COMMUNITY ENGAGEMENT PROJECT
NIMHE MENTAL HEALTH PROGRAMME

REPORT OF THE COMMUNITY-LED RESEARCH PROJECT FOCUSING ON THE MENTAL HEALTH NEEDS OF BLACK AND MINORITY ETHNIC COMMUNITIES IN DONCASTER

By
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Project team

YWCA Doncaster Women's Centre Community Research Group

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

Ninda Randhawa – Project Co-ordinator
I am the BME Programme Manager at YWCA Doncaster Women's Centre. YWCA England & Wales celebrates the diversity of women, their differences and their achievements. The aim is for women to gain greater control of their lives and achieve change for themselves through acquisition of skills, confidence and increased independence. The YWCA vision is for all women to be able to make their own choices, take their own path in life and participate in society, free from discrimination and disadvantage.

My role in the community research project was project co-ordinator. This involved recruiting the researchers from the many links that we have within the community. In addition to co-ordinating the Project I provided emotional and practical support to the researchers, interpreters and participants. I ensured that the focus groups, postal questionnaires, structured one-to-one interviews were organised. I ensured that support mechanisms and risk assessments were put in place. Furthermore, sustaining, motivating and encouraging the researchers to complete their qualification was one of my priorities and also holding the project together. Providing a clear structure for a cohesive project by effectively and responsively supporting each phase. I organised and set up the steering group and networking events that were hosted by Selina Ullah, the Race Equality Lead for the North East. I held responsibility for ensuring that ethical approval was obtained from UCLan for the research to commence.

I feel great satisfaction with my involvement in this project .It gave me the opportunity to meet and work with individuals with a diverse range of experiences and at the same time further my knowledge of inequalities facing black and minority ethnic women. I have also expanded my knowledge in leadership skills. I am both impressed and delighted in the enthusiasm shown by all the research volunteers who remain very positive that the report will provide a solid platform to make a difference to the lives of people from BME communities they represent in Doncaster.

Gulcan Kay
I am one of the researchers and the Turkish interpreter for YWCA Doncaster Women's Centre NIMHE BME community research project. I hold Turkish and British Citizenships and I have lived in Doncaster for ten years with my husband. I served as a Red Crescent Nurse in the Gulf War, when I was 18. I then went to study for my BA Honours in Fine Art; I also gained a certificate in Education at Huddersfield University. I have worked as a lecturer and manager working with adults with learning disability and mental illness. I would like to see positive changes for BME communities in their knowledge and involvement in mental health.

Sanije Myftari

I am from Kosovo. I am married. I have lived in Doncaster for seven years and six months. I have three children. My oldest son is married, to which I have two grandchildren whom I love very much. My aim is to help people especially the asylum seekers from my community. By being a part of this project; by working together with other researchers I would like to make changes in mental health services in Doncaster.

Linditta Matarova
I am from Kosovo. I am 29 years old, married and have two children. I have lived in Doncaster since 1999. When I first came to England I came as a refugee with lots of other people from my community. I work with children in different schools as a bi-lingual classroom assistant where I offer support to children. I am one of the researchers in the Community Mental Health Research Team in Doncaster at YWCA Doncaster Women's Centre. I am very fortunate to be part of this project as I feel I can represent my community. I hope that by working together in this Community Research Project we can find ways to reduce the stigma of mental health. My aim is to support BME women to access relevant mental health services available.

Sanije Namani
I am from Kosovo. I am 30 years old and I am married. I have lived in Doncaster for seven years. I have four children. I am one of the researchers in the community mental health research team in Doncaster at YWCA Doncaster Women's Centre. I am very fortunate to be part of this project. I feel I can find ways to reduce the stigma of mental health.

Emtiaz Baghdad
My name is Emtiaz Baghdad, I am Libyan. I came to this country in 1993 with my husband who is a doctor. We returned in 1999 to Libya and then returned to the UK in 2002. I have lived in many places in the UK. In Glasgow I used to be a support teacher, to which I held this post for a year, I also taught in schools when I was in Libya. At present I am a housewife with three children.

