COMMUNITY ENGAGEMENT PROJECT:

The National Institute for Mental Health in England Community Engagement Programme (2006/7)

REPORT OF THE COMMUNITY LED RESEARCH PROJECT FOCUSSING ON: Sandwell Bangladeshi Mental Health Needs Analysis Research

BY:
Smethwick Bangladeshi Youth Forum

COMMUNITY IN:
Smethwick
West Midlands

By:
Ajib Hussain, Saleha Begum, Nicola Begum, Dunu Miah

DATE: March 2007

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

The PROJECT TEAM:

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

AJIB HUSSAIN – 23 years old. A recent graduate of Wolverhampton University with a degree (BSc [Hons]) in Computing Information Systems for Business. Ajib is employed on this project as a community researcher for his bilingual ability, IT skills and his desire to learn and acquire new skills. He has excellent communication skills and also wanted to contribute and develop his understanding and needs of the wider community. Ajib had no previous experience of working in or with the community. Through his involvement on the project Ajib has gained valuable experience such as developing the questionnaires, making public presentations, translating and undertaking field research. Ajib has also undertaken the university's accredited qualification in Community and Mental Health Research. In addition to his employment on the project Ajib works for House of Fraser. He has also worked in IT with Perceptive Informatics and IBM.

SALEHA BEGUM – 29 years old. Was unemployed after working on the SHEBA project – a community based women's empowerment project based in North Smethwick. She has also been involved in running some young girls group at the North Smethwick Resource Centre. Saleha is a mother of 3 children and a member of the Smethwick Bangladeshi community. She brings with her experience of community engagement work and locality knowledge. Her command of the Bengali (Sylheti) language was of significant value. Although she had no previous experience of health or social care but had knowledge of the community and their needs. She has been involved in developing questionnaires, conducting interviews and field research. She is also undertaking NVQ level 3 qualification in childcare.

NICOLA BEGUM – 26 years old. Nicola is a Graduate of Coventry University with a Degree in Psychology and the project lead researcher. Although Nicola had limited experience of community engagement work she understood the concept and adapted to the role very quickly. Nicola was primarily responsible for the day to day running and updating everyone with developments. As the lead researcher, she assumed the responsibility (with other members of the team) for developing the questionnaires and writing the ethics proforma. She was also given the responsibility for communicating with UCLan support worker, CSIP lead.

The research project has been very beneficial for Nicola as she is pursuing a career in Psychology. She has been able to apply some of her academic learning and also network with professionals in this field. She has undertaken the university qualification gaining invaluable experience in community based research by being able to take a lead on the project. The project has also given her the skills and experience necessary to conduct research in the community in a confident and knowledgeable manner.

DUNU MIAH – 36 years old. Much of Dunu's work involve the day-to-day management and co-ordination of research and information gathering, contributing to strategy and policy development, delivery planning, stakeholder engagement, mapping, evaluation studies and preparing funding applications.

Presently Dunu is employed as a Community Development Officer (with responsibility of health development work) at SBYF with considerable experience of business and management. Over the last 8 years he has also acquired experience of working in the community and voluntary sector organising a number of seminars and conferences to discuss the role of Bangladeshi community in contemporary British society and the contribution and role of statutory agencies. He is presently involved with several projects; Benchmarking and Analysis of Bangladeshi Hospitality Sector Training Needs, Sandwell PCT-CHN: BME Strategy, Health Promotion and Needs Analysis for Sandwell Bangladeshi community and developing successful funding applications.

His contribution to this project has been in co-ordinating and managing the research team, analysis of the data and writing of the report, liasing with the statutory and voluntary sector agencies to seek support and endorsement of the project and arranging interviews.

ACKNOWLEDGEMENTS:

A great many number of people and organisations in their various capacity have contributed to the completion of this research project during the several months in which this endeavour lasted, providing us with useful and helpful assistance. Without their care and kind consideration, this report would likely not have been possible.

Several people have been instrumental in allowing this project to be completed. We would like thank our organisation (SBYF) Chief Officer – Johur Uddin for his encouragement and support and enabling us to submit a proposal to UCLan to undertake such a sensitive but necessary project.

Firstly we would like to thank all our community members – (Sandwell Bangladeshi's) too numerous to mention by name for facilitating and participating in the research and providing us with invaluable insights.

We would also like to specially thank –

- Colleen Shekerie –PCT mental Health Team for her tireless work in advocating the value of the project to officers within statutory agencies and Chairing the Steering Group.
- The members of the project steering group for their encouragement and patience throughout the project, for recognising the value and importance of the project and demonstrating their dedication and interest.
- Ranjit Senghera-CSIP Equality Manager for her support and input in the questionnaire development and providing with useful contacts during the process.
- Nasreen Akther- UCLan, for her tireless and never ending support for the project and the project workers. Without this patience, support and understanding that constitutes a rather difficult balancing act; we probably would not have been able to complete this research.

A special vote of thanks is also due to Syeda Nessa, Syed Khatun, Gulshan, Jaydaa, Ankor Ali, Tof Islam, Shabia Begum, Ruhal Ahmed, Jalal Uddin, Abu Talib, Luky Begum SBYF Staff for assisting with undertaking the field research and facilitating the interviews. We would also like to express our sincere gratitude to firstly Ajaib Khan of the RETHINK project in Small Heath for generously sharing information; Jhan Miah - UClan for providing us with generous feedback on the questionnaires. If we have omitted contribution made by persons not mentioned above, we apologise and thank them sincerely.

Last of all we would like to commend the great job done by the research team throughout the overall process, represented by Dunu Miah, Nicola Begum, Ajib Hussain and Saleha Begum.

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Executive Summary

Introduction

This study is concerned with looking at the mental health needs of Sandwell Bangladeshi community providing and in-depth analysis of their views, experience and issues which impact on how mental health issues are addressed, discussed and overcome. This research is unique for Sandwell Bangladeshis as it is the first study that examines their needs independent of other similar BME groups. Grouping needs of BME community can be misleading. The research further endorses the principle that because different communities are at different stages of development they require different considerations. More specifically the study gives an insular and isolated community a voice that seldomly makes its self heard and present their opinions and views on issues and subject matters that are considered difficult, sensitive and taboo.

Aims and Objectives of the project.

The primary aim of Delivering Race Equality in Mental Health Care is achieving equality and tackling discrimination in mental health services. The purpose of this project is to identify what mental health services are available to the Bangladeshi community in Sandwell, their appropriateness and how they can be improved.

The mental health need of the Bangladeshi community is a complex interrelationship between poverty, inequality, social and cultural values and norms. These complex and multi variable issues create barriers to accessing mainstream mental health services.

Like other BME communities, perceptions and stigma associated with mental health stems from a lack of understanding of the range of mental health conditions and the lack of awareness of the support services available.

The Bangladeshi Mental Health Research project aims to impact on 6 of the DRE 12 point Action Plan -

Point 1: ***Less fear of mental health care and services among BME communities and BME service users.***
Point 2: ***Increased satisfaction with services.***
Point 8: ***An increase in the proportion of BME service users who feel they have recovered from their illness.***
Point 10: ***A more balanced range of therapies such as peer support services, psychotherapeutic and counselling treatments, as well as pharmacological interventions that are culturally appropriate and effective.***
Point 11: ***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.***
Point 12: ***A workforce and organisation capable of delivering appropriate and responsive mental health services to BME communities.***

Awareness & Perception of Mental Health

- Understanding the awareness and perception of mental health is a key aspect in addressing and discussing issues that affect individuals and communities.

- Of the range of responses received some individual's demonstrated high understanding whilst others simply did not understand the meaning of mental health if the definition of mental health as a benchmark is to be used.

- There is high levels of satisfaction amongst the Bangladeshi community about their state of mental health.

- Unusual behaviour records the highest number of frequency as means to identifying person with a mental health problem; significantly a number of respondents did not know or were unsure if they would be able to recognise someone with a mental illness.

- Out of the possible 131 respondent only 14 people recognised all the different disorders. In an ideal situation this figure should be 100%. Grater number of female respondents than male recognises the illnesses.

- The issue of culture and religion has profound effect and influence on the way in which we view and treat mental health. In any given culture mental health is a difficult and challenging issue.

- Respondents felt that Bangladeshi culture had a negative effect in the way in which we perceive Mental Health

- A High proportion think that the Bangladeshi community perceive mental health as Black Magic or possession. It was not clear if this was due to cultural stereotype and bias against mental health or as a direct result of experience. The respondents in the 50+ category did not think mental health is perceived as black magic or possession.

- The finding also shows the community are unlikely to openly admit to having mental health problems, instead choosing to hide it from others because of fear and shame.

- Majority of the respondents identified family issue, finance, work stress, marriage problems, death, Black Magic as well as abuse as a major contributor and cause for mental health suffering. This is not surprising given that the Bangladeshi community live in poor and overcrowded houses in inner city areas, poor economic prospect, low levels of educational attainment, poverty and deprivation, widening intergenerational conflict and breakdown of traditional family structures.

KNOWLEDGE/EXPERIENCE OF MENTAL HEALTH

According to the Department of Health (2006), mental ill health is experienced by one in six people, ranging from distress to severe illness. This illness can be made worse by the way people are perceived and interact with people.

- High percentage of the respondent thought that people suffering from mental illness should be encouraged and supported. The respondents also feel that over time they will be able to integrate and recover from their illness through effective treatment. People with mental health problem are not considered to be unsafe and have the right to be treated as normal. However, significant differences exist on the question of integration in to society. Respondent felt that rehabilitation and integration was dependent on severity of the illness. This is likely to have consequences and would seem to contradict other supportive statement made by respondents.

- Majority of those accessing support were happy with the treatment they received

Jadu/Jado (Black Magic) and Jinn's

Definition:-

> **Black magic or jado**: *'Magic used for evil often with the intent of injuring or killing someone. It may also be done for the personal gain of the practitioner.'*
> **www.clubalien.com/definitions**

> **Jinn**: *'Jinn are created from fire whereas the human beings are created from clay. Although they are invisible to human eyes, the jinn can see us. Like human beings they are also entrusted with responsibilities (careers, family life, etc.). They too will be rewarded for their righteousness and will receive punishment for their wickedness.'*
> **www.inter-islam.org/faith/jinn**

There are a number of coping mechanisms used by different groups ranging from personal resources and religious. Despite the boundaries increasingly becoming bleared between religion and culture, they none the less play a very important mediating role.

- Jadu or Black magic is commonly believed and practised by practitioners across many cultures. Jadu has no religious precedence yet within the Bangladeshi community it is believed and applied for personal gain, as a vendetta or spite. Many Bangladeshi's believe that jadu can and does affect a persons state of mental health.

- Prevalence to believe in jadu is higher in the 21-35 age group and more male than female were likely to believe in jadu.

- A higher proportion of respondents believe in Jinn than Jadu. This is not surprising given that it is mentioned in the Quran and the Hadith.

- In the 36-49 age group higher percentage of males and females believe that mental ill health can not be caused by jinns.

- It is common practice for sufferers of mental health to consult spiritual healers and be less dependent on Eurocentric medication and treatment of mental illness.

- Significantly very few would either go to a spiritual faith healer, counselling service or psychiatrist. However, when respondents were asked if their first choice failed, who you would seek help from next the response was varied and no clear pattern emerges.

- In the 50+, male respondents in this age group are more likely to consult spiritual faith healers than female respondents.

- It is evident from the above findings and knowledge of the community that there is an underlying dependency on Imams and spiritual healers to cure mental health. A huge industry exists to service this need

- In the 21-35 age groups twice as many male respondents believed in the positive effects of the imams and healers than female respondents.

- It is apparent that the level of dependency by the Bangladeshi community on spiritual healers is considerable when attempting to cure mental health problem.

- The effectiveness and success of religious figureheads was rated as average by majority of the respondents.

- In the 21-35 group, 75% male respondents say they would recommend help from healers for people with mental health compared to 62.2% females who would not.

- Women are less likely to recommend others to visit a religious figurehead/spiritual healer for help with their mental health problem than men.

Mental Health Services

The underlying and true hidden burden of mental health within the Bangladeshi community and is not yet known because of the hidden nature.

- Significant majority of Bangladeshi community are not aware of the mental health service provision in their area. This demonstrates a huge void in providing adequate information and services to the community and also hinders progress in achieving appropriate and responsive services therefore not engaging communities.

- The organisations/services respondents were most familiar with are the Samaritans, Sandwell Mental Health Trust, Asian Counselling service, Sandwell Asian Family Support Team and GP counselling service. Despite the familiarity the frequency of identification of services is quite poor and would require redress if the services are to be inclusive.

- Of the respondents who said they have heard of services, very few have been in touch with the service.

Service Provider Response

A service provider questionnaire was developed to obtain an informed view of how the needs of the Bangladeshi community are being met and what the

channels of communication are. Of the questionnaires disseminated through the Sandwell Primary Care Trust – Mental Health Promotion Team.

Statistical analysis and data grouping could not be achieved as only one completed and two partially completed questionnaires were returned.

Evidence suggests that Bangladeshi community are accessing mental health services is very low in numbers. This position can be improved by facilitating surgeries in community centres with interpreters. Service providers also think that prior intervention could decrease the severity of illness and some GPs' have not responded appropriately. Furthermore, those Bangladeshis that don't have members of family who speak English are at increase risk of late referral.

Recommendations

1. More Bengali speaking mental health professionals –
2. Unanimous Bengali Helpline -
3. National Advertising/promotion of mental health on Bengali Community TV Channels-
4. Service Provision Development-
5. Grater working relations between community and statutory sector agencies-
6. Religion orientated models of service
7. Equality and cultural awareness training for professionals-
8. Respite care for Bangladeshi elders through community organisation- Day Care Centre.
9. Community Champions – Mental Health
10. Local service guide to mental health – English and Bengali
11. Increase Communities awareness of mental health

INTRODUCTION:

We often hear the following words or phrases:

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

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

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

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

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

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

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

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

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

The Key Ingredients

According to the Centre for Ethnicity and Health model, a Community Engagement project must have the community at its very heart. In order to achieve this, it is essential to work through a ***host community organisation.*** *This may be an existing community group, but it might also be necessary to set a real or virtual group up where one does not exist already. The key thing is that this host community organisation should have good links to the target 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 once the project is underway. One of the first tasks that this host community organisation undertakes will be to recruit a number of people from the target community to work on the project.*

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

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

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

The final ingredient, according to the Centre for Ethnicity and Health's model, is the provision of appropriate ***support*** *and guidance. We do not expect community groups to become involved for nothing. Typically we would make in the region of £15-20,000 available to the host organisation. We would expect that the bulk of this money would be used to pay people from the target community as community researchers[2]. We then allocate a named member of staff from our Community Engagement Team as a project support worker. This person will visit the project at for at least half a day once a fortnight. It is their role to support and guide the host organisation and the researchers through the project. We also provide a package of training – typically in the form of a series of accredited workshops. The accredited workshops give participants in the project a chance to gain a University qualification whilst they undertake the work. The support workers will also assist the group to pull together a steering group for the project[3]. The steering group is an essential element of the project: without one, it is difficult to see who the community are engaging with and it is unlikely that anything out of the project will be sustained in the longer term. The group will be doing a needs assessment or a consultation exercise, but for what purpose? It is the role of the steering group to ensure that the work that the group undertakes sits with local priorities and strategies, and that there is a mechanism for picking up the findings and recommendations that the group may make. It is also their role to help to pick up the key individuals who are developed through the project process to help them to take their 'next steps'.*

The Community Engagement Team

The Community Engagement Team comprises of 25 members of staff. They work across a range of Community Engagement areas of spe cialism, 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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[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 in a related field.

The Focus Of This Particular Report

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

National Institute for Mental Health in England Community Engagement Programme:

Smethwick Bangladeshi Youth Forum were one of 40 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 improve equality of access, experience and outcomes for Black and minority ethnic mental health service users by:

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

The focus of our work was the needs of Sandwell Bangladeshi community.

SBYF is keen to build its capacity as a community based organisation. Evidence based on secondary data indicates that Mental Health is a major issues and a cause for great concern within the Bangladeshi Community. SBYF recognise the hidden burden of mental health and the profound effect it is having on the community through the different generations, in particular young people and women. The finding will enable SBYF to obtain an informed view on the issues of mental health and well-being and respond better to the needs of the community.

By undertaking this research the finding will enable SBYF to influence service

providers, planners and policy makers to develop and provide appropriate services that meet with the cultural and religious needs of the Bangladeshi community. It would also enable service providers to make provisions more accessible and available.

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

Community Demographics

Sandwell has a population of 282.750 (Census 2001). In the last decade the population has become more ethnically diverse. According to Sandwell Trends 2003 data, the BME population has increased by 5.6%. In 2001, 20.3% of the population is of BME origin as compared to 14.7%in 1991. The borough has the third highest BME population in the region and the eighth highest in England and Wales. The largest BME group in Sandwell are of Indian origin accounting for 9.1% followed by Caribbean – 3.3%, Pakistani 2.9%, Mixed 2.1%, and Bangladeshi 1.2%.

When dispersal or concentration of communities is examined, it is identified that the Bangladeshi residents were the least dispersed. As many as 80% were living in just 5 of Sandwell's 24 wards. Theses wards are identified as North Smethwick, West Bromwich Central/Greets Green, Tipton, Wednesbury and Blackheath.

All BME groups have large population of young people and fewer old people. 58% of black groups and 64% Asian groups are under 30 years as compared with only 39% white population. Sandwell population trend also demonstrate that there has been a 27% increase in the population of young. Specific trends in the Bangladeshi community in Sandwell are presently not available.

Economic Activity & Basic Skills

Unemployment rate is at 8.5% for the borough. In some of the deprived wards were BME communities reside the unemployment rate is as high as 17.7% - Soho &Victoria. The unemployment rate may not be as high as might be expected due to the impact of the New Deal Programme even if participants do not find work. The largest increase in employment between 2000 and 2010 is expected to be in Business Services and Retailing by 26% and 14% respectively.

Sandwell economy is heavily dependent on the manufacturing industry. While on decline it represents 37% of the jobs compared to 18% nationally. The metal manufacturing industry is seven times larger in Sandwell accounting for 14% of employees compared to 2% as a whole for England and Wales. Employment in the metal processing industries is expected to decline by 53% in Basic Metals and 15% in Metal Goods Sector.

The proportion of unemployed young people aged 18-24 is over 25% compared to the national average of 24.9%. However, the levels of unemployment amongst ethnic minority group are higher. Long-term unemployed increases with age – only 2.8% of the unemployed are under 25 and have been out of employment for more than a year. The rate of unemployment for more than 1 year amongst 45-59 year olds is 34.4%.

The Bangladeshi community experiences significant barriers to employment and training, including lack of relevant and recent work experience, lack of appropriate qualifications and vocational skills. Sandwell has the 8th highest proportion of long-term unemployed out of the 36 Metropolitan District outside London. The Borough has high levels of deprivation generally. This is not unexpected when examining the basic skills needs of the population.

Sandwell has the highest proportion of 16-60 year olds with very low and low literacy and numeracy skills. This rate is 11.6% above the national average level. People lacking basic skills qualification tend to be concentrated within the higher age range; however, the proportion of unqualified young people is also of concern. 41% of the population in Sandwell holds no qualification in English language (Sandwell Trends 2003).

