. This is in line with the vision set out in Delivering Race Equality

> "*Give respect"*
> *"Staff should be friendly and helpful"*
> *"Cultural competence training for staff"*
> *"Staff should be more aware of cultural issues"*
> *"More female staff"*
> *"GPs should ask the right questions"*
> "*Inappropriate: don't understand, don't give attention, language barrier, rude, problem getting appointments"* .

"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 " . (*Delivering Race Equality).*

Recommendation 3

1. **Ensure that bilingual staff or a translator is available to all those who require this service to communicate with health professionals. Employing culturally competent gender specific BME/Bilingual Asian workers and , Aalims, Aalimas to meet cultural and religious needs.**

Ensure that all those whose first language is not English has a language needs assessment at first appointment. Raise awareness that South Asian women are entitled to ask for a translator if the health professional does not speak their language. This is in line with the Tees, Esk and Wear Valleys NHS Trust Policy.

- **Bilingual workers and better interpretation** (31 comments)
  "Interpreter in every service"
  "Interpretation in surgeries"
  "Someone there to translate and interpret"
  "Bilingual workers with mental health knowledge"
  "Bilingual counsellors with cultural and religious knowledge"
  "Can't explain problems because of language barriers".
- **Employ BME workers** (10 comments)
  "Helpers of the same cultural background"

Recommendation 4

Ensure that South Asian women suffering mental health problems are offered 'talking therapies' which are culturally sensitive to their needs as alternatives to medication.

The participants felt that more talking therapies such as counselling would be beneficial as a treatment option of their mental health difficulties. The women suggested that they find having someone to discuss their problems and someone to listen to them of great benefit. The women also expressed concerns with regards to medication especially fears of becoming addicted. The women should be made aware that they are entitled to a choice of treatment for their problems.

"*Availability of alternative therapies that women can relate to"*

"Expressive art therapy"

Recommendation 5

All services assure confidentiality.

Care must be taken to assure confidentiality for the South Asian women accessing the Services. This was identified as a major barrier for not accessing services. Further research is suggested in order to establish how health professionals can better assure confidentiality for these women.

"*Support groups and one to one confidential discussions"*

“Assured confidentiality”

“Ensure all information is confidential”

“Confidentiality should be respected”

“Confidentiality broken so hard to trust services” .

Recommendation 6

Ensure that South Asian women have access to a female health professional.

In order to meet the cultural needs of South Asian women they need to access to a female GP for examination purposes or to discuss women’s problems with. The women should be able to request an appointment with a female GP or other appropriate health professional. Gender specific workers should be available, proper medical examinations are not possible if male staff are working with female patients. Their culture and religion does not allow them to be checked by a male GP. Or a female doctor should be available to discuss personal issues in relation to health. Provision of competent confidential interpretation service should be provided. The service needs to publicise in the surgery and should be available in the surgery. 8% felt a support worker would be particularly beneficial and the other results have shown that a person from the south Asian community would help improve understanding and remove the language barrier.

“Cultural and religious needs should be understood to make services more efficient”

Recommendation 7

Drop in services and social support for Asian women

The women involved in this research suggested that social support is a major part of their well being. They said that they would benefit from increased social activities within their community. Suggestions included activities, classes, sports and leisure activities and spiritual support. The local community should look at securing money through grants and charities in order to do so.

The women involved in this research suggested that social support is a major part of their well being. They said that they would benefit from increased social activities within their community.

Suggestions included activities, classes, sports and leisure activities and spiritual support. The local community should look at securing money through grants and charities in order to do so.

Community/Day/Drop in Centre Facilities: 92 people asked for it. Safe spaces in both statutory services and in the community should be developed and promoted.

“Increased availability and easier accessibility”

“Service centres should be accessible 24 hours a day”

“Social support and the opportunity to meet others” **(**7 comments)

“Mixing with like-minded people with similar social needs”

“Seeing I’m not alone and that others in my community are suffering in the same way”

“Talking to those in the same position as me who have a similar problem”

“Some where safe to go to have fun”.