Ulviye Garip
Ben yedi yil once Ingiltere'ye oglumla birlikte Turkiye'den gelsim Geride esimi, on yasindaki kizimi ve oniki yasindaki oglumu biraktim. Yedi ay sonra esim siginmaci olarak bana katildi ancak cocuklarimizi getiremedi. Bes yildir Doncaster'da yasamaktayim, hala gelecegimizin ne olacagi belli degil esim mahkeme bekliyor. Cosuklarimizdan ayri kalnca ikimizin de psikolojisi etkilendi, cocuklarimizi cok ozluyoruz.
Ben mental health projesine katildigim zaman hic bir bilgim yoktu. Degisik kisilerden yeni bilgiler edindim, ogrendiklerimi yakinlarimla paylastim. Ilk kez universite ortamina girip workshoplara katildim. Degisik ulkerden gelen siginmacilarla ve Ingilizlerle calisma firsatim oldu. Ileride Ilgilizcem gelistigi zaman universiteye gitmeyi cok arzuluyorum, bu ruyami gerceklestirecek kendime olan guvenim geldi.
Benimle birlikte projeye katilan arkadasim Sabir sinirdisi edilmesi grup olarak bizi cok uzdu ve caresiz birakti. Sabir'in bu projeye cok emegi gecti ancak tamamlayamadi. Bu projenin kendi toplumum icin oneminin farkindayim cunku azinlik gruplarin ihtiyaclari kultur, din, dil farklari yuzunden karsilanamiyor. Akil hastaliklari herkesin basina gelebilir, bana bir sey olmaz demeyin.

I came to UK seven years ago with my son after leaving my husband and my 12 years old son and 10 years old daughter behind in Turkey with my relatives. My husband alone joined me seven months later as an asylum seeker in England. We

have been living in Doncaster last five years and we have no idea what will be our future. My husband is still waiting to go to court after five years. Our psychology has effected with this uncertainty and we are missing our children a lot.

I didn't know a lot about mental health before joining the project. I have learned new information and shared this knowledge with other asylum seekers. This was the first time in my life I actually involved with a university. It was my teenage dream. I had a chance to work with English people and other asylum seekers and refugees from many nationalities in workshops. I would like very much to improve my English and attend to a university in the future. I believe I have a self-confidence to realise my dream of graduating from a university.

I am very sorry about Sabir Yuksel who was a researcher and send back (deported) to Turkey (after her asylum case closed). I want to tell you that how hard she has worked for the project unfortunately she hasn't seen it complete.

I am aware how important this project for my community. I know that ethnic minorities' mental health needs very hard to meet because of cultures, beliefs and languages difficulty between them and professionals. Everyone can suffer with mental health problems, too eager to say "will not happen to me!"

Rekha Jadhav
My name is Rekha Jadhav, I am 60 years old, married and a mother. I am a member of the Hindu Women's Group in Doncaster. I am a people's person, especially young people. I do voluntary work within Primary Schools to promote cultural awareness. With the many experienced I have I would like to make a difference in when implementing mental health services for BME communities in Doncaster, also ensuring the Hindu community's voice is heard and represented.

Sabir Yuksel
My name is Sabir Yuksel I came from Istanbul, Turkey four years ago as an asylum seeker to which I am still waiting for a decision from the Home Office.

I want to be part of this research so that health professionals can understand the needs of the Turkish/Muslim community. In our community English is the main barrier and people do not know what services are available, especially around mental health. When accessing mental health services they need ongoing support and help with translation.

As an asylum seeker awaiting a decision from the Home Office this puts us under great stress, which affects our mental health and physical health. I know that being part of this community mental health research it will make a difference to the Turkish community and also it will highlight the difficulties that BME asylum seekers face by putting themselves into our shoes by looking into the life of a BME asylum seeker.

Unfortunately Sabir was unable to complete the research as she was deported.

Chinenye Njoku
I am 35 years old, married with 3 children. While unemployed, I went to the YWCA Women's Centre to volunteer and was recruited as a volunteer researcher. I have a Degree in Mass Communication, Diploma in Health and Social Welfare but currently doing a Post Graduate Diploma in Psychology. I had previously done some research

as part of my studies however, I have learnt a lot from the training on mental health as well as community engagement.

Mehmooda Ravi

I am from Pakistan; I have lived in Doncaster for about 50 years. My family was the first Asian family to settle in Doncaster. I have worked with the BME Community on various projects. I am at the moment working as a volunteer for Home-Start. This involves working with families who have children under five years of age, who have difficulties coping with day-to-day life. I am there to give them practical, emotional support and advice. These families are from the asylum seeking and refugee BME communities. I have in the past worked in many schools as a bilingual classroom assistant, I found this very interesting and rewarding, which helped me to organise many charity and cultural events. I also chair *Women Together*, a women's group in Doncaster. We produce items of arts and crafts for sale and display.