Low family income is relatively common in Sandwell and characteristic of Bangladeshi single earner household. According to Sandwell Trend figures, 22.8% full time employees in Sandwell earn less than £250 per week, compared to 18% nationally.

Benefit dependency is also very high. In the ward with the highest dependence, Soho and Victoria, more than a third of the population (37.3%) depend on Income Support or Job Seekers Allowance – a much larger proportion than the next highest, St Paul's which has 25.2% of its population dependent (Sandwell Trends 2003). The largest cluster of Sandwell Bangladeshi community reside in these two wards.

Households & Housing

There are 115,430 households in Sandwell with 30% comprising of single person households. The regional and national average is 31% and 30% respectively. However, Sandwell has a higher proportion of lone parent households accounting for 8%as compared to a national average of 6%.

Owner occupation in Sandwell is lower than the West Midlands regional average of 69%. Owner occupation for Sandwell is 60% and rented accommodation from social landlords accounting for 30% of which 27% is rented from Sandwell Council. Only 5% are privately rented. Despite the low levels of owner occupancy house prices increased by 70% (from £59,700 to £100,900). The average national increase over the same period is 48%.

Aims and Objectives of the project.

The primary aim of Delivering Race Equality in Mental Health Care is achieving equality and tackling discrimination in mental health services. The purpose of this project is to identify what mental health services are available to the Bangladeshi community in Sandwell, their appropriateness and how they can be improved.

The mental health need of the Bangladeshi community is a complex interrelationship between poverty, inequality, social and cultural values and norms. These complex and multi variable issues create barriers to accessing mainstream mental health services.

Like other BME communities, perceptions and stigma associated with mental health stems from a lack of understanding of the range of mental health conditions and the lack of awareness of the support services available.

SBYF recognise that several opportunities and drivers for change exists at the different levels of national/local policy and service provision and development. The data and information collated will be used to challenge service providers care standards and planning framework to ensure that there is equality of access, experience and outcomes. The research will aid DRE's programme of change. Furthermore, the research also supports DRE agenda for action to bring about equality in health and social care and The Five Year Vision. The proposed research would also provide the basis for supporting and implementing Sir Nigel Crisp's 10-point race equality action plan in the NHS, and support NHS trust to fulfil their obligation under the Race relations (Amendment) Act 2000.

To overcome such issues, the research aims to identify and address the following:

Do they know or able to identify mental illness at its onset

Communities understanding of mental health.

- Inadequate understanding of mental health causes problems in early detection. Lack of acknowledgement can affect the quality of treatment

What is the awareness level of existing services

What are the communication channels between service providers and the community

How is the information being provided

Is the Bangladeshi community accessing current mental health provision in Sandwell? Is so the project will seek to identify:

- How is this taking place, how are the referral being made and do current mental health services meet the needs of the community
- What are the experiences of Bangladeshi mental health patents, carers and families within the system
- Was there an opportunity for discussion, to ask question, were they happy
- Was there appropriate provisions for interpreting, explanation of illness and condition
- Was there adequate support from staff and were they signposted to support networks
- Are they given practical advice
- Does the location of the services hinder the uptake of the service
- What mental health services would the Bangladeshi community like to see being developed to meet their needs

Depending on the severity of mental illness do patients feel empowered and able to take control – are they encouraged to beat the illness

Religion and culture has a major role in the identification, treatment and rehabilitation process. It is often perceived that mental illness is the result of black magic referred to as Jado. Religious figureheads and healers are consulted to treat the condition and not medical professional. The research will aim to identify:

- The association between Jado and mental health
- Why go to religious figureheads and healers and not health professionals
- Influence and role of religious leaders (Imams) and healers in the treatment of mental health
- The consultation process and referral method employed in treatment of mental health
- Aim to establish success and failure factors and rate.

Mental illness amongst young Bangladeshi (boys & girls) is a major concern. Within the community the prevalence of drug use and crime is high, resulting in criminal prosecution and imprisonment. This abnormal behaviour is perceived more in terms of Youth delinquency or Jado as opposed to an actual mental disorder. Research would aim to identify

- The mental health issues amongst young people and identify the variable such as socio-economic and influence and dependency on drugs taking
- Examine cultural and intergenerational conflict
- How and were referral process is taking place i.e. police, courts
- What are young peoples understanding of mental health
- Do the think they require mental health support service
- What services would they like to have made available
- Why do current service not meet their needs
- Those who have received treatment, how do they feel about the treatment and information they have received
- Was there an opportunity for them to discussed and ask questions
- Were they satisfied and happy with the response

The Bangladeshi Mental Health Research project aims to impact on 6 of the DRE 12 point Action Plan by addressing the following -

Point 1: ***Less fear of mental health care and services among BME communities and BME service users.*** Our project intends to reduce the taboo of mental health and make it more acceptable to use services and talk openly about mental health issues. We will aim to address attitudes and their effects on lack of service uptake. The questions that relate to this ask about how the community perceive mental illness, what the interviewee thinks are the causes of mental illness, how they feel those with a mental illness should be treated and their views on black magic, etc.

Point 2: ***Increased satisfaction with services.*** highlight needs and therefore increase satisfaction amongst users in order to develop appropriate levels of service. Both the community questionnaire and that for the service providers asks questions in relation to experience of mental health services, how services are being accessed by the Bangladeshi community, what the barriers are to accessing services and proposed improvements.

Point 8: ***An increase in the proportion of BME service users who feel they have recovered from their illness.*** Make available the services that are required by the Bangladeshi service users, to increase uptake, service use and support, in order to enable recovery from illness. This will be actioned by lobbying research findings to tailor services. The questionnaires ask what the problems are with mental health services and why they hinder recovery. They will also look at the service providers' knowledge of Bangladeshi culture to establish whether there is a need for mental health staff to receive appropriate training to deal with this group and whether there is a need for service providers to employ Bangladeshi staff. The community are also asked/questioned about why other sources of help are sought before mainstream mental health services are accessed.

Point 10: ***A more balanced range of therapies such as peer support services, psychotherapeutic and counselling treatments, as well as pharmacological interventions that are culturally appropriate and effective.*** We propose to encourage services users to become involved in self-help and to steer away from traditional therapies whilst developing culturally sensitive approaches that involve one-to-one, group and counselling therapies. The community questionnaire asks where they would go for help initially, why spiritual healers are generally a point of call with mental health problems in order to establish how effective this is for them and how they have found mental health service provision. Also, service providers are asked about their awareness of the Bangladeshi community, how these users are treated, their own need for training on cultural issues and what suitable changes they recommend.

Point 11: ***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.*** Advocate for support in BME communities in Sandwell, specifically to Bangladeshi service users, we will attempt to inform professionals to be culturally sensitive and we aim to influence local mental health policy, practice, planning and implementation. This is evident in both questionnaires where direct questions are asked about what isn't working for Bangladeshi mental health service users and how improvements could be made to services.

Point 12: ***A workforce and organisation capable of delivering appropriate and responsive mental health services to BME communities.*** SBYF aims to ensure that as an organisation, they build on their capacity in co-ordinating and delivering community needs-based mental health provisions that are culturally acceptable. The field research will also provide insight into current failings, reasons for this and how mental health service providers can be more sensitive to the needs of the Bangladeshi community.

METHODOLOGY:

The Sandwell Bangladeshi mental health research project is a initiative that provide an unique opportunity to look at the reason or complex issues that act as barriers to accessing services and how this might be overcome.

In many respect this is the first research of its kind that looks at the Bangladeshi community needs as opposed to a generic study which often group this severely disadvantage group with other South Asian community. The Bangladeshi community is the youngest of the settled South Asian community. There are some synergies between the needs of the south Asian communities, however, some needs of the community are different and requires different considerations at different levels.

This study is a qualitative research project carried out by means of a partnership approach involving the-

- Mental Health Services
- Primary Care Trust
- Bangladeshi Voluntary Sector Organisations (Sandwell)
- Asian Counselling Service
- Sandwell Council

The methodology employed for undertaking this research project commenced with the recruitment of project workers. A job description was prepared to recruit and select the correct candidate to undertake the work. At the outset it was established that for the research to be successfully undertaken the project workers would have to come from within the community, which was also consistent with the community engagement model. Given the scope of the project, it was established that the project would require two male and two female researchers who can speak Sylheti. The job opportunities were advertised through the networks of community organisations, community leaders and personal approach to service user expressing interest in job opportunities. Applications were received in the form of CV's and the candidates were invited for interviews. The criteria set out in the community engagement model were followed. Within the job description it was specified that attending 6 research training and workshop devised by UCLan was a mandatory requirement and part of the job offer. Furthermore, as an Investor in People accredited organisation, all employees are encouraged to identify and notify SBYF of their training needs to enable them to execute their duties to the standard expected by the organisation. The project co-ordinator and UCLan support worker supported the workers.

Due to the apparent language barriers within the community, the research team adopted a questionnaire method study. As the research was a capacity building project, the workers had the responsibility for devising and developing the questionnaires based on the project proposal and analysing the data. Two sets of questionnaires were devised consisting only of the issues related to or associated with mental health and mental health services regardless of age and sex. Both the Community and Service provider questionnaire went through an evolutionary process. The community questionnaire was revised 8-9 times before approval was obtained. This was a lengthy and time consuming process and resulted in the project falling behind scheduled. Because of her academic (not only factor) background Nicola took the lead on gathering feedback, communicating with stakeholders and lead contacts. Ajib structured the questionnaire and Saleha with others help to translate the questionnaire in Bengali with the help of family and friends, so that there would be consistency when asking the questions during the data collection process/field research.

All project workers were involved in undertaking the research. The community were contacted through community organisations and mosques. Information on the project was provided through the production of an information leaflet. Furthermore, one to one meeting with community representatives were held to explain the purpose of the project in detail to seek their endorsement and approval. One to One interviews were conducted with participant members of the community at the different community venues. There was a degree of reluctance to participate by the Bangladeshi community preferring to advocate responsibility.

A steering community was appointed to oversee the project. Bangladeshi Community representative organisations, CSIP, FIS, PCT Commissioners, NHS Mental Health Trust, mental Health Practitioners and other stakeholders were invited to contribute and direct the research and share their expertise. This would ensure that the project fits with local and national strategic priorities. Furthermore, it will ensure that Sandwell policy makers and local planners develop sustainable and appropriate services targeted at the Bangladeshi community and accept the findings and the recommendations of the report. The steering group would also function as a further check against any ethical issues that may arise in the development of the project.

At the initial steering group meeting, it was decided that the group meets every six weeks in order to discuss and keep the research on track. It has been agreed that members of the steering group are emailed in between meeting dates to be informed of progress on a more regular basis so that any comments can be made as the researchers work rather than delaying valuable feedback strictly to meetings. The group have been told what is expected from their contribution to the research. Members have been told that copies of the questionnaires will be passed to them and advice on ethical practice will be sought at all points during the development and field research stages. They have also been made aware that they need to advice and guide on all aspects of the project, from commenting on research tools, ethics, report writing, recommendations, placements for researchers, shadowing opportunities and resources that they may be able to give to the project and in recommending ways to raise the profile of the research.

It is hoped that the study would identify the barriers faced by Bangladeshi community and respond by providing appropriate services to improve the quality of life for those requiring access to mental health care.

Section 2:

UCLan Core data

Respondents by Age Group

	Total:
15 or under	0
16-18	9
19-21	13
22-24	16
25-29	18
30-39	41
40-49	11
50+	23
Total:	131

Table B: Gender

	Total No:
Male	59
Female	72
Transgender	0

Table C:

Ethnicity

	Number of Respondents
WHITE	
British	0
Irish	0
Other (give details)	0
MIXED	
White and Black Caribbean	0
White and Black African	0
White and Asian	0
Other (give details)	0
ASIAN or ASIAN BRITISH	
Indian	0
Pakistani	0
Bangladeshi	131
Other (give details)	0
BLACK or BLACK BRITISH	
Caribbean	0
African	0
Other (give details)	0
CHINESE or ANY OTHER ETHNIC GROUP	

Chinese	0
Other (give details)	0

Table D:

Were you born in the UK

Yes	No
48	83

If not, how long have you lived in the UK

Table E:

	Less than 1 year	1-5 years	6-10 years	11+ years
Number of respondents	3	5	12	63

Citizenship Status

Table F:

	British Citizen	Asylum Seeker	Refugee	Other (Bangladeshi)
Number of respondents	115	0	0	16

Religion

Table G:

	Number of Respondents
None	0
Muslim	131
Christian	0
Jewish	0
Hindu	0
Sikh	0
Buddhist	0
Other (please specify)	0

Table H:

Do you have a disability

	Yes	No
Number of respondents	4	127

Table I:

Sexuality

	Lesbian or gay women	Homosexual or gay man	Heterosexual or straight	Bisexual	Not answered
Number of respondents	1	0	126	0	4

Result Analysis

Table Q2: How would you describe the state of your Mental Health?

Figures as Frequency of Respondent in the category

	17-20		21-35		36-49		50+	
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Very Poor	0	0	0	0	0	0	1	0
Poor	0	0	4	3	1	0	2	0
Average	2	0	8	13	2	6	13	11
Good	3	3	10	11	6	5	6	2
Very Good	3	7	6	10	4	1	1	0

Table Q3: How would you recognise if you or someone had a mental health problem?

Figures as Frequency of respondent in the category

	17-20		21-35		36-49		50+	
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Change in or Unusual Behaviour	**4**	**7**	**22**	**18**	**8**	**6**	**6**	**10**
Person Isolates or distant Self from others	0	1	2	3	0	0	1	0
Stress, anxiety, Depression, other Mental Health Problem Listed	**2**	**0**	**0**	**1**	**0**	**1**	**0**	**0**
Don't know/unsure	2	0	1	4	2	2	0	0
Emotional Change	**0**	**2**	**2**	**7**	**0**	**1**	**1**	**1**
Wouldn't be able to recognise	0	0	0	1	2	1	1	1
Change in Physical Appearance	**0**	**0**	**1**	**1**	**0**	**0**	**0**	**0**
Ask Them	0	0	0	2	1	1	1	1

Table Q4: Awareness/Recognition of Mental Health by Respondent Group

Figures as Frequency of Respondent in the category

	17-20		21-35		36-49		50+	
	M	F	M	F	M	F	M	F
Nervous Breakdown	3	7	22	28	9	9	2	5
Paranoia	6	7	19	25	6	8	3	9
Visions	3	6	15	17	2	2	2	2
Voices	4	9	20	21	4	6	0	6
Anxiety	3	4	15	23	6	9	7	10
Depression	5	5	24	31	8	9	5	12
Insomina	6	3	8	16	4	8	3	8
Stress	4	4	17	24	6	11	8	10
Psychosis	5	7	16	26	4	6	2	4
Dementia	4	5	14	18	4	6	2	7
Self Harm	5	5	20	28	8	7	2	8
Schizophrenia	6	9	20	23	10	7	3	7
Other	0	0	5	1	0	0	0	0
Recognition of All	0	1	4	8	0	1	0	0

Table Q5A: Have suffered from mental health problems (such as those listed in Figure Q4) .

Figures as Frequency of respondent in the category	17-20		21-35		36-49		50+	
	M	F	M	F	M	F	M	F
YES	1	1	15	17	4	8	5	11
N0	7	9	13	19	9	4	5	2
Unsure	0	0	0	1	0	0	0	0

Table Q5B: Which Ones.

Figures as Frequency of respondent in the category

	17-20		21-35		36-49		50+	
	M	F	M	F	M	F	M	F
Stress	0	1	2	4	0	1	3	3
Anxiety	0	0	0	0	1	0	0	0
Depression	0	0	6	5	0	2	0	1
At least two of (Stress, Anxiety, Depression, Self Harm, Insomnia, Nervous Breakdown)	1	0	5	6	2	5	1	7
Nervous Breakdown	0	0	0		0	0	0	
N/A	7	9	13	20	10	4	5	2
Self Harm	0	0	0	1	0	0	0	0
Most of those listed in Q4	0	0	1	0	0	0	0	0
Paranoia, Stress and Depression	0	0	1	0	0	0	0	0
Suicidal Thoughts	0	0	0	1	0	0	0	0
Paranoia, Stress and Depression	0	0	0	0	0	0	0	0
Phychosis	0	0	0	0	0	0	1	0

Table Q5C: Did you seek help.

Figures as Frequency of respondent in the category

	17-20		21-35		36-49		50+	
	M	F	M	F	M	F	M	F
YES	0	0	7	8	3	6	3	6
N0	1	1	8	9	0	2	2	5
N/A	7	9	13	20	10	4	5	2

Table Q6: What support did you get and from whom.

Figures as Frequency of respondent in the category

	17-20		21-35		36-49		50+	
	M	F	M	F	M	F	M	F
GP	0	0	4	5	2	2	3	2
Counsellor	0	0	0	0	2	1	1	0
Family or Friend	0	0	2	6	4	2	0	4
Spiritual Faith Healer	0	0	1	0	1	1	0	0
Other	0	0	0	0	0	0	0	1
N/A	8	10	21	26	16	6	6	6

Table Q7: Effect of Bangladeshi Culture on Perception of Mental Health.

Figures as Frequency of respondent in the category

	17-20		21-35		36-49		50+	
	M	F	M	F	M	F	M	F
Positive Effect	0	0	3	4	1	5	5	4
Negative Effect	6	10	22	31	12	7	4	6
Unsure / Don't Know	2	0	3	2	0	0	1	0

Table Q8: Effect of Religion on Perception of Mental Health.

Figures as Frequency of respondent in the category

	17-20		21-35		36-49		50+	
	M	F	M	F	M	F	M	F
Positive Effect	1	6	16	22	6	8	7	9
Negative Effect	3	3	7	8	6	2	2	0
Both - Positive & Negative Effect	1	0	1	0	1	1	0	1
Unsure / Don't Know	3	1	11	7	0	1	1	3

Table Q9: Which of the following describes how the Bangladeshi Community perceives Mental Health Problems.

Figures as a Percentage of respondent in the category

	17-20		21-35		36-49		50+	
	M	F	M	F	M	F	M	F
They are Ignorant of it	*37.5*	*60*	57.1	56.8	*61.5*	*58.3*	30	76.9
They think it is Black Magic or Possession	*75*	*80*	64.3	78.4	*76.9*	*66.7*	5	11
They are ashamed of it	*25*	*50*	60.7	64.9	*76.9*	*83.3*	60	61.5
They would Openly Admit it	*0*	*10*	7.1	21.6	*15.4*	*8.3*	1	38.5
They want to Hide it from others	*75*	*70*	82.1	73	*69.2*	*66.7*	50	76.9
They Fear it	*37.5*	*40*	67.9	43.2	*76.9*	*41.7*	30	76.9
They want to Understand More about it	*12.5*	*10*	10.7	27	*23.1*	*50*	30	61.5
They see it as a Normal part of life	*25*	*20*	21.4	45.9	*46.2*	*33.3*	30	53.8
They avoid dealing with/thinking about it	*62.5*	*40*	75	64.9	*46.2*	*58.3*	40	61.5
Other	*0*	*0*	0	0	*0*	*0*	0	0
Unsure	*0*	*0*	0	5.4	*0*	*0*	0	0

Unsure 2 people - ignorant = 5.4%

Table Q10: Why participants thought Bangladeshi people may suffer from Mental Health problems.