Some where safe to go to have talk”.

“*go for outing so they stay healthy and so this way they wont suffer with mental* health”.

Also they want a place where they feel safe, free, and if they need so they can get help, Although it seems that Day/Drop in Centre has significant role to play in mental wellbeing because talking to other members of same community sharing information feeling safe all contribute to mental well being. I suggest that all Local services need to give some consideration to this recommendation. Moreover, by working jointly to pool resources in to one pot would help to achieve this.

Recommendation 8
Strategic Planning and Implementation

- This report and its recommendations be included in the FIS action plan which ought and hopefully will cut across all agencies that are interested in enabling people living in mental distress to recover.

Reference:

1. Billiappa,J (1991) Illness or distress? Alternative models of Mental Health, Confederation of Indian Organisation.

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8. The Nisaa Project (2004) enhancing Black and Minority Ethnic Women's Opportunities for Well Being in Middlesbrough, University of Teesside

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Appendices

1 - Raw data scores

2 – Questionnaire

3 - Consent Form

4 – Confidentiality statement

Appendix 1- Raw data scores

Core Questions

Question	Response	Score	%
Age Last Birthday	15 or under	0	0
	16-18	5	5
	19-21	5	5
	22-24	7	7
	25-29	16	15
	30-39	37	34
	40-49	19	18
	50+	16	16
Gender	Female	107	100
Ethnicity	Pakistani	100	93
	Bangladeshi	2	2
	Indian	4	4
	Asian	1	1
Were you born in the UK?	Yes	37	35
	No	70	65
If no, how long have you lived here?	< 1 year	0	0
	1-5 years	6	9
	6-10 years	14	20
	11 years +	48	68
	No response	2	3
Status	British Citizen	83	77
	Refugee	0	0
	Asylum Seeker	2	2
	Other	4	4
	No response	18	17
What is your first language?	Spoken: Punjabi	63	59
	Urdu	61	57
	English	63	59
	Bengali	2	2
	Hindi	2	2
	Pashto	1	1
	Written: Punjabi	0	0
	Urdu	48	45
	English	58	54
	Hindi	2	2
	Bengali	1	1

	No response None	1 16	1 15
What is your religion?	Muslim Hindu Jewish	103 3 1	96 3 1
What is your sexuality?	Heterosexual Don't wish to answer No response	97 3 6	91 6 3
Do you have a disability?	Yes No No response	8 94 5	7 88 5

Personal Experience

Question	Response	Score	%
Have you experienced any of the following symptoms?	Depression	50	47
	Guilt	14	13
	Anxiety	37	34
	Mood Swings	41	38
	Suicidal attempts	8	7
	Sleeping problems/nightmares	28	26
	Physical aches & pains	37	34
	Emotional Aches & pains	23	21
	Eating problems	22	20
	Stress	55	51
	Anger	44	41
	Relationship problems	24	22
	Tiredness	59	55
	Difficulty concentrating	28	26
	Post natal depression	7	7
	Memory Loss	8	7
	Panic Attacks	12	11
	Fears	18	17
	Serious Illness	9	8
	Poverty	2	2
	Racial Abuse	11	10
	Family Problems	30	28
	Bereavement	22	20
	Domestic Violence	10	9
	Migraine	29	27
	Loss of appetite	14	13
	Financial Problems	12	11
	Homelessness	2	2

	Social Isolation Unemployment Other None No response	8 10 2 10 5	7 9 2 9 5
Did any of these experiences affect your mental health?	Yes No	49 43	53 47
Did you seek help?	Yes No	42 7	86 14
If yes, who did you seek help from at first point of contact?	GP Mental health nurse Psychiatric Day Hospital Community Mental Health Nurse Mental Health Social worker Counsellor Psychologist Family and Friends Others in the same position Other	39 2 0 1 1 6 5 16 10 4	93 5 0 2 2 14 12 38 24 10
Were you given any choice of treatment?	Yes No No response	31 6 2	80 15 5
Were you referred to a specialist mental health service by your GP?	Yes No No response	6 31 2	15 80 5
Rate on a scale of 0-5 how this helped	0 1 2 3 4 5 No response	4 1 1 18 3 1 14	10 2 2 43 7 2 33
What things do you do in your life that keep you happy, stop you worrying about things and help your well-being?	Sport or exercise Hobbies Prayer Relaxation Study Family Friends None	41 36 94 43 36 68 72 0	38 33 87 40 33 63 67 0