I was very pleased when I became part of the Community Based Research Project at YWCA Doncaster Women's Centre. I can see that this project will help to improve services and give service users better access to and information on mental health services; as well as a chance to have input about their treatment and say what services they would find beneficial. I am very pleased to be involved in this research project and hope to gain experience in the field of research.

Acknowledgements

This report has many authors and many voices speak within its pages. The introduction has been written by the Centre for Ethnicity and Health at the University of Central Lancashire (UCLan) as the support organisation for the research. Representatives from YWCA and Doncaster Women's Centre have written the section on Doncaster Women's Centre. All other sections derive from work, writings and discussions of the 11 community researchers who write at times with a collective voice and at other times with individual voices. They report views and experiences of the 167 people resident in Doncaster who took part in this research.

YWCA Doncaster Women's' Centre, community research team Ninda Randhawa (Project co-ordinator), Gulcan Kay (volunteer researcher and translator), Sanije Miftari (volunteer researcher), Linditta Matarova (volunteer researcher and translator), Sanije Namani (volunteer researcher), Emtiaz Bagdhadi (volunteer researcher), Ulviye Garip (volunteer researcher) Rekha Jadhav (volunteer researcher), Sabir Yuksel (volunteer researcher), Chinenye Njoku (volunteer researcher), Mehmooda Ravi (volunteer researcher) thank all those who participated in and contributed to this research.

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Executive summary

This is a report of research carried out by YWCA Doncaster Women's Centre community research group in the programme of Delivering Race Equality (DRE)[1] in Mental Health Care run by the Centre for Ethnicity and Health (CEH)[2], at University of Central Lancashire (UCLan).

Centre for Ethnicity and Health

The Centre for Ethnicity and Health promote a Model of Community Engagement, developed over a number of years and in particular through their work for the Department of Health in 2000 to get local Black and Minority Ethnic (BME) community groups across England to conduct their own needs assessments in relation to drugs education, prevention, and treatment services.

The community engagement model means at the end of an assessment there will be individuals in the community who gain from undertaking the work, who have learned about the issue of concern, who have learned about the needs of their communities. These individuals will be able to continue to articulate needs to local service providers.

CEH UCLan trained and supported YWCA volunteers and staff over a ten-month period to carry out community research to influence mental health service provision for BME women in Doncaster. Our research set out to examine the extent to which issues for BME communities identified in '*Delivering race equality in mental health care'* action plan (Department of Health 2005) such as fear of statutory mental health services and dissatisfaction with services, had relevance for women in Doncaster and if any concerns were specific or different for women. The research aimed to look particularly at the mental health needs of women who are asylum seekers and refugees.

Community research group

We recruited volunteer researchers from women currently using services at Doncaster Women's Centre who were identified through their Individual Personal Plans as likely to have an interest in collaborating with CEH UCLan. Over the course of the research between June 2006 and May 2007 eleven volunteer researchers, two translators, three YWCA project workers and two managers became the Community Research Group. We were all engaged in the process of enquiry and learning about BME asylum seekers' and refugee women's experiences of mental health services in Doncaster. We felt the loss of one volunteer researcher when the Home Office repatriated Sabir Yuksel. For our research we decided to use postal questionnaires, one-to-one structured interviews and focus groups, to which the researchers' knowledge would be added.

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[1] www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4100773

[2] www.uclan.ac.uk/facs/health/ethnicity/communityengagement/nimhe.htm

Results

A total of 165 women and 13 men took part in the research, including the 11 community researchers. 25 refugees and 30 asylum seekers reporting their status took part in the research. Not all respondents declared their citizenship status.

We found that most respondents (81%) did not know about mental health services in Doncaster. Of those who had used mental health services only half had a good experience. There is room for improvement; to design services that reach out and meet the needs of diverse BME groups in Doncaster, particularly women in Asylum Seeker and Refugee Communities.

Asylum seekers and refugees suffer deeply from material and emotional loss, loss of family and support networks, culture shock with the sudden change in their circumstances and environment. Long periods of waiting with uncertainty for Home Office decisions on asylum cases, cause great anxiety among asylum seekers and has resulted a direct impact on their mental health.