Figures as a Percentage of respondent in the category

	17-20		21-35		36-49		50+	
	M	F	M	F	M	F	M	F
Family Issues	62.5	90	92.9	94.6	92.3	100	90	100
Work Stress	37.5	50	60.7	48.6	53.8	50	70	53.8
Finance	25	40	85.7	73	76.9	75	40	84.6
Marriage Problems	50	50	75	83.8	84.6	83.3	50	84.6
Death	37.5	40	60.7	62.2	61.5	66.7	20	76.9
Black Magic	37.5	50	75	62.2	46.2	75	30	76.9
Living Conditions	50	30	42.9	37.8	30.8	58.3	20	69.2
Childhood Trauma	37.5	40	53.6	40.5	46.2	41.7	30	46.2
Environmental Factors	87.5	10	28.6	27	15.4	41.7	20	30.8
Social Stressors	25	50	50	54.1	46.2	33.3	40	53.8
Abuse (Physical or Emotional)	75	60	67.9	73	69.2	75	20	61.5
Emotional Issues	37.5	50	53.6	43.2	61.5	58.3	30	53.8
Other	0	0	0	0	0	0	0	0

Table Q11: How much do the following affect your Mental Health.

Figures as Frequency of respondent in the category

Respondent Group 17-20

Table Q11(a):	1-Not at all		2-Some times or Mildly		3-Unsure		4-Often or Quite strongly		5-Extremely	
	M	F	M	F	M	F	M	F	M	F
Area you live in	37.5	60	25	30	12.5	10	12.5	0	12.5	0
Parents/Family influence	25	60	0	10	12.5	10	37.5	10	25	10
Peer pressure/Friendship Issues	37.5	60	25	20	12.5	10	12.5	0	12.5	10
Bullying	50	60	25	20	0	20	25	0	0	0
Drugs	50	50	25	10	12.5	20	12.5	0	0	20
Crime	62.5	40	0	20	37.5	30	0	10	0	0
Criminal Justice System	37.5	40	25	30	25	10	12.5	20	0	0
Intergenerational Conflict	37.5	60	25	10	25	20	12.5	10	0	0
Religious/Cultural Influences	50	40	25	30	25	10	0	20	0	0
School/College/Work	25	40	50	40	12.5	10	12.5	10	0	0
Racism/Prejudice	50	40	25	50	25	10	0	0	0	0
Marital Relations	75	50	0	20	12.5	10	12.5	20	0	0

Respondent Group 21-35

Table 11(b):	**1-Not at all**		**2-Some times or Mildly**		**3-Unsure**		**4-Often or Quite strongly**		**5-Extremely**	
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Area you live in	50	64.9	25	21.6	17.9	10.8	3.6	0	3.6	2.7
Parents/Family influence	39.3	21.6	21.4	29.7	10.7	13.5	21.4	24.3	7.1	10.8
Peer pressure/Friendship Issues	50	59.5	10.7	21.6	17.9	5.4	17.9	5.4	3.6	8.1
Bullying	42.9	59.5	14.3	10.8	10.7	13.5	17.9	10.8	14.3	5.4
Drugs	42.9	54.1	14.3	13.5	0	13.5	21.4	2.7	21.4	16.2
Crime	35.7	59.5	17.9	10.8	21.4	8.1	17.9	16.2	7.1	5.4
Criminal Justice System	35.7	73	10.7	10.8	28.6	8.1	17.9	5.4	7.1	2.7
Intergenerational Conflict	39.3	45.9	21.4	21.6	14.3	21.6	17.9	5.4	7.1	5.4
Religious/Cultural Influences	50	45.9	7.1	29.7	21.4	13.5	7.1	8.1	14.3	2.7
School/College/Work	28.6	70.3	28.6	16.2	14.3	8.1	17.9	5.4	10.7	0
Racism/Prejudice	39.3	51.4	3.6	24.3	21.4	10.8	14.3	8.1	21.4	5.4
Marital Relations	42.9	45.9	7.1	16.2	17.9	13.5	17.9	18.9	14.3	5.4

Respondent Group 36-49

Table 11(c):	**1-Not at all**		**2-Some times or Mildly**		**3-Unsure**		**4-Often or Quite strongly**		**5-Extremely**	
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Area you live in	61.5	41.7	30.8	41.7	7.7	0	0	8.3	0	8.3
Parents/Family influence	61.5	41.7	30.8	25	7.7	0	0	8.3	0	25
Peer pressure/Friendship Issues	76.9	58.3	23.1	16.7	0	8.3	0	8.3	0	8.3
Bullying	76.9	58.3	15.4	8.3	0	16.7	7.7	16.7	0	0
Drugs	76.9	58.3	15.4	8.3	0	8.3	7.7	0	0	25
Crime	69.2	41.7	15.4	8.3	7.7	8.3	7.7	33.3	0	8.3
Criminal Justice System	61.5	50	15.4	8.3	15.4	41.7	7.7	0	0	0
Intergenerational Conflict	53.8	41.7	38.5	8.3	7.7	33.3	0	8.3	0	8.3
Religious/Cultural Influences	61.5	50	30.8	0	7.7	16.7	0	33.3	0	0
School/College/Work	69.2	58.3	30.8	25	0	8.3	0	0	0	8.3
Racism/Prejudice	61.5	50	38.5	8.3	0	16.7	0	16.7	0	8.3
Marital Relations	46.2	50	46.2	25	7.7	8.3	0	16.7	0	0

Respondent Group 50+										
Table 11(d):	**1-Not at all**		**2-Some times or Mildly**		**3-Unsure**		**4-Often or Quite strongly**		**5-Extremely**	
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Area you live in	60	69.2	10	7.7	20	7.7	10	15.4	0	0
Parents/Family influence	40	61.5	10	7.7	10	7.7	20	7.7	20	15.4
Peer pressure/Friendship Issues	50	84.6	10	7.7	20	0	20	7.7	0	0
Bullying	80	92.3	20	0	0	7.7	0	0	0	0
Drugs	80	84.6	0	7.7	10	7.7	0	0	10	0
Crime	50	53.8	20	15.4	10	7.7	10	23.1	10	0
Criminal Justice System	60	69.2	20	23.1	20	7.7	0	0	0	0
Intergenerational Conflict	50	69.2	10	7.7	30	7.7	0	0	10	15.4
Religious/Cultural Influences	60	61.5	20	7.7	0	7.7	10	15.4	10	7.7
School/College/Work	80	92.3	10	7.7	10	0	0	0	0	0
Racism/Prejudice	60	69.2	20	7.7	0	7.7	10	0	10	15.4
Marital Relations	40	69.2	10	0	0	7.7	20	0	30	23.1

Table Q12: People with Mental Health problem should be:-

Figures as a Percentage of respondent in the category

		17-20		21-35		36-49		50+	
		M	F	M	F	M	F	M	F
Should be Encouraged and Supported	Yes	100	80	100	86.5	84.6	75	90	76.9
	No	0	20	0	10.8	15.4	25	10	23.1
	Unsure	0	0	0	2.7	0	0	0	0
Are Able to integrated into Society	Yes	62.5	50	53.6	59.5	38.5	58.3	60	84.6
	No	37.5	50	42.9	37.8	61.5	41.7	40	15.4
	Unsure	0	0	3.6	2.7	0	0	0	0
Are able to recover, live and work normally	Yes	87.5	80	67.9	78.4	84.6	91.7	80	46.2
	No	12.5	20	25	18.9	15.4	8.3	20	53.8
	Unsure	0	0	7.1	2.7	0	0	0	0
Will not be able to recover at all	Yes	0	0	7.1	97.3	15.4	8.3	10	7.7
	No	100	100	89.3	2.7	84.6	91.7	90	92.3
	Unsure	0	0	3.6	0	0	0	0	0
Can be treated effectively	Yes	62.5	70	82.1	73	76.9	75	70	69.2
	No	37.5	30	10.7	24.3	23.1	25	30	30.8
	Unsure	0	0	7.1	2.7	0	0	0	0
Should be kept away from others	Yes	12.5	20	17.9	10.8	23.1	8.3	10	38.5
	No	87.5	80	78.6	86.5	76.9	91.7	90	61.5
	Unsure	0	0	3.6	2.7	0	0	0	0
Are unsafe to be around	Yes	12.5	30	25	10.8	23.1	0	10	7.7
	No	87.5	70	60.7	86.5	76.9	100	90	92.3
	Unsure	0	0	14.3	2.7	0	0	0	0
Have the right to be treated normally	Yes	87.5	70	82.1	83.8	84.6	83.3	60	84.6
	No	12.5	30	14.3	13.5	15.4	16.7	40	15.4
	Unsure	0	0	3.6	2.7	0	0	0	0
Others		0	0	0	0	0	0	0	0

Figures as a Percentage of respondent in the category

Table Q13:

		17-20		21-35		36-49		50+	
		M	F	M	F	M	F	M	F
Have you or anyone you know ever suffered with mental health issue	Yes	37.5	40	60.7	62.2	53.8	66.7	50	46.2
	No	62.5	60	39.3	37.8	46.2	33.3	50	53.8

Table Q14(a):

		17-20 M	17-20 F	21-35 M	21-35 F	36-49 M	36-49 F	50+ M	50+ F
Prescribed medication for a mental health issue diagnosed by GP	Yes	0	0	10.7	16.2	7.7	33.3	10	7.7
	No	100	100	85.7	83.8	92.3	66.7	90	84.6
	N/A	0	0	3.6	0	0	0	0	7.7

Table Q14(b):

		17-20 M	17-20 F	21-35 M	21-35 F	36-49 M	36-49 F	50+ M	50+ F
Say In the treatment option	Yes	0	0	7.1	5.4	7.7	25	0	0
	No	0	0	14.3	10.8	0	16.7	10	23.1
	N/A	100	100	78.6	83.8	92.3	58.3	90	76.9

Table Q15:

		17-20 M	17-20 F	21-35 M	21-35 F	36-49 M	36-49 F	50+ M	50+ F
Additional Therapy offered alongside the medication	Yes	0	0	3.6	8.1	7.7	16.7	0	0
	No	0	0	17.9	10.8	92.3	25	10	23.1
	N/A	100	100	78.6	81.1	0	58.3	90	76.9

Table Q16:

		17-20 M	17-20 F	21-35 M	21-35 F	36-49 M	36-49 F	50+ M	50+ F
Happy with the treatment	Yes	0	0	3.6	10.8	7.7	16.7	0	7.7
	No	0	0	7.1	5.4	0	8.3	0	0
	N/A	100	100	89.3	83.8	92.3	75	100	92.3

Figures as a Percentage of respondent in the category

Table Q17:

		17-20		21-35		36-49		50+	
		M	F	M	F	M	F	M	F
Do you believe in Jadu	Yes	37.5	40	57.1	48.6	30.8	33.3	60	46.2
	No	50	60	39.3	40.5	46.2	58.3	30	53.8
	Unsure	12.5	0	3.6	10.8	23.1	8.3	10	0

Table Q18:

Do you believe in Jinn	Yes	62.5	70	78.6	73	61.5	66.7	80	92.3
	No	25	30	17.9	18.9	38.5	25	20	7.7
	Unsure	12.5	0	3.6	8.1	0	8.3	0	0

Table Q19:

Can mental health problems be caused by Jadu	Yes	50	70	64.3	45.9	38.5	50	80	92.3
	No	37.5	30	32.1	40.5	46.2	50	20	7.7
	Unsure	12.5	0	3.6	13.5	15.4	0	0	0

Table Q20:

Can mental health problems be caused by Jinn.	Yes	62.5	50	60.7	35.1	38.5	25	60	76.9
	No	25	50	39.3	45.9	61.5	75	30	23.1
	Unsure	12.5	0	0	18.9	0	0	10	0

Table Q21: Whom they would go to if they had a mental health problem in the First Instance.

Figures as a Percentage of respondent in the category

	17-20		21-35		36-49		50+	
	M	F	M	F	M	F	M	F
GP	50	70	42.9	59.5	76.9	66.7	30	69.2
Imam	12	20	10.7	2.7	7.7	8.3	60	7.7
Spiritual Faith Healer	0	0	7.1	0	0	0	0	0
Counselling Service	0	0	3.6	0	0	0	0	0
Psychiatrist	0	0	3.6	0	0	0	0	0
Family Member	25	10	17.9	35.1	15.4	17.7	10	23.1
Friend/Colleague	0	0	7.1	0	0	8.3	0	0
Don't Know	12.5	0	7.1	2.7	0	0	0	0
Other	0	0	0	0	0	0	0	0

Table Q22: If first choice failed, who would you seek help from next.

Figures as a Percentage of respondent in the category

	17-20		21-35		36-49		50+	
	M	F	M	F	M	F	M	F
GP	12.5	20	21.4	27	23.1	33.3	50	23.1
Imam	0	20	35.7	18.9	23.1	33.3	20	69.2
Spiritual Faith Healer	12.5	20	3.6	5.4		8.3	20	7.7
Counselling Service	0	20	0	8.1	15.4	8.3	0	0
Psychiatrist	37.5	10	3.6	5.4	0	0	0	0
Family Member	0	10	7.1	13.5	15.4	8.3	0	0
Friend/Colleague	12.5	0	0	18.9	0	0	0	0
Don't Know	25	0	25	2.7	23.1	8.3	0	0
Other	0	0	3.6	0	0	0	10	0

Other = Hospital

Table Q23: Faith in the positive effects of Imams/Spiritual healers on mental health.

Figures as a Percentage of respondents in the category

	17-20		21-35		36-49		50+	
	M	F	M	F	M	F	M	F
Yes	62.5	60	75	37.8	30.8	41.7	90	61.5
No	0	30	17.9	45.9	53.8	50	10	38.5
Unsure	37.5	10	7.1	16.2	15.4	8.3	0	0

Table Q24: Belief that people in the community would seek help from a religious figurehead/spiritual healer before their GP.

Figures as a Percentage of respondents in the category

	17-20		21-35		36-49		50+	
	M	F	M	F	M	F	M	F
Yes	62.5	90	89.3	78.4	69.2	58.3	100	61.5
No	25	10	3.6	16.2	15.4	41.7	0	30.8
Unsure	12.5	0	7.1	5.4	15.4	0	0	7.7

Table Q25: How effective religious figureheads/spiritual healers are at helping people with mental health problems.

Figures as a Percentage of respondents in the category

	17-20		21-35		36-49		50+	
	M	F	M	F	M	F	M	F
Not at all	12.5	10	17.9	32.4	53.8	33.3	10	15.4
Poor	12.5	10	14.3	13.5	0	16.7	0	7.7
Average	37.5	60	17.9	40.5	38.5	41.7	30	46.2
Good	25	10	25	10.8	7.7	8.3	40	30.8
Very Good	12.5	10	17.9	0	0	0	20	0
Unsure	0	0	7.1	2.7	0	0	0	0

Table Q26: Personal recommendation to others to visit a religious figurehead/spiritual healer for help with their mental health problem.

Figures as a Percentage of respondents in the category

	17-20		21-35		36-49		50+	
	M	F	M	F	M	F	M	F
Yes	37.5	40	75	35.1	15.4	41.7	60	38.5
No	37.5	60	21.4	62.2	69.2	58.3	40	61.5
Unsure	25	0	3.6	2.7	15.4	0	0	0

Table Q27: Is mental health a growing problem within the Bangladeshi Community

Figures as a Percentage of respondents in the category

	17-20		21-35		36-49		50+	
	M	F	M	F	M	F	M	F
Yes	37.5	30	60.7	75.7	46.2	66.7	70	69.2
No	12.5	60	32.1	21.6	53.8	25	30	30.8
Unsure	50	10	7.1	2.7	0	8.3	0	0

Table Q28: Is there a need to talk about mental health issues in the Bangladeshi Community.

Figures as a Percentage of respondents in the category

	17-20		21-35		36-49		50+	
	M	F	M	F	M	F	M	F
Yes	87.5	90	60.7	75.7	46.2	66.7	70	69.2
No	0	10	32.1	21.6	53.8	25	30	30.8
Unsure	12.5	0	7.1	2.7	0	8.3	0	0

Table Q30: Are you able to explain and discuss the emotional difficulties that you are experience when you go to your GP or Mental Health professional.

Figures as a Percentage of respondents in the category

	17-20		21-35		36-49		50+	
	M	F	M	F	M	F	M	F
Yes	12.5	40	64.3	48.6	53.8	58.3	30	46.2
No	62.5	40	25	43.2	46.2	41.7	70	53.8
Unsure	25	20	10.7	8.1	0	0	0	0

Table Q31: Awareness of mental health service provisions in your area.

Figures as a Percentage of respondents in the category

	17-20		21-35		36-49		50+	
	M	F	M	F	M	F	M	F
Yes	25	0	14.3	13.5	15.4	8.3	20	7.7
No	75	100	85.7	86.5	84.6	91.7	80	92.3

Table Q33: Have you heard of the following services for mental health in Sandwell.

Figures as a Percentage of respondents in the category

		17-20		21-35		36-49		50+	
		M	F	M	F	M	F	M	F
Community Mental Health Team	Yes	0	10	3.6	24.3	7.7	0	30	7.7
	No	100	90	96.4	75.7	92.3	100	70	92.3
Sandwell Asian Family Support Team	Yes	12.5	60	10.7	18.9	15.4	8.3	20	7.7
	No	87.5	40	89.3	81.1	84.6	91.7	80	92.3
Sandwell Mind - Refresh	Yes	0	0	10.7	8.1	0	0	0	0
	No	100	100	89.3	91.9	100	100	100	100
Rethink	Yes	0	0	17.9	5.4	7.7	0	0	0
	No	100	100	82.1	94.6	92.3	100	100	100
Sandwell Mental Health Trust	Yes	25	40	25	18.9	23.1	8.3	30	7.7
	No	75	60	75	81.1	76.9	91.7	70	92.3
Asian Counselling Service	Yes	0	10	0	27	15.4	8.3	20	15.4
	No	100	90	100	73	84.6	91.7	80	84.6
Samaritans	Yes	50	30	35.7	35.1	15.4	25	0	0
	No	50	70	64.3	64.9	84.6	75	100	100
Child & Adolescents Mental Health Services	Yes	12.5	0	3.6	8.1	7.7	0	20	0
	No	87.5	100	96.4	91.9	92.3	100	80	100
GP Counselling Service	Yes	12.5	40	3.6	24.3	7.7	8.3	20	0
	No	87.5	60	96.4	75.7	92.3	91.7	80	100
Primary Care workers at GP Surgeries	Yes	12.5	20	7.1	8.1	7.7	0	10	7.7
	No	87.5	80	92.9	91.9	92.3	100	90	92.3
Head2Head Young Person's Counselling Service	Yes	12.5	20	0	2.7	0	0	0	0
	No	87.5	80	100	97.3	100	100	100	100
Kushi Sandwell asian Mental Health Service	Yes	0	0	0	10.8	7.7	8.3	0	0
	No	100	100	100	89.2	92.3	91.7	100	100
Other service/group	Yes	0	0	0	0	0	0	0	0
	No	0	0	0	0	0	0	0	0

Table Q34: Have you ever been in touch with any of the services identified in Table Q33.