Awareness

Question	Response	Score	%
Are you aware of any of the following?	Social Care Department	32	30
	NHS	89	83
	Voluntary orgs	22	20
	Psychiatrist	21	20
	Community MH Nurse	16	15
	MH Day Centre	20	19
	Counsellor	37	34
	Friends or relatives	67	62
	CBT	11	10
	Self help groups	5	5
Where do you find information about health service providers?	Leaflets	56	51
	Internet	26	24
	GP surgery	85	79
	Family & friends	62	58
	Translated literature	37	34
	Asian TV/Radio	21	20
	Other	4	4

Services

Question	Response	Score	%
Have you ever attended or been referred to?	GP	91	85
	Mental health day centre	3	3
	Psychiatric Day hospital	0	0
	Psychiatrist	2	2
	Community MH Nurse	3	3
	Community MH Team	0	0
	MH Social Worker	1	1
	Psychologist	2	2
	Psychotherapist	1	1
	Voluntary org	2	2
	My Sisters Place	11	10
	Advice Bureau	30	28
	Sahara Group	29	27
	Sure start	57	53
	Middlesbrough Refuge	3	3
	Age Concern	14	13
	Counsellor	6	6
	Other	4	4

Recommendations

Questions	Response	Score	%
What kind of help do you think South Asian Women in Middlesbrough with Mental Health problems should receive?	Support of friends & relatives	90	84
	Medication	64	60
	Counselling	81	75
	Therapy	78	73
	Information	83	77
	Spiritual	63	59
	Drop-ins	71	66
	Day Centres	73	68
	Help from others	68	63
	Hospital	57	53
	Support worker	77	72
	Voluntary Groups	66	61
	Carer from own community	72	68
	Other	0	0
How can mental health services become more responsive and aware of your needs?	Gender specific	84	78
	Bilingual workers	91	85
	Cultural competence training	86	80
	Worker understanding	75	70
	Respect & Dignity	90	86
	Religious needs	79	73
	Other	0	0

Appendix 2

Core Questions

1. Age last birthday:

a. 15 or under ☐
b. 16 – 18 ☐
c. 19 – 21 ☐
d. 22 – 24 ☐
e. 25 – 29 ☐
f. 30 – 39 ☐
g. 40 – 49 ☐
h. 50 + ☐

2. Gender

a. Male ☐
b. Female ☐
c. Transgender or transsexual ☐

a. Ethnicity: White
a. British ☐
b. Irish ☐
c. Other (please explain)

Mixed

a. White and Black Africa ☐
b. White and Asian ☐
c. Other (please explain)

Asian or Asian British

a. Indian ☐
b. Pakistani ☐
c. Bangladeshi ☐
d. Other (please explain)

Black or Black British

a. Caribbean ☐
b. African ☐
c. Other (please explain)

Chinese or Other Group

a. Chinese ☐
b. Other (please explain)

----

3. Were you born in the UK?

Yes ☐
No ☐
If no, how long you lived here:

a. Less than 1 year ☐
b. 1 – 5 years ☐
c. 6 – 10 years ☐
d. 11 years or more ☐

3. Are you a:

a. British Citizen ☐
b. Refugee ☐
c. Asylum Seeker ☐

D Other (please explain)

----

4. What is your first language?

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

5. What is your religion:

a. None ☐
b. Christianity ☐
c. Buddhist ☐
d. Hindu ☐
e. Jewish ☐
f. Muslim ☐
g. Sikh ☐