Recommendations

Our research and these recommendations form part of the Delivering Race Equality in Mental Health Care (Department of Health 2005) action plan and aspire to make a difference to BME, asylum seekers and refugee communities in Doncaster. We recommend the following from our work:

More appropriate and responsive services

1) Interpretation Services
   Service commissioners should include resources for translation services, including training and support for translators in all mental health service specifications and budgets. This will include a translator at the first access point where non-English speaking peoples contact the service as well as during medical consultation. Service budgets and practice should take account of additional time to allow for translation; realistically this is four times that with an English-speaker.

2) Counselling Outreach Services
   We suggest funding and supporting two posts working from Doncaster Women's Centre YWCA: a part-time counsellor and fulltime outreach worker to deliver services to women in women-only settings in the Centre and other community settings.

3) Female Community Development Worker (CDW)
   We recommend the appointment of a female CDW in Doncaster. CDWs are fundamental to the Delivering Race Equality action plan and male CDWs compromise service equality for a significant portion of BME women. A female CDW is better placed to engage a significant portion of BME, asylum seeker and refugee women in planning services around sensitive mental health issues.

4) Well Woman Clinic
   We recommend funding for the establishment and running of a well women clinic in safe women-only space at Doncaster Women's Centre, which

encompasses a drop-in centre with a female doctor so that people can talk about menopause, get pregnancy tests and advice.

5) Same-sex Appropriate and Responsive Services
We recommend that mental health services should be pro-active in offering women the opportunity to see a woman professional such that it does not jeopardize the service they receive. The local health service Trusts should carry out an audit of staff to identify and address potential gaps in all services when providing same-sex professionals.

6) Access to Information and Advocacy
We recommend that the information and advocacy service currently being provided at Doncaster Women's Centre be developed further in other community settings. Through this service women are able to access information on a one-to-one basis and in facilitated support groups in a women-only environment.

7) Education: training service professionals in cultural sensitivity
We recommend funding for a Doncaster-wide co-ordinated programme of education on the culture, customs and religion of different ethnic communise for all health professionals and workers who deliver services to BME peoples. The education programmes need to be compulsory the whole organisations from managers to community workers and should have a participative, reflexive approach which analyses organisational structures as well as staff understanding and attitudes.

Community engagement

8) Spiritual and Religious Intervention
We recommend that spiritual and religious aspects be integrated with mental health treatment. For Muslims integration can be achieved through well respected, trusted and qualified Imams who are paid for consultations and are on a list of people who can be contacted by health services. We suggest this includes also a knowledgeable Muslim woman who can help in cases where a woman feels she can only talk to another woman. One solution that we offer here is to train women from the relevant communities to do this. We recommend initiating consultation with religious and spiritual centres and mental health service providers and users to address how this support might be offered, supported and funded.

9) User Involvement
We recommend health professionals take account of user desires for involvement in their own treatment.

10) Help for asylum seekers to work
We recommend help for asylum seekers to use their abilities and skills and experience to benefit themselves and their host community. Doncaster Metropolitan Borough Council should coordinate the creation of a local scheme that gives services, uses their ideas and makes them feel respected and useful.

Introduction

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

Background
We often hear the following words or phrases:

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

Sometimes they are used interchangeably to mean the same thing. Sometimes the same word or phrase is used by different people in the same meeting to mean different things. The Centre for Ethnicity and Health has a very specific notion of community engagement, and this section is an attempt to describe it. The Centre's Model of Community Engagement has 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 (DoH) awarded a contract to what was then the Ethnicity and Health Unit at the University of Central Lancashire (UCLan) to administer and support a new grants initiative. The initiative aimed to get local Black and Minority Ethnic (BME) community groups across England to conduct their own needs assessments, in relation to drugs education, prevention, and treatment services.

The DoH had two key things in mind when it commissioned the work: first, it wanted a number of reports to be produced that would highlight the drug-related needs of a range of BME communities; second, and to an extent even more important, was the process by which this was to be done. If all the Department 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 BME communities, talked to them about their needs, written up a report, and produced yet another set of reports that potentially would not have any long-term impact.