Figures as a Percentage of respondents in the category

		17-20		21-35		36-49		50+	
		M	F	M	F	M	F	M	F
Have you ever been in touch with any of the services identified in Figure Q33	Yes	12.5	0	0	16.2	7.7	0	10	7.7
	No	87.5	100	100	83.8	92.3	100	90	92.3

Figures as a Percentage of respondents in the category

		17-20		21-35		36-49		50+		
		M	F	M	F	M	F	M	F	
Were you given the opportunity to discuss and ask question	Yes	0	0	0	10.8	7.7	0	10	0	Table Q35(b):
	No	0	0	0	5.4	0	0	0	0	
	N/A	100	100	100	83.8	92.3	100	90	100	
Was an assessment and care plan developed for you	Yes	0	0	0	8.1	7.7	0	10	0	Table Q35(c):
	No	0	0	0	8.1	0	0	0	0	
	N/A	100	100	100	83.8	92.3	100	90	100	
If Yes to Q35©, did you have a say in what was offered	Yes	0	0	0	5.4	0	0	0	0	
	No	0	0	0	8.1	7.7	0	0	0	
	N/A	100	100	100	86.5	92.3	100	100	100	
Were you happy with the treatment offered	Yes	0	0	0	8.1	7.7	0	10	0	Table Q35(d):
	No	0	0	0	8.1	0	0	0	0	
	N/A	100	100	100	83.8	92.3	100	90	100	
Were your family, or those close to you, involved in the help you received	Yes	0	0	0	5.4	7.7	0	10	0	Table Q35(e):
	No	0	0	0	10.8	0	0	0	0	
	N/A	100	100	100	83.8	92.3	100	90	100	
Were you offered an interpreter	Yes	0	0	0	10.8	7.7	0	10	0	Table Q35(f):
	No	0	0	0	2.7	0	0	0	0	
	N/A	100	100	100	86.5	92.3	100	90	100	
Were you told about local support networks	Yes	0	0	0	8.1	7.7	0	10	0	Table Q35(g):
	No	0	0	0	8.1	0	0	0	0	
	N/A	100	100	100	83.8	92.3	100	90	100	
Did you make use of these	Yes	0	0	0	2.7	0	0	10	0	
	No	0	0	0	5.4	0	0	0	0	
	N/A	100	100	100	91.9	100	100	90	100	

Were they useful	**Yes**	0	0	0	2.7	0	0	10	0	**Table Q35(h):**
	No	0	0	0	0	0	0	0	0	
	N/A	100	100	100	97.3	100	100	90	100	
Were staff supportive	**Yes**	0	0	0	13.5	7.7	0	10	0	**Table Q35(j):**
	No	0	0	0	2.7	0	0	0	0	
	N/A	100	100	100	83.8	92.3	100	90	100	
Is it important that staff are sensitive to your religious and cultural needs	**Yes**	0	0	0	16.2	7.7	0	10	0	**Table Q35(k):**
	No	0	0	0	0	0	0	0	0	
	N/A	100	100	100	83.8	92.3	100	100	100	
Were you offered any practical advice or an explanation about the state of your mental health	**Yes**	0	0	0	16.2	0	0	10	0	**Table Q35(m):**
	No	0	0	0	0	0	0	0	0	
	N/A	100	100	100	83.8	100	100	90	100	
Was the service easy or difficult to get to	**Easy**	0	0	0	10.8	7.7	0	10	0	**Table Q35(n):**
	Difficult	0	0	0	5.4	0	0	0	0	
	N/A	100	100	100	83.8	92.3	100	90	100	
Do you feel more in control of your Mental Health as a result of using this service	**Yes**	0	0	0	13.5	0	0	10	0	**Table Q35(o):**
	No	0	0	0	2.7	0	0	0	0	
	N/A	100	100	100	83.8	100	100	90	100	
Are you satisfied with the help you received	**Yes**	0	0	0	13.5	7.7	0	10	0	**Table Q35(p):**
	No	0	0	0	2.7	0	0	0	0	
	N/A	100	100	100	83.8	92.3	100	90	100	
Do current mental health services meet your religious and cultural needs	**Yes**	0	0	0	10.8	7.7	0	10	0	**Table Q35(q):**
	No	0	0	0	5.4	0	0	0	0	
	N/A	100	100	100	83.8	92.3	100	90	100	
Do the services have appropriate Staff to deal with Bangladeshi Service users	**Yes**	0	0	0	5.4	7.7	0	10	0	**Table Q35(r):**
	No	0	0	0	10.8	0	0	0	0	
	N/A	100	100	100	83.8	92.3	100	90	100	
Does location hinder access	**Yes**	0	0		8.1	7.7	0	10	0	**Table Q35(u):**
	No	0	0		8.1	0	0	0	0	
	N/A	100	100		83.8	92.3	100	90	100	

Section 3:

Understanding The Mental Health Needs of the Sandwell Bangladeshi Community

Introduction

This study is concerned with looking at the mental health needs of Sandwell Bangladeshi community providing an in-depth analysis of their views, experience and issues which impact on how mental health issues are addressed, discussed and overcome. This research is unique for Sandwell Bangladeshis as it is the first study that examines their needs independent of other similar BME groups. Grouping needs of BME community can be misleading. The research further endorses the principle that because different communities are at different stages of development they require different considerations. More specifically the study gives an insular and isolated community a voice that seldomly makes its self heard and present their opinions and views on issues and subject matters that are considered difficult, sensitive and taboo. One of the main reason why many policies prove unsuccessful is due to the lack of information (Ghaill, Mac an, and Haywood, 2005). Eade, 1996; Eade and Garbin, 2002, say that "we need to know about their specific needs so that public policy makers, as well as individual institutions, can target limited resources in a more strategic fashion at this highly disadvantaged minority ethnic community".

Categorical Information Analysis

For the purpose of this research (consistent with the original project proposal) the aim was to conduct 150 interviews across 4 different age groups identified in Table 4; across the 5 (Smethwick, West Bromwich, Tipton, Wednesbury and Blackheath) location in which Sandwell Bangladeshis are clustered and reside. Of the 5 locations research was limited to Smethwick, West Bromwich & Tipton as these area's have established community engagement centres, where as the other areas do not. Furthermore, previous attempts to work in these areas have proven to be difficult due to the insular nature and the dynamics that exist within the community.

Table 4: Respondent by Age Group

	17-20	21-35	36-49	50+	Total
Male	8	28	13	10	**58**
Female	10	37	12	13	**73**
Total	**18**	**65**	**25**	**23**	**131**

The target samples are all Bangladeshi living in Sandwell and have been selected objectively to ensure that it is a representative profile of the community. Names and addresses of respondents not recorded on the questionnaires.
Of the 150-target, only 131 one to one target interviews were achieved of which 44% accounted for male and 56% female respondents. As Figure 4, illustrates, the number of respondents in the 17-20, 21-35 and 50+ are similar accounting for 44, 43 and 43% respectively where as the respondent in 36-49 target group were higher at 52%.

Of the female respondent, target group 36-49 only had a fewer respondents than male accounting for 48%. The other age groups had higher number respondents than male. As a percentage the figures are were consistent for target group 17-20, 21-35 and 50+ accounting for 56, 57 and 57% respectively. It would be fairly accurate to assume that the balance between male and female is reasonable.

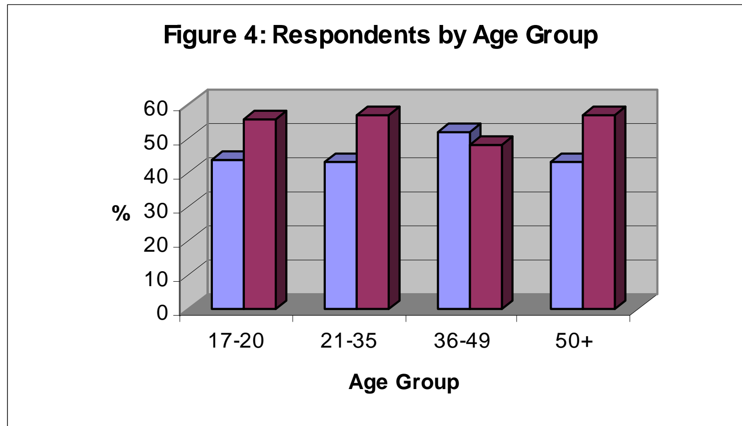
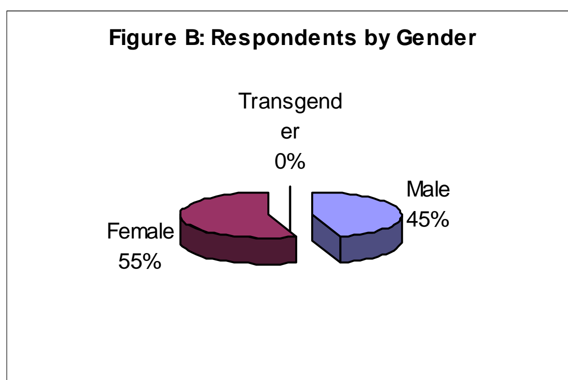


Table A, below shows a detailed breakdown of the respondents by age and by gender. Figure B, shows that the proportion of female account for 55% of all respondents as oppose to 45% for male.

Table A:

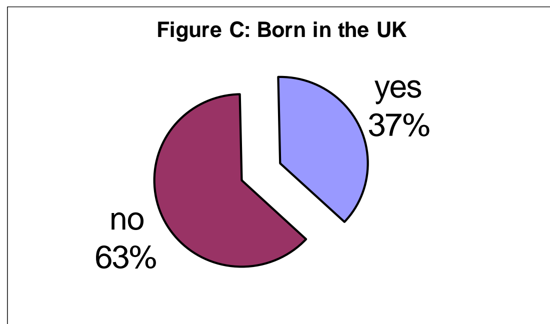
Respondents by Age Group

	Total:
15 or under	0
16-18	9
19-21	13
22-24	16
25-29	18
30-39	41
40-49	11
50+	23
Total:	131

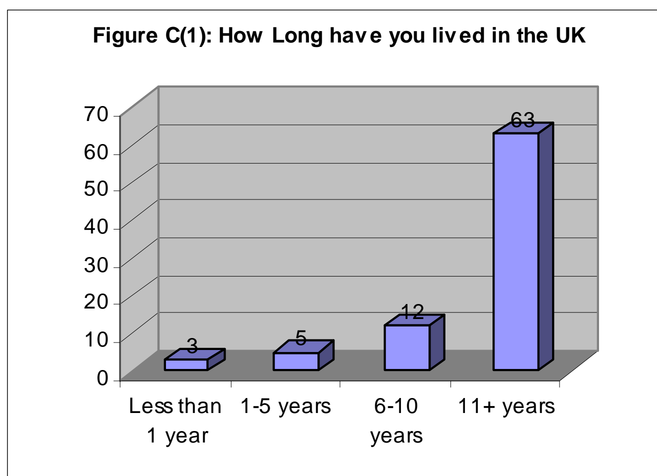


In respect of the respondent place of birth as shown in figure C, 37% were born in the UK whilst 63% were born outside of the UK. This position is not surprising

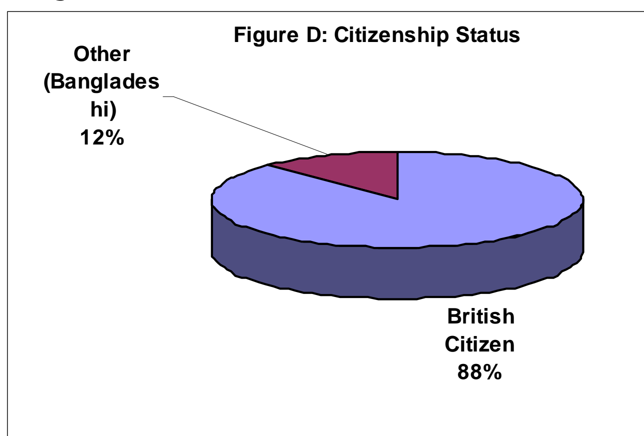
as the Bangladeshi community is the youngest of all South Asian communities in terms of migration and settlement patterns in the UK.



When the length of settlement of those not born in the UK it is identified that examined as figure C(1) shows 76% accounting for 63 of the respondents have been settled for more than 11years and only 3.6% (3 people) have been settled for less than 1 year.



Given that large proportion of the respondents have been settled in the UK for over 6-10 and 11+ years combined with those born in the UK, it is not surprising that 88% are British Citizen and only 12% have Bangladeshi Nationality as shown in Figure D.



in respect of religion, 100% of the respondent were muslim (see Table G, p19); 4 of the respondent reported to have disability (Table H, p19). Table I, shows that one respondent identified them self as a lesbian or gay women and the remainder were either heterosexual (126) or did not answer.

Research Result Findings Analysis

Awareness & Perception of Mental Health

"how a person thinks, feels, and acts when faced with life's situations. Mental health is how people look at themselves, their lives, and the other people in their lives; evaluate their challenges and problems; and explore choices. This includes handling stress, relating to other people, and making decisions" www.dphilpotlaw.com/html/glossary.html

Understanding the awareness and perception of mental health is a key aspect in addressing and discussing issues that affect individuals and communities.

In this section the questions aim to identify how aware the respondents are about mental health and their views. The sequence of questions aim to identify what the respondent understood about mental health; how they rated their own mental health; their ability to recognise and identify problems and illnesses; the impact of culture and religion and the multivariable factors that may cause mental health problems amongst the Bangladeshis.

Understanding of Mental Health

According to the World Health Organisation (WHO), there is no one authorised or definitive definition of mental health. This is due to cultural differences, subjective interpretation and differing professional theories. "*Mental Health has been defined variously by scholars from different cultures. Concepts of mental health include subjective well-being, perceived self-efficacy, autonomy, competence, inter-generational dependence and self-actualization of one's intellectual and emotional potential, among others. From a cross-cultural perspective, it is nearly impossible to define mental health comprehensively. It is, however sometimes used as a broader definition, and professionals generally agree that mental health is broader than a lack of mental disorders*" WHO

Respondents were asked what their understanding of mental health was. Of the range of responses received some individual's demonstrated high understanding whilst others did not. Some simply did not understand the meaning of mental health if the definition of mental health as a benchmark is to be used.

The following response (sample) were provided by respondent in the different groups-

17-20:

MALE

- *"it's the way you think, the way it affects your normal life"*
- *"when someone is not fully able in their mind"*
- *" when someone is not in control of their mind and they have no idea of what they are doing"*
- *"everyone has got a part of mental health in them just can't see. Physical health –break arm , you can see, but mental health you can't. I am ware of it"* 19yrs
- *"someone who is crazey, has a problem with controlling their emotion"* 19yrs
- *"Crazy"* 17yrs

FEMALE

- *"it is a state of mind that may develop due to major problems one is/has experienced. Some cases of mental health may be due to hereditary cases or disease and can be treated accordingly"* 20yrs
- *"any illness occurring from within"* 20yrs

- *"mad people"* 17yrs
- *"stability of the mind"* 19yrs
- *"mental health is certain behaviour that are associated with the mindset. It hasd a negative association to it.*

21-35:

MALE

"*an in capacity to process thoughts properly or what is considered normal*" 34 yrs
" *how happy or stressful a person is feeling Mental health is a wide range of things from not being able to cope with day to day living to more severe forms as harming your self*" 25yrs
"*someone who is ill*" 26yrs
"*someone who is physically well but not well in the mind who suffers from depression*" 23yrs
"*not very much*" 30yrs
"*Don't Know*" 23yrs
"*its god given and will heal or will get better in due course*" 35yrs
" *I've never thought about it*"
"*it's a shock in life*" 32yrs
"*people with problems – mentally and physically*"25yrs
"*what creates it. Symptoms. Cause of mental health are many. All relate well-being and health. Vast area, can not be answered concisely. Very difficult to talk about its not like a headache don't you know*" 31 years

Female

"if you have a peace of mind everything is well" 24yrs
"being unwell. More pressure of family" 34yrs
"I am a care. Everyone different. Some are one way, others feel different way. Family stress" 32yrs
"tension and pressure" 27yrs
"worries and problems" 24yrs
"like a brain disorder, people act weird and different from everyone else" 33yrs
"mental disorder resulting from stress, anxiety and most likely financial difficulty and inability to cope with the day to day life"
"bad things" 31yrs
"someone who has special needs" 29yrs
"Someone who might be depressed or in extreme cases, schizophrenia. I believe that any mental health issue originates from not being able to talk about problems or in severe cases start from childhood" 33yrs

36-49

MALE

"someone who suffers from the disease of the brain" 41yrs
"mad, slow, deranged" 36yrs
"I din't know. I don't understand the term" 48yrs
"its not good" 43years
"it can be something which originates in your head" 42yrs
"problems associated with the mind, stress, worries, anxiety atc."

FEMALE

"depression" 39yrs
"not very much" 36yrs
"tension. Way people feel. Everyone has different mental health issues. Mine relates to my home, family. This falls on women. A man doesn't know what is in the home" 47yrs
"its linked to your mind. How you deal with And see things. Sometimes people worry so much they fall ill. They loose faith in getting better" Smethwick

50+

MALE

"I think it more to do with Black Magic" 71yrs
"I have liver problems which causes me a lot of worries regarding health. My understanding of mental health I think is caused mainly by physical health" 68yrs
"a persons brain problems" 61yrs
"good"
"its something very bad. Worrying, stress is very bad" 52yrs

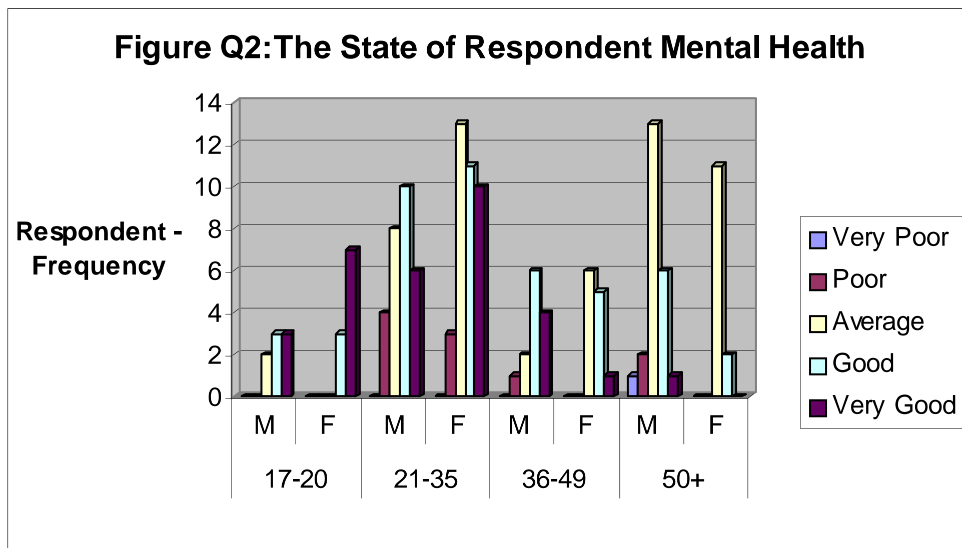
FEMALE

"some people have worries. Lead to illness" 55yrs
"I think it is an illness in your head or mind because you can't see the signs. People may think it doesn't exist or you are making it up. Because the can't see it like if you broke your leg for example" 57yrs
"don't know" 69yrs
"it is an illness that affects your mind and your ability to function. From this illness many other illness form" 55yrs

From the data collated in relation to the above qualitative question demonstrate variable levels of understanding. However, the data also suggests that there is a considerable level of unsureity, no understanding and misinterpretation.