H. Other (please explain)

----

6. Sexuality:

a. Lesbian or gay women ☐
b. Homosexual or gay man ☐
c. Heterosexual or straight ☐
d. Bisexual ☐
e. Do not wish to answer ☐
f. Other (please explain)

----

7. Do you have a disability;

Yes (please explain)

No ☐

Personal Experience

1. What does mental health well being mean to you? Please explain

____

____

2. Have you experienced any of the following symptoms? Please tick

   a. Depression ☐
   b. Guilt ☐
   c. Anxiety ☐
   d. Mood Swings ☐
   e. Suicidal attempts ☐
   f. Sleeping problems and nightmares ☐
   g. Physical aches & pain ☐
   h. Emotional aches & pains ☐
   i. Eating problems ☐
   j. Stress ☐
   k. Anger ☐
   l. Relationship problems ☐
   m. Tiredness ☐
   n. Difficulty concentrating or an inability to make decisions ☐
   o. Post natal depression ☐
   p. Memory loss ☐
   q. Panic attacks ☐
   r. Fears ☐
   s. Serious illness ☐
   t. Poverty ☐
   u. Racial abuse ☐
   v. Family problems ☐
   w. Bereavement or loss of loved ones ☐
   x. Domestic violence ☐
   y. Mood swing ☐
   z. Migraine ☐
   aa. Loss of appetite or separation from family or friends ☐
   bb. Financial problems ☐
   cc. Homelessness ☐
   dd. Social isolation ☐
   ee. Unemployment ☐
   ff. Other ☐
   gg. None ☐

3. Did any these experiences affect your mental health?
   Yes
   No (if no go to question? Need to link them to the next appropriate question maybe in the awareness section)

4. Did you seek help?

   Yes ☐ No ☐

   If no why not?

   ____
   ____
   ____
   ____

If yes, who did you seek help from at first point of contact?

a. GP ☐
b. A psychiatric Day Hospital ☐
c. A psychiatrist ☐
d. A Community Mental Nurse (CMHN) ☐
e. A Mental Health Social Worker ☐
f. A Counsellor ☐
g. A psychologist ☐
h. Family and friends ☐
i. Help from others in the same positions ☐
j. Other, please state ---

4b. was this help appropriate for your need?
4c. if yes, please explain (how it was appropriate)

   ____
   ____
   ____
   ____

4d. if no please explain (how it was inappropriate)

5. If you seeked help from a GP as a first point of contact were you given any choice of treatment?

   Yes ☐ No ☐

What treatment were you offered? Please explain:

   ____
   ____
   ____
   ____

6. Was the treatment plan offered to you appropriate?

   Yes ☐ No ☐

7. Rate on a scale of 0-5 how much this has helped?

0 = Not at all ☐ 5 = Very much ☐

8. What things do you have in your life that keep you happy, stop you worrying about things and help your well-being? Please select all that apply

a. Sports or exercises ☐
b. Hobbies ☐
c. Prayer ☐
d. Relaxation ☐
e. Study ☐
f. Family ☐
g. Friends ☐
h. None ☐
i. Other (please state)

Awareness

1. Are you aware of any of the following? (Please select all that you are aware of)

If you have actually used any of the services then please tick.

a. Social care department ☐
b. NHS ☐
c. Voluntary organisation such as mind ☐
d. Psychiatrist ☐
e. Community mental health nurse (CMHN) ☐
f. Mental health day care centre ☐
g. Counsellor ☐
h. Friends or relative ☐
i. Cognitive behaviour therapy ☐
j. Other (Please state)
----

2. Where do you find information about health services providers? Please select all that apply.

a. Leaflets ☐
b. Internet ☐
c. GP surgery ☐
d. Family and friends ☐
e. Translated literature ☐
f. Asian TV/Radio ☐
g. Other (please state)