The state of Mental Health

When respondents were asked to describe their state of mental health very few expressed it as very poor. As figure Q2, shows respondents either feel average, good or very good (Please also see Table Q2



33% and 56% of Young people within the 17-20 groups described their mental health as good and very good respectively. However, more female than male respondents feel very good. In the 21-35 category 10.8% of the respondents reported feeling poor, however, for average and good the frequency is the same - 21 respectively accounting for 32.3% each. 24.6% (16) of the respondent felt their state of mental health is very good. Small variance can be seen between male and female. 35.1% (13) female reported their state of mental health as average, as opposed to 35.7% (10) male who report theirs is good. This result is not supervising given that despite the high levels of social disadvantage young Bangladeshis (girls and boys) are found to be at a reduce risk of psychological distress as compared to their white counterparts. High levels of family support and high ethnic concentration provide protective factors for mental health (Stansfeld and Haines, 2004). It could be hypothesised that such protective factors permeates through the different groups and as such counterbalance the deprivation and disadvantage aspect.

Respondents in the 36-49 years category show similar patterns to that of the 21-35 age group. 44% reported good state of mental health followed by average and very good accounting for 32% and 20% respectively. Males report higher levels of good (46.2%) and very good (30.8%) mental health as oppose to 50% of women who say theirs is average with 41.7% for good. Within the 50+ category 40% of the male respondents say their Mental health is good as oppose to 84.6% who say theirs is average.

Recognising Mental Health problem.

Given that there is high levels of satisfaction amongst the Bangladeshi community about their state of mental health respondents were asked how they would recognise if they or someone they know had a mental health problem. Table Q3, below shows that change in or unusual behaviour records the highest number of frequency as means to identifying person with a mental health problem. 10.6% respondent identified Emotional change as a means to recognise someone with mental health problem, significantly 8% of the respondents did not know or were unsure if they would be able to recognise someone with a mental illness.

Table Q3: How would you recognise if you or someone had a mental health problem?

Figures as Frequency of respondent in the category

	17-20		21-35		36-49		50+	
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Change in or Unusual Behaviour	**4**	**7**	**22**	**18**	**8**	**6**	**6**	**10**
Person Isolates or distant Self from others	0	1	2	3	0	0	1	0
Stress, anxiety, Depression, other Mental Health Problem Listed	**2**	**0**	**0**	**1**	**0**	**1**	**0**	**0**
Don't know/unsure	2	0	1	4	2	2	0	0
Emotional Change	**0**	**2**	**2**	**7**	**0**	**1**	**1**	**1**
Wouldn't be able to recognise	0	0	0	1	2	1	1	1
Change in Physical Appearance	**0**	**0**	**1**	**1**	**0**	**0**	**0**	**0**

Ask Them	0	0	0	2	1	1	1	1

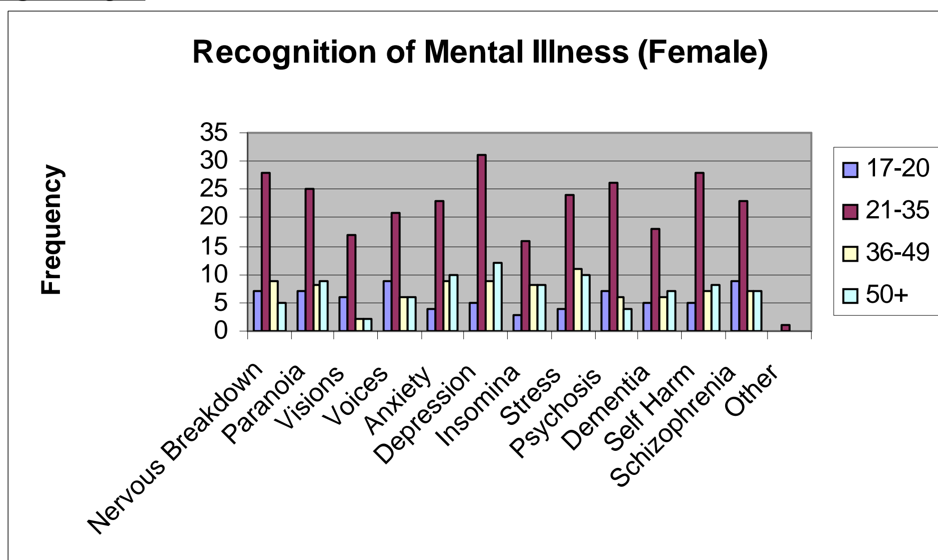
Recognising Mental Health disorder

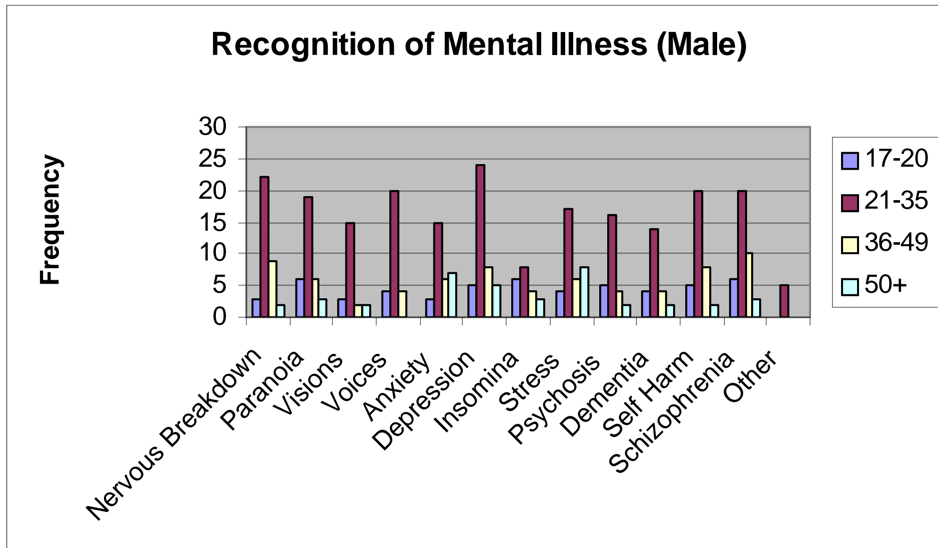
Mental health problems can affect anyone, regardless of age, race, gender or background. Different disorders take different forms and affect people in different ways. Psychiatric disorders are more severe and debilitating for the individual sufferers their families and careers. Common mental disorders such as anxiety and depression have profound effect on the community. Common mental disorders result in 1/3rd of days lost from work due to ill health and 1/5th of all consultations with GP's (Weich and McManus, 2002).

As mental health is about how we think and behave respondents were asked from a list of common mental disorders and psychiatric disorders such as schizophrenia, which they would recognise as a mental health problem. Out of the possible 131 respondent only 14 people recognised all the different disorders. In an ideal situation this figure should be 100%. Grater number of female respondents than male recognise the illnesses, for example, in the 21-35 group recognition frequency was 8 and 4 for female and male respondents respectively. Figure Q4 shows recognition age and gender groups.

Recognition of the disorders is quite high amongst the females than the male.

Figure Q4:





All respondent were able to identify one or more of the illnesses from the options provided. However, hearing voices score was zero for male 50+, who did not consider it to be a mental illness.

Recognition frequencies for some illnesses were higher than others. Nervous breakdown, paranoia, voices, anxiety, depression, stress, self-harm, psychosis and schizophrenia had higher scores than others across all categories.

Depression was the most recognised, followed by schizophrenia, paranoia, stress and self harm. However, some differences do exist, for example, within the 17-19 group the percentage of female respondents recognition of Nervous breakdown as an illness was 70% as oppose to 38% for male. More female (9) in the 50+ group think paranoia is a illness than male (3). One other significant variance is the in the recognition of stress. In the 36-49 group 92% female compared to 46% male considered it an illness. Within the same group a similar pattern can be seen for anxiety. Further variances can be seen in figure Q4(a).

Table Q4(a): **Recognition of Mental Health Problem as a Percentage by Respondent Group**

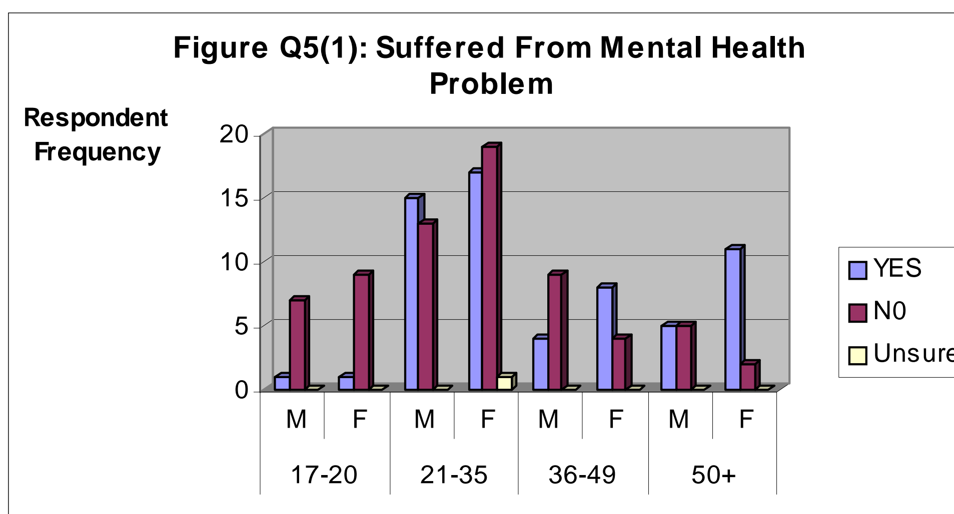
	17-20		21-35		36-49		50+	
	Male%	Female %	Male %	Female %	Male %	Female %	Male %	Female %
Nervous Breakdown	38	70	79	76	69	75	20	38
Paranoia	75	70	68	68	46	67	30	69
Visions	38	60	54	46	15	17	20	15
Voices	50	90	71	57	31	50	0	46
Anxiety	38	40	54	62	46	75	70	77
Depression	63	50	86	84	62	75	50	92
Insomnia	75	30	29	43	31	67	30	62
Stress	50	40	61	65	46	92	80	77
Psychosis	63	70	57	70	31	50	20	31
Dementia	50	50	50	49	31	50	20	54

Self Harm	63	50	71	76	62	58	20	62
Schizophrenia	75	90	71	62	77	58	30	54
Other	0	0	18	3	0	0	0	0
Recognition of All	**0**	**10**	**14**	**22**	**0**	**8**	**0**	**0**

Suffered from Mental Health Problems (such as those in figure Q4(A))

As the respondents within the study were able to identify with several of the disorders listed above, the respondents were asked that if they had suffered from any of the illnesses.

As figure Q5(1) shows, within the 17-20 age category 90% of the respondents said no they did not suffer from any mental ill health. However, the number of respondents who have and have not suffered from mental ill health is significantly closer within the age category of 21-35. 53.6% male respondent said they have suffered from a mental health problem and 46.4% said no. A similar trend emerges for the female respondents. 45.9% said yes and 51.5% said no. Only 2.7% (1) was unsure. Furthermore, 50% male in the 50+ age group said they have suffered from mental ill health.



Please see Table Q5A also for data source:

The high acknowledgement factor within the 21-35 group could be as a result of better education and knowledge. Furthermore, respondents within this group are also likely to be second generation Bangladeshis.

For those respondents who said they have suffered from a mental illness, majority declined to say which. This could be due to the shame or discussion of personal mental health with others outside of clinical settings is considered taboo. Of those who provided an answer stress and depression were the most common and identifiable illnesses across all age and gender groups.

Table Q5B: Which Ones.

Figures as Frequency of respondent in the category

17-20		21-35		36-49		50+	
M	F	M	F	M	F	M	F

Stress	0	1	2	4	0	1	3	3
Anxiety	0	0	0	0	1	0	0	0
Depression	0	0	6	5	0	2	0	1
At least two of (Stress, Anxiety, Depression, Self Harm, Insomnia, Nervous Breakdown)	1	0	5	6	2	5	1	7
Nervous Breakdown	0	0	0		0	0	0	
N/A	7	9	13	20	10	4	5	2
Self Harm	0	0	0	1	0	0	0	0
Most of those listed in Q4	0	0	1	0	0	0	0	0
Paranoia, Stress and Depression	0	0	1	0	0	0	0	0
Suicidal Thoughts	0	0	0	1	0	0	0	0
Paranoia, Stress and Depression	0	0	0	0	0	0	0	0
Phychosis	0	0	0	0	0	0	1	0

The respondents were also asked if they asked for help. The 17-20 group respondents said no and in the 21-35 group yes and no response were equal in proportion. Within the 36-49 and 50+ groups, 3 male and 6 female respondents said they have sought help. However, a significant number of 50+ female respondents said they did not ask for help (see table Q5C). The perceptions and stereotype of persons suffering from mental ill health makes admission a difficult process, in particular amongst South Asian communities.

Table Q5C: Did you seek help.

Figures as Frequency of respondent in the category

	17-20		21-35		36-49		50+	
	M	F	M	F	M	F	M	F
YES	0	0	7	8	3	6	3	6
N0	1	1	8	9	0	2	2	5
N/A	7	9	13	20	10	4	5	2

Support was most often sought from either a GP or family and friends. However, as Table Q6 shows, the 36-49 age group identify 2 male and 1 female respondent received support from Mental Health counsellor.

Table Q6: What support did you get and from whom.

Figures as Frequency of respondent in the category

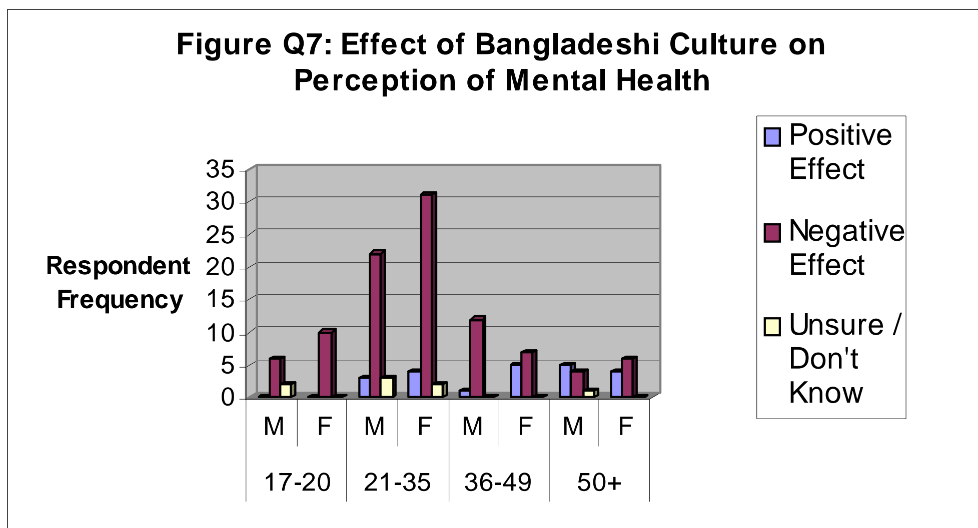
	17-20		21-35		36-49		50+	
	M	F	M	F	M	F	M	F
GP	0	0	4	5	2	2	3	2
Counsellor	0	0	0	0	2	1	1	0
Family or Friend	0	0	2	6	4	2	0	4
Spiritual Faith Healer	0	0	1	0	1	1	0	0
Other	0	0	0	0	0	0	0	1
N/A	8	10	21	26	16	6	6	6

Effect of culture and religion

The issue of culture and religion has profound effect and influence on the way in which we view and treat mental health. In any given culture mental health is a difficult and challenging issues.

If the distinction between a mentally healthy person and one that is not is based on the theoretical perspective that psychological health depends on accurate perceptions of reality then the question that arises is what is reality? What is reality through the eyes and experience of one person may not necessarily be the same as another with different set of experiences, values and of a different cultural, religious and social background.

Respondents were asked if they thought Bangladeshi Culture had a positive or negative affect on the way mental health is perceived.



**see Table Q7 for data source:*

As figure Q7 shows, majority of the respondents felt that Bangladeshi culture had a negative effect in the way in which we perceive Mental Health. None of the 17-20 group, considered culture to have a positive effect, although 2 male respondents were unsure. Opinion was divergent in the in the 36-49 female group. 5 respondents considered culture as having a positive effect. Within the 50+ group, the gap between negative and positive were between the two gender was narrower.

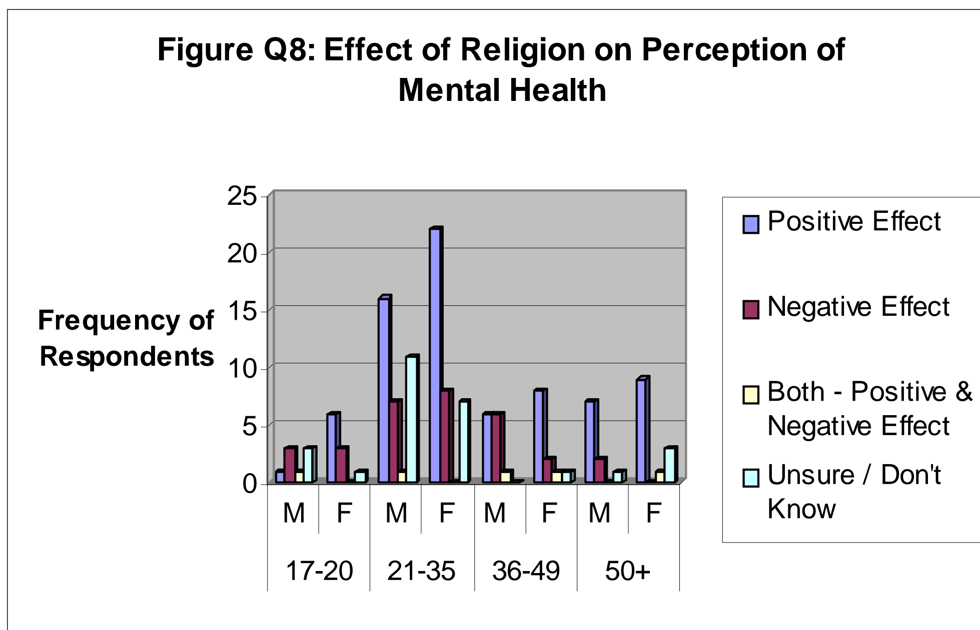
The reason given by respondents for its negative effect include -
Generally lack of education and stigma
They think 100 out of 100 cases are either black magic or possession
Its gets disregarded, not seen as an illness
They don't understand that a person can suffer in such ways and think its all made up
Because they always give the impression that an outside being – a sprit, possesses a person. They don't recognise the illness as a illness

As to the effect of religion on perception of mental health, the majority felt that its effect was positive as shown in figure Q8. This is not supervising given that all respondents are Muslim by faith and Islam is both a religion and a culture that governs and influences the everyday life of its believers. However, a significant

number (11 male and 7 female) in the 21-35 age group did not know or were unsure.

The reason given by the respondents for its negative effect are –
Because Islam teaches you to help people who are ill and who are suffering the need care
Allah can help to improve a person's life
Faith helps when you are in trouble. You ask Allah's help
It is our religion to be healthy and of pure mind
It is thought that mental disorder can be fixed by priest, by tabeez etc.

See appendix 2



**see Table Q8 for data source:*

How Bangladeshis perceive mental health problems

Perception is a considerable barrier to addressing mental health issues. Table Q9 shows, some differences in opinion. In the 17-20 and the 50+ group male respondent were less inclined to think the community were ignorant of it compared to females. The percentage of respondents who agreed with statement that on black magic was consistently high amongst all age and gender groups, except 50+ group only 5% male and 11% female respondents agreed.

Table Q9: Which of the following describes how the Bangladeshi Community perceive Mental Health Problems.

Figures as a Percentage of respondent in the category

	17-20		21-35		36-49		50+	
	M	F	M	F	M	F	M	F
They are Ignorant of it	*37.5*	*60*	57.1	56.8	*61.5*	*58.3*	30	76.9

They think it is Black Magic or Possession	75	80	64.3	78.4	76.9	66.7	5	11
They are ashamed of it	25	50	60.7	64.9	76.9	83.3	60	61.5
They would Openly Admit it	0	10	7.1	21.6	15.4	8.3	1	38.5
They want to Hide it from others	75	70	82.1	73	69.2	66.7	50	76.9
They Fear it	37.5	40	67.9	43.2	76.9	41.7	30	76.9
They want to Understand More about it	12.5	10	10.7	27	23.1	50	30	61.5
They see it as a Normal part of life	25	20	21.4	45.9	46.2	33.3	30	53.8
They avoid dealing with/thinking about it	62.5	40	75	64.9	46.2	58.3	40	61.5
Other	0	0	0	0	0	0	0	0
Unsure	0	0	0	5.4	0	0	0	0

As Table Q9 shows, Male respondents in the 17-20 and 50+ categories were less inclined to think that the community are ignorant of the mental health problems. However, a high proportion of the 17-20 female, the 21-35, 36-49 and 50+ respondents thought that the Bangladeshi community perceived the community to be ignorant of mental health. Furthermore, a high proportion of the 17-20, 21-34 and 35-49 group respondents thought that the Bangladeshi community perceive mental health as Black Magic or possession. It was not clear if this was due to cultural stereotype and bias against mental health or as a direct result of experience. The respondents in the 50+ category did not think mental health is perceived as black magic or possession.

The finding also shows the community are unlikely to openly admit to having mental health problems, instead choosing to hide it from others because of fear and shame. Fear of stigma was quite high amongst male respondents in the 21-35 and 36-49 groups accounting for 67.9% and 76.9% respectively. The respondents also perceived that the community were less inclined to want to understand more about mental health and more likely to avoid dealing with the illness.

The following statements were made by the respondents.

" lack of education . Understanding esxists between family members. They fear it because they think they will loose social status" ID11

"they think it's destined to happen to them" ID24

"lack of education. Uneducated people jump to the idea of possession. Most people are ashamed of it because their priorities are not in order. Bangladeshi culture shuns the idea of communication with others, even spouses, to solve problems" ID34

Why Bangladeshi people may suffer from Mental Health problems.

The factors that cause mental health problems are multivariable. When respondents were asked why Bangladeshi people may suffer from mental health problem the results varied by gender and age distribution as table Q10 shows.

Table Q10: Why participants thought Bangladeshi people may suffer from Mental Health problems.

Figures as a Percentage of respondent in the category

	17-20		21-35		36-49		50+	
	M	F	M	F	M	F	M	F
Family Issues	62.5	90	92.9	94.6	92.3	100	90	100
Work Stress	37.5	50	60.7	48.6	53.8	50	70	53.8
Finance	25	40	85.7	73	76.9	75	40	84.6
Marriage Problems	50	50	75	83.8	84.6	83.3	50	84.6
Death	37.5	40	60.7	62.2	61.5	66.7	20	76.9
Black Magic	37.5	50	75	62.2	46.2	75	30	76.9
Living Conditions	50	30	42.9	37.8	30.8	58.3	20	69.2
Childhood Trauma	37.5	40	53.6	40.5	46.2	41.7	30	46.2
Environmental Factors	87.5	10	28.6	27	15.4	41.7	20	30.8
Social Stressors	25	50	50	54.1	46.2	33.3	40	53.8
Abuse (Physical or Emotional)	75	60	67.9	73	69.2	75	20	61.5
Emotional Issues	37.5	50	53.6	43.2	61.5	58.3	30	53.8
Other	0	0	0	0	0	0	0	0

Majority of the respondents identified family issue, finance, work stress, marriage problems, death, Black Magic as well as abuse as a major contributor and cause for mental health suffering. This is not surprising given that the Bangladeshi community live in poor and overcrowded houses in inner city areas, poor economic prospect, low levels of educational attainment, poverty and deprivation, widening intergenerational conflict and breakdown of traditional family structures. Expectation of the different generations varies greatly. Younger people and second generation Bangladeshi's life expectation differ in that they are exposed to certain influences and societal norms which conflicts with the values and cultural norms of the first generation. Education and the lack of social integration and mobility are key factors also.

Factors affecting Mental Health

When trying to determine how certain factors such as the area you live in, parental and family influence, crime, drugs, bullying, religious/cultural influences, racism etc, the result did not show statistically significant differences between the age groups. The majority of the respondent claimed that these factors did not affect their mental health as shown in table 11a, 11b, 11c and 11d.

Table Q11: How much do the following affect your Mental Health.

Figures as Frequency of respondent in the category

Respondent Group 17-20

Table Q11(a):	1-Not at all		2-Some times or Mildly		3-Unsure		4-Often or Quite strongly		5-Extremely	
	M	F	M	F	M	F	M	F	M	F
Area you live in	37.5	60	25	30	12.5	10	12.5	0	12.5	0
Parents/Family influence	25	60	0	10	12.5	10	37.5	10	25	10

Peer pressure/Friendship Issues	37.5	60	25	20	12.5	10	12.5	0	12.5	10
Bullying	50	60	25	20	0	20	25	0	0	0
Drugs	50	50	25	10	12.5	20	12.5	0	0	20
Crime	62.5	40	0	20	37.5	30	0	10	0	0
Criminal Justice System	37.5	40	25	30	25	10	12.5	20	0	0
Intergenerational Conflict	37.5	60	25	10	25	20	12.5	10	0	0
Religious/Cultural Influences	50	40	25	30	25	10	0	20	0	0
School/College/Work	25	40	50	40	12.5	10	12.5	10	0	0
Racism/Prejudice	50	40	25	50	25	10	0	0	0	0
Marital Relations	75	50	0	20	12.5	10	12.5	20	0	0

Respondent Group 21-35

Table 11(b):	**1-Not at all**		**2-Sometimes or Mildly**		**3-Unsure**		**4-Often or Quite strongly**		**5-Extremely**	
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Area you live in	50	64.9	25	21.6	17.9	10.8	3.6	0	3.6	2.7
Parents/Family influence	39.3	21.6	21.4	29.7	10.7	13.5	21.4	24.3	7.1	10.8
Peer pressure/Friendship Issues	50	59.5	10.7	21.6	17.9	5.4	17.9	5.4	3.6	8.1
Bullying	42.9	59.5	14.3	10.8	10.7	13.5	17.9	10.8	14.3	5.4
Drugs	42.9	54.1	14.3	13.5	0	13.5	21.4	2.7	21.4	16.2
Crime	35.7	59.5	17.9	10.8	21.4	8.1	17.9	16.2	7.1	5.4
Criminal Justice System	35.7	73	10.7	10.8	28.6	8.1	17.9	5.4	7.1	2.7
Intergenerational Conflict	39.3	45.9	21.4	21.6	14.3	21.6	17.9	5.4	7.1	5.4
Religious/Cultural Influences	50	45.9	7.1	29.7	21.4	13.5	7.1	8.1	14.3	2.7
School/College/Work	28.6	70.3	28.6	16.2	14.3	8.1	17.9	5.4	10.7	0
Racism/Prejudice	39.3	51.4	3.6	24.3	21.4	10.8	14.3	8.1	21.4	5.4
Marital Relations	42.9	45.9	7.1	16.2	17.9	13.5	17.9	18.9	14.3	5.4

Respondent Group 36-49

Table 11(c):	**1-Not at all**		**2-Sometimes or Mildly**		**3-Unsure**		**4-Often or Quite strongly**		**5-Extremely**	
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Area you live in	61.5	41.7	30.8	41.7	7.7	0	0	8.3	0	8.3
Parents/Family influence	61.5	41.7	30.8	25	7.7	0	0	8.3	0	25
Peer pressure/Friendship Issues	76.9	58.3	23.1	16.7	0	8.3	0	8.3	0	8.3
Bullying	76.9	58.3	15.4	8.3	0	16.7	7.7	16.7	0	0

	M	F	M	F	M	F	M	F	M	F
Drugs	76.9	58.3	15.4	8.3	0	8.3	7.7	0	0	25
Crime	69.2	41.7	15.4	8.3	7.7	8.3	7.7	33.3	0	8.3
Criminal Justice System	61.5	50	15.4	8.3	15.4	41.7	7.7	0	0	0
Intergenerational Conflict	53.8	41.7	38.5	8.3	7.7	33.3	0	8.3	0	8.3
Religious/Cultural Influences	61.5	50	30.8	0	7.7	16.7	0	33.3	0	0
School/College/Work	69.2	58.3	30.8	25	0	8.3	0	0	0	8.3
Racism/Prejudice	61.5	50	38.5	8.3	0	16.7	0	16.7	0	8.3
Marital Relations	46.2	50	46.2	25	7.7	8.3	0	16.7	0	0

Respondent Group 50+

Table 11(d):	**1-Not at all**		**2-Some times or Mildly**		**3-Unsure**		**4-Often or Quite strongly**		**5-Extremely**	
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Area you live in	60	69.2	10	7.7	20	7.7	10	15.4	0	0
Parents/Family influence	40	61.5	10	7.7	10	7.7	20	7.7	20	15.4
Peer pressure/Friendship Issues	50	84.6	10	7.7	20	0	20	7.7	0	0
Bullying	80	92.3	20	0	0	7.7	0	0	0	0
Drugs	80	84.6	0	7.7	10	7.7	0	0	10	0
Crime	50	53.8	20	15.4	10	7.7	10	23.1	10	0
Criminal Justice System	60	69.2	20	23.1	20	7.7	0	0	0	0
Intergenerational Conflict	50	69.2	10	7.7	30	7.7	0	0	10	15.4
Religious/Cultural Influences	60	61.5	20	7.7	0	7.7	10	15.4	10	7.7
School/College/Work	80	92.3	10	7.7	10	0	0	0	0	0
Racism/Prejudice	60	69.2	20	7.7	0	7.7	10	0	10	15.4
Marital Relations	40	69.2	10	0	0	7.7	20	0	30	23.1

KNOWLEDGE/EXPERIENCE OF MENTAL HEALTH

Views on people with mental health problems

According to the Department of Health (2006), mental ill health is experienced by one in six people, ranging from distress to severe illness. This illness can be made worse by the way people are perceived and interact with people.

Table Q12: People with Mental Health problem should be:-

Figures as a Percentage of respondent in the category

		17-20		**21-35**		**36-49**		**50+**	
		M	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Should be Encouraged and Supported	**Yes**	100	80	100	86.5	84.6	75	90	76.9

	No	0	20	0	10.8	15.4	25	10	23.1
	Unsure	0	0	0	2.7	0	0	0	0
Are Able to integrated into Society	**Yes**	62.5	50	53.6	59.5	38.5	58.3	60	84.6
	No	37.5	50	42.9	37.8	61.5	41.7	40	15.4
	Unsure	0	0	3.6	2.7	0	0	0	0
Are able to recover, live and work normally	**Yes**	87.5	80	67.9	78.4	84.6	91.7	80	46.2
	No	12.5	20	25	18.9	15.4	8.3	20	53.8
	Unsure	0	0	7.1	2.7	0	0	0	0
Will not be able to recover at all	**Yes**	0	0	7.1	97.3	15.4	8.3	10	7.7
	No	100	100	89.3	2.7	84.6	91.7	90	92.3
	Unsure	0	0	3.6	0	0	0	0	0
Can be treated effectively	**Yes**	62.5	70	82.1	73	76.9	75	70	69.2
	No	37.5	30	10.7	24.3	23.1	25	30	30.8
	Unsure	0	0	7.1	2.7	0	0	0	0
Should be kept away from others	**Yes**	12.5	20	17.9	10.8	23.1	8.3	10	38.5
	No	87.5	80	78.6	86.5	76.9	91.7	90	61.5
	Unsure	0	0	3.6	2.7	0	0	0	0
Are unsafe to be around	**Yes**	12.5	30	25	10.8	23.1	0	10	7.7
	No	87.5	70	60.7	86.5	76.9	100	90	92.3
	Unsure	0	0	14.3	2.7	0	0	0	0
Have the right to be treated normally	**Yes**	87.5	70	82.1	83.8	84.6	83.3	60	84.6
	No	12.5	30	14.3	13.5	15.4	16.7	40	15.4
	Unsure	0	0	3.6	2.7	0	0	0	0
Others		0	0	0	0	0	0	0	0

As the data in table Q12, shows high percentage of the respondent thought that people suffering from mental illness should be encouraged and supported. The respondents also feel that over time they will be able to integrate and recover from their illness through effective treatment. People with mental health problem are not considered to be unsafe and have the right to be treated as normal.

However, significant differences exist on the question of integration in to society. Opinion within the 17-20 age group were equally divided. Within the 21-34 age group the opinion between male and female respondent were not significantly different. The biggest differences were in the 36-49 age group accounting for 61.5% and 41.7% for male and female respectively. Respondent felt that rehabilitation and integration was dependent on severity of the illness. This is likely to have consequences and would seem to contradict other supportive statement made by respondents.

Data from the EMPIRIC report suggest that "*psychiatric morbidity was related, in part, to an individual's coping mechanism and their level of support. The direct pathway implies that high levels of social support and social contact act to improve levels of well-being, or to enhance self appraisal and self esteem, thereby positively influencing mental health*" (Kerry Sproston and Kamaldeep Bhui 2002)

Suffering with mental health issue

"Evidence from studies of treatment rates suggest that the prevalence of mental illness among population broadly described as South Asian, appears on balance to be lower. It has been suggested that these lower detected rates could reflect language and communication difficulties, or a general reluctance among some South Asian groups to consult with doctors over mental health problems" (J Nazroo and William O'Conner 2002).

Within the 21-35 age group, grater number of male and female respondents have or knew of someone suffering from mental ill health, accounting for 60.7% and 62.2% respectively. A similar pattern emerges within the 36-49 age group with 66.7% and 53.8% female and male respectively knowing or they have suffered from mental ill health. As shown in table Q13, within the 50+ age groups the percentages are evenly distributed.

Table Q13:	%	17-20		21-35		36-49		50+	
		M	F	M	F	M	F	M	F
Have you or anyone you know ever suffered with mental health issue	Yes	37.5	40	60.7	62.2	53.8	66.7	50	46.2
	No	62.5	60	39.3	37.8	46.2	33.3	50	53.8

Table Q14(a):	%								
Prescribed medication for a mental health issue diagnosed by GP	Yes	0	0	10.7	16.2	7.7	33.3	10	7.7
	No	100	100	85.7	83.8	92.3	66.7	90	84.6
	N/A	0	0	3.6	0	0	0	0	7.7

When respondents were asked – table Q14a, if they had ever been prescribed medication for a mental health issue by their GP, majority of the respondent have said no. However, 33% female respondents in the 36-49 age group say they were prescribed medication for their illness. This would support Nazroo and O'Conner's finding of communication difficulties resulting in the reluctance to consult with GP's over mental health. Furthermore, as table Q14b show's some people have not been given a say in the treatment option or offered additional therapy alongside medication.

Of the respondent who had been offered a treatment option and additional therapy, this was in the form of –

"behaviour therapy" ID22
"GP offered to listen if I ever needed someone to talk to" ID25
"counsellor" ID45
"I asked for therapy rather than medication" ID49

Table Q14(b):

Say In the treatment option	**Yes**	0	0	7.1	5.4	7.7	25	0	0
	No	0	0	14.3	10.8	0	16.7	10	23.1
	N/A	100	100	78.6	83.8	92.3	58.3	90	76.9

Table Q15:

Additional Therapy offered alongside the medication	**Yes**	0	0	3.6	8.1	7.7	16.7	0	0
	No	0	0	17.9	10.8	92.3	25	10	23.1
	N/A	100	100	78.6	81.1	0	58.3	90	76.9

Table Q16:

Happy with the treatment	**Yes**	0	0	3.6	10.8	7.7	16.7	0	7.7
	No	0	0	7.1	5.4	0	8.3	0	0
	N/A	100	100	89.3	83.8	92.3	75	100	92.3

Majority of those accessing support were happy with the treatment they received as shown in Table Q16.

Jadu/Judo (Black Magic) and Jinns'

Defination:-

> **Black magic or jado**: *'Magic used for evil often with the intent of injuring or killing someone. It may also be done for the personal gain of the practitioner.'*
> **www.clubalien.com/definitions**

> **Jinn**: *'Jinn are created from fire whereas the human beings are created from clay. Although they are invisible to human eyes, the jinn can see us. Like human beings they are also entrusted with responsibilities (careers, family life, etc.). They too will be rewarded for their righteousness and will receive punishment for their wickedness.'*
> **www.inter-islam.org/faith/jinn**

There are a number of coping mechanisms used by different groups ranging from personal resources and religion. Despite the boundaries increasingly becoming bleared between religion and culture, they none the less play a very important mediating role.

Figures as a Percentage of respondent in the category

Table Q17:		17-20		21-35		36-49		50+	
		M	F	M	F	M	F	M	F
Do you believe in Jadu	**Yes**	37.5	40	57.1	48.6	30.8	33.3	60	46.2
	No	50	60	39.3	40.5	46.2	58.3	30	53.8

	Unsure	12.5	0	3.6	10.8	23.1	8.3	10	0

Table Q18:

Do you believe in Jinn	**Yes**	62.5	70	78.6	73	61.5	66.7	80	92.3
	No	25	30	17.9	18.9	38.5	25	20	7.7
	Unsure	12.5	0	3.6	8.1	0	8.3	0	0

Table Q19:

Can mental health problems be caused by Jadu	**Yes**	50	70	64.3	45.9	38.5	50	80	92.3
	No	37.5	30	32.1	40.5	46.2	50	20	7.7
	Unsure	12.5	0	3.6	13.5	15.4	0	0	0

Table Q20:

Can mental health problems be caused by Jinn.	**Yes**	62.5	50	60.7	35.1	38.5	25	60	76.9
	No	25	50	39.3	45.9	61.5	75	30	23.1
	Unsure	12.5	0	0	18.9	0	0	10	0

Jadu or Black magic is commonly believed and practised by practitioners across many cultures. Jadu has no religious precedence yet within the Bangladeshi community belief system it is applied for personal gain, as a vendetta or in spite . Many Bangladeshi's believe that jadu can and does affect a persons state of mental health.