Services

1. Have you ever attended or been referred to:

a. A GP ☐
b. A mental health day care centre ☐
c. A psychiatric Day Hospital ☐
d. A psychiatrist ☐
e. A community Mental Nurse (CMHN) ☐
f. Community Mental Health Team ☐
g. A Mental Health Social Worker ☐
h. A Psychologist ☐
i. A psychotherapist ☐
j. Voluntary organisation such as Mind ☐
k. My sisters place (MSP) ☐
l. Advice bureau ☐
m. Sahara Group ☐
n. Sure Start ☐
o. Middlesbrough Refuge ☐
p. Age Concern ☐
q. A counsellor ☐
r. Other, please state
----

7. What did you find helpful about the support you received?

a. What was most helpful?
----
b. What was least helpful?
----

3. What make it hard for you to access services?

___

___

___

Recommendation

1. What kind of help do you think **South Asian Women** in **Middlesbrough Community** with **Mental Health Problems** should receive?

a. Support of relatives and friends ☐
b. Medication ☐
c. Counselling ☐
d. Therapy ☐
e. Information ☐
f. Spiritual ☐
g. Drop-ins ☐
h. Help from others in the same positions ☐
i. Hospital ☐
j. Support worker ☐
k. Voluntary groups (mind) ☐
l. Carer from their own community ☐
m. Other (please give details)

2. How can mental health services become more responsive and aware of your cultural need?

a. Gender specific ☐
b. Bi lingual workers ☐
c. Cultural competence training for staff ☐
d. Workers understanding of BME related health problems ☐
e. Respect and dignity towards services users and cares ☐
f. Other (please state)

3. How could we make these services better for your Community?

____

____

____

4. Can you suggest THREE THINGS that could be done to improve mental health service provision for South Asian Women? Please try to be as specific as possible. Give us much detail as you can about the changes you would like to see.

____

____

____

____

____

____

Thank you for taking the time and efforts to complete the questionnaire.

We will use this information to suggest improvements to Mental Health Services in Middlesbrough.

WOULD YOU LIKE A COPY OF THE REPORT WHICH SHOULD BE READY IN SPRING 2007?

Yes
No

Translated (urdu)
English
Other languages

Appendix 3

Community Engagement Programme

Consent Form

The purpose of this form is to confirm that you are happy with the conditions under which you are completing the Community Engagement questionnaire. You should only sign it once you have read it, or had it read it to you and you are sure that you fully understand it.

1. The purpose of the questionnaire and the Community Engagement Project is to measure access to **Mental Health Services** in **Middlesbrough** and to try to identify areas in which access to services can be improved to better meet the needs of **Women** from the **South Asian Community**.

2. The questions in section one are 'core' questions which are dictated by the **UNIVERSITY** of **Central LANCASHIRE** which is managing the community Engagement project on behalf of **NIMHE.**

3.The remainder of the questions are linked directly to the focus of the research.

4. You may decline to answer any question that you feel uncomfortable with.

5. You may decide to terminate the interview at any point if you so wish.

Appendix 4

Confidentiality Statement

The purpose of this research is to look at the access and barriers to **Mental Health Services** for **Women of South Asian Descent.**

The research methodology meets the necessary ethical and confidentiality requirements. This means

- Your feedback will be considered highly confidential and will only be used for research purpose in order to improve existing services.
- Your personal details will not be passed on to anyone else.
- Interviews will be take place in a confidential environment and all questionnaires and recorded information will be stored in locked facility within the office.
- You are not required to give personal details as your name and address etc.

The research is funded by NIMHE, supported by UCLAN and managed by SAHARA.

a) All information given during the course of the interview is confidential and also that the information will be kept confidential unless a potential harm or abuse is identified to the participant or another person/child.
b) Your participation is voluntary.
c) You can stop the interview at any time.
d) You do not have to answer any question that they do not want to.
e) The information provided will go towards compiling a final report no names or addresses will be given.

WE WOULD BE GRATEFUL IF YOU COULD ANSWER ALL OUR QUESTIONS.

I have read and understand the Confidentiality statement or I have had the Confidentiality Statement read to me and I understand the contents.