Islam as a religion forbids such practice and beliefs. When respondents were asked if they believe in jadu, their opinions were divergent. As table Q17 shows, respondents in the 17-20 and the 36-40 age group were less inclined to believe in jadu, although differences between believers and non believers were less significant. Prevalence to believe in jadu was higher in the 21-35 age group and more male than female were likely to believe in jadu accounting for 57.1% and 48.6% respectively. In the 50+ category 60% male respondents say they believe in jadu.

Although jadu is unproven or unsubstantiated, for many including the Bangladeshis the association between jadu and mental health is interlinked. When respondents were asked if jadu can cause mental health problems, 70% females in the 17-20 age groups said yes compared to 50% for male respondents as table Q19 shows. However, in the 21-35 age groups more male respondents compared to female respondent considered jadu as a cause for mental ill health. In the 36-49 age group 46.2% male and 50% female respondent believe that ill mental health can not be cause by jadu. However, more significantly within the 50+ age group respondents believe that jadu can cause mental ill health accounting for 80% and 92.3% for males and females respectively. This would have significant ramifications given that the head of households within Bangladeshi community are in this age category. This may have an impact on the help sought for mental heath suffers in those families.

Using jadu and jinn's are a means of explaining and coping with mental illness is quite common. Mental ill health is brought upon to bear as a vendetta by others as oppose to other medical factors or individuals action and events.

Whilst many believe in jadu, a higher proportion of respondents believe in Jinn (see definition). This is not surprising given that it is mentioned in the Quran and the Hadith. As table Q18 shows, the differences in belief is not significantly different across the age groups except in the 50+ age group where the belief is the strongest at 80% and 92.3% for males and females respectively.

Justification to believing in jinns are,

"jinns are spiritual beings"ID4
"in the Quran allah referes to good and bad jinns" ID 10
"jinn's can only possess humans if they are woken or interrupted "ID15
"jado is an act, which requires the jinn" ID34
"islamically there are good and bad jinn's. If a bad jinn possesses one then it can affect ones mental health" ID 48
"people are more afraid of black magic than jinn's" ID71

On the question of whether jinn can cause mental health problems large majority are in agreement that it is possible as table Q20 shows. However, significantly the 36-49 group shows that 61.5% and 75% males and females respectively believe that mental ill health can not be caused by jinns. Female respondents in the 21-35 groups had a similar position. THis is surprising given that the same group (45.9%) considered that jadu can cause mental health problems.

Whom you would go to with a mental health problem

It is common practice for sufferers of mental health to consult spiritual healers and be less dependent on Eurocentric medication and treatment of mental illness.

Table Q21: Whom they would go to if they had a mental health problem in the First Instance.

Figures as a Percentage of respondent in the category

	17-20		21-35		36-49		50+	
	M	F	M	F	M	F	M	F
GP	50	70	42.9	59.5	76.9	66.7	30	69.2
Imam	12	20	10.7	2.7	7.7	8.3	60	7.7
Spiritual Faith Healer	0	0	7.1	0	0	0	0	0
Counselling Service	0	0	3.6	0	0	0	0	0
Psychiatrist	0	0	3.6	0	0	0	0	0
Family Member	25	10	17.9	35.1	15.4	17.7	10	23.1
Friend/Colleague	0	0	7.1	0	0	8.3	0	0
Don't Know	12.5	0	7.1	2.7	0	0	0	0
Other	0	0	0	0	0	0	0	0

It was surprising then that when respondents were asked whom they would go to first if they had a mental health problem (table Q21), majority would go to their GP for advice and treatment. However, in the 50+ age group 60% male respondent say they would go to an Imam and 35.1% female respondents in the 21-35 age group say they would go to a family member. Language barriers could a factor in this as majority of older generation Bangladeshis do not speak English, thus communication would be a issue.

Significantly very few say they would go either to a spiritual faith healer, counselling service or psychiatrist. However, when respondents were asked if their first choice failed, who you would seek help from next the response was varied and no clear pattern emerges.

Of the male respondents in the 17-20 category, 37.5% say they would go to a psychiatrist. More importantly 25% of respondent also say they don't know (see table Q22). The female respondents in this age group were likely to either go to a imam, GP, Spiritual faith healer or counselling service. In the 21-35 and 36-49 age group the GP or the Imam would be the preferred choices. Significantly 25% and 23.1% males in these groups say they would not know where to go for support.

In the 50+ age group, 50% male respondents compared with 23.1% female would go to the GP, where as 69.2% female would go to the imam compared to 20% male. The male respondents in this age group are more likely to consult spiritual faith healers than female respondents.

Table Q22: If first choice failed, who would you seek help from next.

Figures as a Percentage of respondent in the category

	17-20		21-35		36-49		50+	
	M	F	M	F	M	F	M	F
GP	12.5	20	21.4	27	23.1	33.3	50	23.1
Imam	0	20	35.7	18.9	23.1	33.3	20	69.2
Spiritual Faith Healer	12.5	20	3.6	5.4		8.3	20	7.7
Counselling Service	0	20	0	8.1	15.4	8.3	0	0
Psychiatrist	37.5	10	3.6	5.4	0	0	0	0
Family Member	0	10	7.1	13.5	15.4	8.3	0	0
Friend/Colleague	12.5	0	0	18.9	0	0	0	0
Don't Know	25	0	25	2.7	23.1	8.3	0	0
Other	0	0	3.6	0	0	0	10	0

Other = Hospital

It is evident from the above findings and knowledge of the community that there is an underlying dependency on Imams and spiritual healers to cure mental health. A huge industry exists to service this need. When the respondents were asked if they had faith in the positive effects of Imams/spiritual healers on mental health the results differed. In the 17-20 age group 62.5% of the male respondents said yes, whilst 37.5% were unsure, however, 60% female respondents said yes and 30% said no (see table Q23).

In the 21-35 age groups twice as many male respondents believed in the positive effects of the imams and healers than female respondents accounting for 75% and 37.8% respectively. However, in the 36-49 age groups neither the male or female respondents believed in their positive effects of imams and healers on mental health accounting for 53.8% and 50% respectively.

In the 50+ age category satisfaction was high. 90% male and 61.5% female had faith in the imams and healers; however, 38.5% female did not. The impact of treatment provided by Imams and faith healers is subjective dependent on the experiences of the individuals. The views of respondents are:

"I have seen it used on family members" ID4
"When they do their treatment I find it helpful to me" ID7
"they in my opinion know more about the religion than me so I'd put more of my faith inthem" ID10

"if the imam is good then its possible and you respect their decision. However, if the Imam is bad then it can lead to improper conduct"ID22
"what the doctors can't diagnose and effectively treat we go to alternative solutions" ID23
"we need help from both GP and Imam"

Impact of Imams/Spiritual Healers on Mental Health

Table Q23: Faith in the positive effects of Imams/Spiritual healers on mental health.
Figures as a Percentage of respondents in the category

	17-20		21-35		36-49		50+	
	M	F	M	F	M	F	M	F
Yes	62.5	60	75	37.8	30.8	41.7	90	61.5
No	0	30	17.9	45.9	53.8	50	10	38.5
Unsure	37.5	10	7.1	16.2	15.4	8.3	0	0

Despite earlier findings that people would go to their GP for help with mental health, respondents believe that the Bangladeshi community would seek help from religious figurehead/spiritual healers before their GP, as the results in table Q24 shows. However, 41.7% and 30.8% female respondents in the 36-49 group and 50+ group respectively say they would not.

Table Q24: Belief that people in the community would seek help from a religious figurehead/spiritual healer before their GP.
Figures as a Percentage of respondents in the category

	17-20		21-35		36-49		50+	
	M	F	M	F	M	F	M	F
Yes	62.5	90	89.3	78.4	69.2	58.3	100	61.5
No	25	10	3.6	16.2	15.4	41.7	0	30.8
Unsure	12.5	0	7.1	5.4	15.4	0	0	7.7

The reasons given by respondents for this are:

"Because it's a way of life for them and they are told what they want to hear" ID2
"I don't trust the local GP. I think others feel the same" ID7
"they believe Imams are more effective"ID13
"because they might be cursed by black magic" ID16
"because they don't distinguish a medical problem maybe they go for peace of mind, at least they've tried everything"ID25
"because the Bangladeshi community see mental health problems as jadu related in the first instance, therefore, they would visit imam's who have more knowledge about this than the medical profession" ID 56
"they may understand the Imam/spiritual faith healers more than their GP and get more help from them rather than being prescribed medication, which may help them to cope but not cure them" ID57

Table Q25: How effective religious figureheads/spiritual healers are at helping people with mental health problems.
Figures as a Percentage of respondents in the category

	17-20		21-35		36-49		50+	
	M	F	M	F	M	F	M	F
Not at all	12.5	10	17.9	32.4	53.8	33.3	10	15.4
Poor	12.5	10	14.3	13.5	0	16.7	0	7.7
Average	37.5	60	17.9	40.5	38.5	41.7	30	46.2
Good	25	10	25	10.8	7.7	8.3	40	30.8

Very Good	12.5	10	17.9	0	0	0	20	0
Unsure	0	0	7.1	2.7	0	0	0	0

It is apparent that the level of dependency by the Bangladeshi community on spiritual healers is considerable when attempting to cure mental health problem. When respondents were asked how effective their treatment was, opinions were once again very divergent as table Q25 shows.

The effectiveness and success of religious figureheads was rated as average by majority of the respondents. However, in the 21-35 age group 32.4% female respondents considered it not effective at all. This was also the opinion of 53.8% male respondents and 33.3% female respondents in the 36-49 age group.

In the 50+ group 40% male and 30.8% female rated the effectiveness of healers and religious figureheads helping people with mental health as good.

When respondents were asked if they would recommend others to visit a religious figurehead/spiritual healer for help with their mental health problem opinions differ again by gender and age.

Table Q26: Personal recommendation to others to visit a religious figurehead/spiritual healer for help with their mental health problem.

Figures as a Percentage of respondents in the category

	17-20		21-35		36-49		50+	
	M	F	M	F	M	F	M	F
Yes	37.5	40	75	35.1	15.4	41.7	60	38.5
No	37.5	60	21.4	62.2	69.2	58.3	40	61.5
Unsure	25	0	3.6	2.7	15.4	0	0	0

As the figures in table Q26 shows, in the 17-20 group, 37.5% male say yes as compared with 60% female respondents who say no. 25% male are unsure.

In the 21-35 group, 75% male respondents say they would recommend help from healers for people with mental health problems as oppose to 62.2% females who would not. In the 36-49 group 69.2% male respondents would not recommend religious figureheads were as 41.7% of the female respondents would recommend faith healers. Male respondents in the 50+ group were likely to recommend healers, however equal number of females - 61.5% were unlikely to recommend the use of such practioners.

The pattern that emerges from the above data is that women are less likely to recommend others to visit a religious figurehead/spiritual healer for help with their mental health problem than men.

The explanations offered for this are:

"I've used them in the past" ID4
"I have strength in my faith but I would go for help to a religious figurehead before attempting anything else" ID10
"If illness cant be identified by doctors " ID12
"Sometimes they are not effective. I don't really believe they can help" ID13

Mental Health and the Bangladeshi Community

The underlying and true hidden burden of mental health within the Bangladeshi community is not yet known because of it secretive and hidden nature. When respondents were asked if mental health is a growing problem the opinion once again differed.

Table Q27: Is mental health a growing problem within the Bangladeshi Community
Figures as a Percentage of respondents in the category

	17-20		21-35		36-49		50+	
	M	F	M	F	M	F	M	F
Yes	37.5	30	60.7	75.7	46.2	66.7	70	69.2
No	12.5	60	32.1	21.6	53.8	25	30	30.8
Unsure	50	10	7.1	2.7	0	8.3	0	0

In the 17-20 group 37.5% male respondents thought it was, whilst 60% female respondents said no. 50% of male in this group were also unsure. However, within the 21-35 group both the male and female respondents thought it was a growing problem accounting for 60.7% and 75.7% respectively. This is in contrast to 53.8% of the male respondents who do not think mental health is a problem as shown in table Q27 below.
Justification given for why mental health is a growing problem are:

"people don't know how and don't want to deal with anyone with mental health problems" ID10
"family, cultural and religious issues can contribute to mental health problems" ID11
"breakdown of social values, unemployment and family finance" ID23
"high levels of unemployment, drug abuse and trans-generational conflict. Also it's to do with cultural identity, the British Bangladeshi" ID43
"due to more people doing black magic"ID46
"arranged marriages, collision of two worlds because it doesn't fit anymore. People more aware of rights and less of cultural obligation" ID53

As the data in table Q27 illustrates, respondents form the Bangladeshi community think that there is a growing problem of mental health within the Bangladeshi community. When the respondents were asked if these issues need to be discussed within the Bangladeshi community the majority of the respondents recognised the need.

Table Q28: Is there a need to talk about mental health issues in the Bangladeshi Community.
Figures as a Percentage of respondents in the category

	17-20		21-35		36-49		50+	
	M	F	M	F	M	F	M	F
Yes	87.5	90	60.7	75.7	46.2	66.7	70	69.2
No	0	10	32.1	21.6	53.8	25	30	30.8
Unsure	12.5	0	7.1	2.7	0	8.3	0	0

There are a significant few whom do not think there is a need. In the 21-35 group 32.1% male compared with 21.6% female who would not advocate discussions.

However, the largest group who do not think the need talk about mental health issues are the male respondents in the 36-49 age group accounting for 53.8%.

Respondents response to why there is a need are:
"to educate" ID2
"so people are aware" ID4
"people don't know what mental health is" ID9
"if we get involved it can encourage destigmatising mental health. People can try to understand it" ID25
"to give Bangladeshi community a better understanding" ID69
"problems won't disappear if they're not talked about" ID59

Communication is a crucial factor in conveying message or interacting with one another. When respondents were asked if they are able to explain and discuss the emotional difficulties that they are experiencing when they go to their GP or mental health professional, the results show a mixed response as shown in table Q28 below

Table Q30: Are you able to explain and discuss the emotional difficulties that you are experience when you go to your GP or Mental Health professional.
Figures as a Percentage of respondents in the category

	17-20		21-35		36-49		50+	
	M	F	M	F	M	F	M	F
Yes	12.5	40	64.3	48.6	53.8	58.3	30	46.2
No	62.5	40	25	43.2	46.2	41.7	70	53.8
Unsure	25	20	10.7	8.1	0	0	0	0

In the 17-20 group 62.5% of the male respondents say they can not explain and discuss emotional issues with GP or mental health professional. Male and female respondents within this group who are unsure account for 25% and 20% respectively. Within the 21-35 group, 64.3% of the male respondents say they are able to discuss emotional issues, however, 43.2% female respondents say they are not able to. In the 36-49 groups the difference is less significant between the two genders. 46.2% male compared to 41.7%female say that they are unable to discuss emotional issues with their GP's. In the 50+ group the result is a little more significant between the males and females. 70% male respondents can not explain or discuss emotional issues compared with only 53.8% for females.

The hidden issue of somatisation can not be ignored as a factor for high responses to the inability to explain and discuss the emotional difficulties. The inability to distinguish between physical distress and emotional distress is often a contributory cause for severe mental health problems. Language barriers particularly amongst the elderly and the newly arrivals would be high. Lifestyle change and access to adult learning provision would be necessary to overcome such problems .

Explanations offered by respondent as to why they cannot explain and discuss the emotional difficulties are:

"I don't trust my doctor" ID6
"I don't feel I have that relationship with them " ID13
"Doctors don't believe in Jado and jinn, they think it's a scientific issue" ID15
"barriers to language those who know. Others find it difficult to translate. Those who go to translate other do not do an effective or proper job" ID22
"never has time to listen, doctor is medical not for emotional issue" ID39
"can't translate" ID40

"not as comfortable, if it was female GP things could be different"ID68
"too embarrassed, doctor isn't trustworthy" ID71

How Bangladeshi Community could be engaged to develop understanding of Mental Health

In order to understand how to facilitate the need to talk respondents were asked how they think the Bangladeshi community could be encouraged to understand and find out more about mental health issue the following responses were received:

"Talk , teach about what is good to do" ID106
"To get advice support open discussions at community centre" ID114
"Through counselling, community group discussions" ID116
"Home visit to explain mental health. Peer group discussions and community activities" ID105
"Use case studies of people with mental health and how they were helped to promote services by reaching communities" ID118
"To get in touch with services that deal with community members and work with them so that they can offer support to people" ID54
"Doctors and home support" ID102
"Open discussions" ID121
"Maybe they should have a DVD made into the style of a drama which people can watch" ID117
"I don't know really, maybe if the stigma and shame attached can be taken away somehow" ID120
"Have events in local centre" – ID98
"Discuss at the GP" ID99
Home visits for the ladies
Have more informal points of contacts
"They won't try and understand it unless it happens to them" ID112
"Through community centres that hold talks, in Bengali, so that the older generations can fully understand theses issues. Also using the media e.g. Bengali talk shows on Asian channels" ID57
"Bilingual leaflets sent to their homes" ID71
"If there were talks and events about it in community centres or even the mosques" ID69
"Need more awareness. People are unaware at present" ID75
"Bangladeshi workshop facilitators" ID91
"Let them understand that it is nothing to be ashamed of, it is an illness like the flu that needs to be treated" – 47
"Train imams or community leaders.. encourage people not to be ashamed of it. Change perception" ID128
"Leaflets in Bengali. One to one sessions – group sessions
"More information should be available at community centres" ID50
"More advertising in Bengali language" ID7
"Provide the community with literature" ID55

Mental Health Services

The objective is to identify how the Bangladeshi community can be made more aware of mental health services and how they currently access such services. The section also aims to establish how appropriate and responsive the services are at targeting and meeting the needs of the community.

Awareness of mental health service provision

Awareness is an important element in bridging inequality in mental health. When service providers were asked if they were aware of the mental health service provision in their area, significant majority answered no across all age groups and genders. See table Q31.

Table Q31: Awareness of mental health service provisions in your area.

Figures as a Percentage of respondents in the category

	17-20	21-35	36-49	50+

	M	F	M	F	M	F	M	F
Yes	25	0	14.3	13.5	15.4	8.3	20	7.7
No	75	100	85.7	86.5	84.6	91.7	80	92.3

This demonstrates a huge void in providing adequate information and services to the community and also hinders progress in achieving appropriate and responsive services and equality in access to provision by marginalised communities such as the Bangladeshis. In order to accessibility issues service providers need to work more closely with Bangladeshi led voluntary sector organisation to disseminate information on their services. Urgent action and strategies would be necessary correct the current position.

When respondents were asked how they were made aware of the mental health provision in their area, it was not conclusive that one method of communication prevailed over others. For the majority they had not received any form of communication at all. Of those who had received information the sources varied from GP services, posters and leaflets, local community centres and word of mouth

Respondents were also asked if they knew or have heard of organisations delivering mental health provision in Sandwell. As the data in table Q33 shows, very few have heard of the services. The organisations/services respondents were most familiar with are the Samaritans, Sandwell Mental Health Trust, Asian Counselling service, Sandwell Asian Family Support Team and GP counselling service. Despite the familiarity the frequency of identification of services is quite poor and would require redress if the services are to be inclusive.

Table Q33: Have you heard of the following services for mental health in Sandwell.

Figures as a Percentage of respondents in the category

		17-20		21-35		36-49		50+	
		M	F	M	F	M	F	M	F
Community Mental Health Team	Yes	0	10	3.6	24.3	7.7	0	30	7.7
	No	100	90	96.4	75.7	92.3	100	70	92.3
Sandwell Asian Family Support Team	Yes	12.5	60	10.7	18.9	15.4	8.3	20	7.7
	No	87.5	40	89.3	81.1	84.6	91.7	80	92.3
Sandwell Mind - Refresh	Yes	0	0	10.7	8.1	0	0	0	0
	No	100	100	89.3	91.9	100	100	100	100
Rethink	Yes	0	0	17.9	5.4	7.7	0	0	0
	No	100	100	82.1	94.6	92.3	100	100	100
Sandwell Mental Health Trust	Yes	25	40	25	18.9	23.1	8.3	30	7.7
	No	75	60	75	81.1	76.9	91.7	70	92.3
Asian Counselling Service	Yes	0	10	0	27	15.4	8.3	20	15.4
	No	100	90	100	73	84.6	91.7	80	84.6
Samaritans	Yes	50	30	35.7	35.1	15.4	25	0	0
	No	50	70	64.3	64.9	84.6	75	100	100
Child & Adolescents Mental Health Services	Yes	12.5	0	3.6	8.1	7.7	0	20	0
	No	87.5	100	96.4	91.9	92.3	100	80	100
GP Counselling Service	Yes	12.5	40	3.6	24.3	7.7	8.3	20	0

	No	87.5	60	96.4	75.7	92.3	91.7	80	100
Primary Care workers at GP Surgeries	**Yes**	12.5	20	7.1	8.1	7.7	0	10	7.7
	No	87.5	80	92.9	91.9	92.3	100	90	92.3
Head2Head Young Person's Counselling Service	**Yes**	12.5	20	0	2.7	0	0	0	0
	No	87.5	80	100	97.3	100	100	100	100
Kushi Sandwell asian Mental Health Service	**Yes**	0	0	0	10.8	7.7	8.3	0	0
	No	100	100	100	89.2	92.3	91.7	100	100
Other service/group	**Yes**	0	0	0	0	0	0	0	0
	No	0	0	0	0	0	0	0	0

Of the respondents who said they have heard of services, very few have been in touch with the service. Of the respondents only 12.5% of male in the 17-20 group claim to have accessed the service and 16 .2% female in the 21-35 group have accessed services. The data shows that more men than women have accessed the services.

Table Q34: Have you ever been in touch with any of the services identified in Figure Q33.

Figures as a Percentage of respondents in the category

		17-20		21-35		36-49		50+	
		M	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Have you ever been in touch with any of the services identified in Figure Q33	**Yes**	12.5	0	0	16.2	7.7	0	10	7.7
	No	87.5	100	100	83.8	92.3	100	90	92.3

Of the respondents who have been in touch, the following services were used:

GP and Councellor – ID123
Child and Adolescent Mental Health service – ID27
Head -2-Head, Primary Care, Sandwell Minds – ID35
Asian Counselling Service, GP Counselling Service – ID49
CAMHS – ID 66&97
GP Counselling Service – ID88

When the respondents were asked how they were referred it was apparent that they were either self referred or referred through GP services or the hospital.

The data presented below is not significant to enable analysis as the frequency of individual accessing the services too low. Of the individuals accessing the service

Figures as a Percentage of respondents in the category

17-20		21-35		36-49		50+	
M	**F**	**M**	**F**	**M**	**F**	**M**	**F**

Question	Response									Table
Were you given the opportunity to discuss and ask question	Yes	0	0	0	10.8	7.7	0	10	0	Table Q35(b):
	No	0	0	0	5.4	0	0	0	0	
	N/A	100	100	100	83.8	92.3	100	90	100	
Was an assessment and care plan developed for you	Yes	0	0	0	8.1	7.7	0	10	0	Table Q35(c):
	No	0	0	0	8.1	0	0	0	0	
	N/A	100	100	100	83.8	92.3	100	90	100	
If Yes to Q35©, did you have a say in what was offered	Yes	0	0	0	5.4	0	0	0	0	
	No	0	0	0	8.1	7.7	0	0	0	
	N/A	100	100	100	86.5	92.3	100	100	100	
Were you happy with the treatment offered	Yes	0	0	0	8.1	7.7	0	10	0	Table Q35(d):
	No	0	0	0	8.1	0	0	0	0	
	N/A	100	100	100	83.8	92.3	100	90	100	
Were your family, or those close to you, involved in the help you received	Yes	0	0	0	5.4	7.7	0	10	0	Table Q35(e):
	No	0	0	0	10.8	0	0	0	0	
	N/A	100	100	100	83.8	92.3	100	90	100	
Were you offered an interpreter	Yes	0	0	0	10.8	7.7	0	10	0	Table Q35(f):
	No	0	0	0	2.7	0	0	0	0	
	N/A	100	100	100	86.5	92.3	100	90	100	
Were you told about local support networks	Yes	0	0	0	8.1	7.7	0	10	0	Table Q35(g):
	No	0	0	0	8.1	0	0	0	0	
	N/A	100	100	100	83.8	92.3	100	90	100	
Did you make use of these	Yes	0	0	0	2.7	0	0	10	0	
	No	0	0	0	5.4	0	0	0	0	
	N/A	100	100	100	91.9	100	100	90	100	
Were they useful	Yes	0	0	0	2.7	0	0	10	0	Table Q35(h):
	No	0	0	0	0	0	0	0	0	
	N/A	100	100	100	97.3	100	100	90	100	
Were staff supportive	Yes	0	0	0	13.5	7.7	0	10	0	Table Q35(j):
	No	0	0	0	2.7	0	0	0	0	
	N/A	100	100	100	83.8	92.3	100	90	100	
Is it important that staff are sensitive to your religious and cultural needs	Yes	0	0	0	16.2	7.7	0	10	0	Table Q35(k):
	No	0	0	0	0	0	0	0	0	
	N/A	100	100	100	83.8	92.3	100	100	100	

Question	Response									Table
Were you offered any practical advice or an explanation about the state of your mental health	**Yes**	0	0	0	16.2	0	0	10	0	**Table Q35(m):**
	No	0	0	0	0	0	0	0	0	
	N/A	100	100	100	83.8	100	100	90	100	
Was the service easy or difficult to get to	**Easy**	0	0	0	10.8	7.7	0	10	0	**Table Q35(n):**
	Difficult	0	0	0	5.4	0	0	0	0	
	N/A	100	100	100	83.8	92.3	100	90	100	
Do you feel more in control of your Mental Health as a result of using this service	**Yes**	0	0	0	13.5	0	0	10	0	**Table Q35(o):**
	No	0	0	0	2.7	0	0	0	0	
	N/A	100	100	100	83.8	100	100	90	100	
Are you satisfied with the help you received	**Yes**	0	0	0	13.5	7.7	0	10	0	**Table Q35(p):**
	No	0	0	0	2.7	0	0	0	0	
	N/A	100	100	100	83.8	92.3	100	90	100	
Do current mental health services meet your religious and cultural needs	**Yes**	0	0	0	10.8	7.7	0	10	0	**Table Q35(q):**
	No	0	0	0	5.4	0	0	0	0	
	N/A	100	100	100	83.8	92.3	100	90	100	
Do the services have appropriate Staff to deal with Bangladeshi Service users	**Yes**	0	0	0	5.4	7.7	0	10	0	**Table Q35(r):**
	No	0	0	0	10.8	0	0	0	0	
	N/A	100	100	100	83.8	92.3	100	90	100	
Does location hinder access	**Yes**	0	0		8.1	7.7	0	10	0	**Table Q35(u):**
	No	0	0		8.1	0	0	0	0	
	N/A	100	100		83.8	92.3	100	90	100	

BRIEF STORIES FROM QUESTIONNAIRES

I went to the doctors (local doctor in Wednesbury) to speak to him about my father's mental health. My father was under the impression that the whole family was trying to kill him. He wouldn't eat for the fear of being poisoned, wouldn't sleep, it got to a point were his health had deteriorated. He suffered from diabetes but didn't believe it was diabetes. The doctor said it was 'old age' nothing wrong with his mental health. Took a few visits by different family members till he was referred to Edward Street Clinic, West Bromwich. An appointment came through for him only it took them a year to reply to us. My dad went to Bangladesh by then and we couldn't stop him going. He doesn't want to come back we now know he is suffering from schizophrenia.

A friend of mine loved a girl; his name is 'J'. He loved her so much that he couldn't think of anything else. More over he trusted her too much his every dream, plan was built related to his girl. However one thing he didn't know was that the girl couldn't trust him, the girl was playing around with him. One day he proposed to the girl but unfortunately she said 'no'. It hurt him so much that he planned to commit suicide and he felt he was like an alien in this world. He stopped talking, laughing to others including his family who he felt were too strict. Suddenly I found out his behaviour was changing and now he is totally engulfed by depression, and he lost his hair.

Bad experiences due to lack of knowledge of symptoms to look out for, help wasn't accessible as we didn't know ourselves what was happening. If mental health status had been publicised then maybe we could have accessed help. It is very hard to explain to elder family members of this condition as they dismiss it, they don't accept MH as a problem which can he helped the Bangladeshi community class it as just being mad.

A teenager had taken an overdose and ended up in hospital. Once everyone realised what had happened, we realised the teenager had been keeping quiet and not speaking about his problems to anyone. The whole family were very sympathetic, and trying hard to understand how it escalated so far. The teenager had a one off manic episode and 3-6 months of up and down mood swings involving self-harm. The family and hospital were happy to arrange therapy sessions, the mother-received advice on how to deal with the teenager which helped a great deal (this was done via an interpreter) The teenager is much better now, and family communicate much better with the teenager. However as a community, these kind of issues are not talked about openly, unless its immediate family, this is a problem. Even though the patient has more or less recovered, he/she feels reluctant to meet people from the time the illness happened because they feel embarrassed. Overall, family support has helped enormously however the mother at first did suggest going to an Imam. However other family members explained it to her about mental health issues, and that the problem arose due to problems at school and personality disorder and not because of Jinn's. I would also like to mention that siblings of teenager who are from Bangladesh and are also grown teenagers couldn't understand the concept of mental health and why it happened.

Having a very demanding job has a level of stress, which is seen as the norm so my stress levels periodically rise and fall. I counteract this by taking part in sporting activity regularly.

Women in our community are more susceptible to mental illness in our community because they are under pressure and become trapped. They need confidence and control. Women's immediate problems because they are mothers and affect children, fathers have always been absent re-address balance so women/men can be equal.

My mum brought these combs from Bangladesh and said that this man did something on them and it can cure your headaches. My sister said you shouldn't believe in things like that. Mom said 'Don't say that he's got a gift from God to remove headaches'. My sister said if he got a gift from God, then you should look to God just like he does.

I have very poor health, liver problems and diabetes, which causes me to lose sleep, changes in eating patterns. My state of mind is not always good due to ill health. A lot of the time I'm always feeling down due to my health.

I personally myself have not ever had a mental health breakdown. But I have suffered from depression and stress. I was part of a workshop women's group called Healing with stitching. Women got together and talked to share problems and find solutions.

I firstly lost my sleep; I found it really difficult at night to just rest. I was worrying about a lot of things it was a difficult period in my life. My father had died and suddenly I was the eldest, everything was on me, I just couldn't cope with all the family arguments, sorting things out here and abroad. I became very irritable with my family. I felt they were annoying me all the time so I distanced myself from them, even my children because I couldn't sleep. My mum forced me to see the doctor. My GP asked me a few questions about why I couldn't sleep. I didn't feel comfortable asking for his help or confiding in him so he referred me to a counsellor. I went to regular sessions. I felt talking to a stranger was easier as they wouldn't judge me. I was also taking regular mediation I think both helped me. I continued to take my medication and the counselling stopped. They didn't think I needed it anymore I feel much better now.

When I hit 30 years I felt I had lost my childhood I had a panic attack due to stress that led me to depression, feelings of dying took me along time to get better with help from GP. Since having my child I feel much stronger through having gone through all the experiences.

I felt very depressed after my first child, I felt I couldn't talk to anybody or ask for help because your expected to carry on as normal and be the life saver in a lot of situations etc.

I had been suffering with depression since the birth of my first child and since I came to this country leaving behind my family and friends. I didn't know what it

was for a long time so I didn't seek any help I only went to the GP for other reasons like I couldn't sleep at night, lack of appetite etc. When the doctor prescribed anti-depressants I wasn't told about any counselling services. I only found out about this service by chance when my friend forced me to go to a community event where by chance that day a counsellor had come to let us know about what services she offered so I made an appointment to see her but she only will come to see you at your surgery which is convenient for me as my surgery is far, so I didn't make the effort mostly. It would be better if she could come to a local community centre for appointments.

I felt very depressed after my first child. I felt I couldn't talk to anybody or ask for help because your expected to carry on as normal and be the life saver in a lot of situations etc.

Section 4

Service Provider Response

A service provider questionnaire was developed to obtain an informed view of how the needs of the Bangladeshi community are being met and what the channels of communication are. Of the questionnaires disseminated through the Sandwell Primary Care Trust – Mental Health Promotion Team.

Statistical analysis and data grouping could not be achieved as only one completed and two partially completed questionnaires were returned.

Awareness / Perception

From the information received it would be accurate to conclude that the service providers acknowledge the mental health needs of the Bangladeshi community. Some of the organisations provide direct services but not specifically to Bangladeshi community but the whole south Asian community, whilst statutory service providers provide sign posting service through link workers. However, the statutory service providers acknowledge that the communication channels with the Bangladeshi community are poor.

Evidence suggests that Bangladeshi community are accessing mental health services is very low in numbers. This position can be improved by facilitating surgeries in community centres with interpreters. Service providers also think that prior intervention could decrease the severity of illness and some GPs' have not responded appropriately. Furthermore, those Bangladeshis that don't have members of family who speak English are at increase risk of late referral.

Service providers do think that the Bangladeshi community face specific barriers in accessing mental health service due to,

- Culture
- Language skills
- Poor service / responses from GP
- Social Isolation

To overcome these barriers and improve service provision, service providers have used interpreters to talk to individual families and GPs' and by identifying community locations where satellite surgeries may take place. Furthermore, service delivery providers do not think location hinders access to services and that the community needs do not differ from other south Asian communities. This could be accurate as generically they are one people with similar needs. However, their services do not meet the needs of the Bangladeshi community

Knowledge /Experience

Bangladeshi service users are appropriately signposted to support agencies for and where necessary linguistic support is provided through an interpreter. If the client record is retained by the referral agencies then they are followed up.

Service providers do belief that somatisation has a detrimental affect on the identification of mental illness amongst Bangladeshis especially by non mental health professionals such as doctors. Not being able to communicate emotions is an issue amongst the Bangladeshi community as well as other communities. The need for cultural awareness and somatic issues training exists especially for GP's

Youths

The factors that affect the mental health of young Bangladeshis are multi variable. Crime and drugs are particularly prevalent fuelled by lack of education and social mobility as well as employment opportunity. The mental health needs of the young Bangladeshis are not adequate as staffing the mental health workforce does not reflect the community.

Section 5

Recommendation

1. **More Bengali speaking mental health professionals**
Mental health teams and link workers to reflect community (bilingual workers), thus ensuring health professionals refer people from the Bangladeshi community to the appropriate form of services. This would also enable interventions to take place in early stages of mental illness development, advocating prevention and cure.

2. **Unanimous Bengali Helpline -**
A Bengali telephone helpline offering advice on wide rage of issues on mental health and appropriate signposting. It would be advantageous to have Sylheti speaking advocates/advisors.

3. **National Advertising/promotion of mental health on Bengali Community TV Channels-**
The quickest means to a mass target market. This form of communication is now preferred by the community and is much more effective than paper base promotional products.

4. **Service Provision Development-**
Closer ties should be fostered between link workers, front line staff and community Mental Health Team. The Bangladeshi led voluntary sector organisations in Sandwell could act as a intermediaries. This would also enable community organisation to refer people to mental health services breaking down the barriers to access. This would be an innovative approach to access development.

5. **Grater working relations between community and statutory sector agencies-**
There are a number of voluntary and statutory sector organisations delivering mental health projects. However, in the Sandwell area none are very proactive in attempting to improving access to their service. Community and Voluntary organisations with the support and backing of the statuary sector should promote outreach as the central theme to promote mental health services. This would ensure that people know what type of services are available where. This would address the issue of lack of awareness amongst potential service users or carers.

6. **Religion orientated models of service**
The belief in Jinn’s and Jadu is quite strong within the community. Whilst many may not acknowledge it existence the belief is very strong. The proposal is to develop a culturally sensitive out reach project to disseminate

information on Jinn possessions and Jadu through the Mental Health Trust with a dedicated and knowledgeable worker in post. The project should be able to take referrals from the doctors and health professional for individual who wish to talk about these issues and be advised on appropriate course of action. The aim would be to pick up people at early stage of developing common mental disorders which leads to isolation resulting in severe forms of mental health problem.

7. Equality and cultural awareness training for professionals-

Trust between GP and patient in Sandwell is very low as demonstrated by the research finding. GPs' need to build trust with patients.
GPs' and health professionals should undertake training in cultural competence and mental health issues.

8. Respite care for Bangladeshi elders through community organisation- Day Care Centre.

Developing a respite care programme would enable to come of their environment and meet and talk to others about concerns and issues. This could be then used as a means of support group whilst releasing cares to either become economically active or progress in to learning. This will address some of the issues surrounding family problems and other such related issues. Furthermore, it could act as a vehicle to providing care in the community.

9. Community Champions – Mental Health

Using community learning champion and older peoples champion it is proposed that resources are targeted at developing mental health champions. The persons would work across different agencies targeting specific peer groups.

10.Local service guide to mental health – English and Bengali

Awareness of mental health issues and services across the Bangladeshi community is relatively poor. This would enable the community to learn of the variety if mental illness ranging from the acute to the severe form. It will advise on what action to take and the process to follow. The document will serve a duel purpose of capacity building and emotional wellbeing

11.Increase Communities awareness of mental health.

It was apparent from the research finding that the community are not aware of the range of illness associated mental health, what might cause them and how the symptoms can be recognised. These information sessions would target lay members of the Bangladeshi community including young people and older people. There should be a greater emphasis on health promotion to reduce the problems of somatisation.

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