This scheme was different, however. The DoH 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 BME communities to undertake the work themselves. These groups might not have known anything about drugs, or anything about undertaking a needs assessment at the start of the project. What they would have was 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 BME 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 bisexual 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. 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[3] (whoever this is) so 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 co-ordination and infrastructure (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 is to recruit a number of people from the target community to work on the project.

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

The final ingredient 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[4]. 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 while they undertake the work. The support workers will also assist the

[3] 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).
[4] 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.

group to pull together a steering group for the project[5]. 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.'

A Host Community Organisation	With good links to the target community	To provide basic infrastructure 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; ongoing support and guidance; personal tutor	Statutory partnerships; Steering groups; Sustainability

The Community Engagement Team

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

<table>
<tr><td colspan="4">National Programme Directors</td></tr>
<tr><td>Northern Team</td><td>Midlands Team</td><td>Southern Team</td><td rowspan="2">Senior Programme Advisors</td></tr>
<tr><td>Senior Support Worker</td><td>Senior Support Worker</td><td>Senior Support Worker</td></tr>
<tr><td rowspan="3">Support Workers
X 3</td><td rowspan="3">Support Workers
X 3</td><td rowspan="3">Support Workers
X 6</td><td>Drug Interventions Programme</td></tr>
<tr><td>Regeneration</td></tr>
<tr><td>Mental Health</td></tr>
<tr><td colspan="4">Teaching And Learning Team</td></tr>
<tr><td colspan="4">Administration Team</td></tr>
<tr><td colspan="4">Communications Officer</td></tr>
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[5] 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

The focus of this report on the community engagement programme is the experience of women. The objective of the work is to deliver and improve the quality of access, experience and outcomes for black and minority ethnic women accessing mental health services.

Through YWCA Doncaster Women's Centre's experience of working with women of diverse ethnicities, we have gained an understanding of, and gathered information on, their needs as well as our skills, qualities and needs as an organisation to deliver services that are culturally appropriate and accessible to the diverse group.

Views expressed in this report are not those of UCLan.

Aims and objectives of the work

Our research set out to examine the extent to which issues for BME communities identified in '*Delivering race equality in mental health care'* action plan (Department of Health 2005) such as fear of statutory mental health services and dissatisfaction with services, had relevance for women in the BME community in Doncaster and if any concerns were specific or different for women. We intend to examine these by collecting data from BME, asylum seekers and refugee women to ascertain:

- Attitudes to mental health services in Doncaster
- Level of satisfaction with mental health services
- Opinions of the range of therapies available in Doncaster, such as peer support services and psychotherapeutic and counselling treatments
- View's on the role for the Black and minority ethnic communities and Black and minority ethnic service users in: training professionals in the development of mental health policy: and in the planning and provision of services

YWCA England & Wales

YWCA England & Wales is the leading charity working with the most disadvantaged young women in England and Wales. Young women face unique problems in today's society. They are largely unheard and lack influence. We want a future where they can overcome prejudice and take charge of their own lives. We run services to support them and campaign with them to combat the discrimination they face.

In 2005-6 YWCA carried out a twelve-month programme with all staff on diversity to develop and implement policy for diversity, which would be owned by and meaningful for the whole organisation.

YWCA[6] set up a community research group at Doncaster Women's Centre as part of the National Institute for Mental Health in England (NIMHE) Black and Minority Ethnic Mental Health programme[7]. YWCA Doncaster Women's Centre community research group is one of 29 groups in a programme Delivering Race Equality (DRE)[8] in Mental Health Care run by the Centre for Ethnicity and Health (CEH)[9], University of Central Lancashire (UCLan). CEH UCLan trained and supported YWCA volunteers and staff over a ten-month period to carry out community research to influence mental health service provision for Black and Minority Ethnic people in Doncaster.

YWCA Doncaster Women's Centre's work with BME women

YWCA Doncaster Women's Centre has been developing work with women from BME communities since 2002. Over the course of five years we have attracted funding from different sources to develop our work across a variety of themes including crime, healthy living, diversity and service access, and neighbourhood learning.

Prior to the start of the CEH community research project 365 women from 18 different countries of origin were registered with YWCA Doncaster Women's Centre attending various programmes at the Centre and making use of drop-in session; this rose to 600 in 2006 (see Appendices). Through our experience of working with women of diverse ethnicities, we have gained understanding and gathered information of their needs, as well as of our own skills, qualities and needs, as an organisation, to deliver services that are culturally appropriate and accessible to a diverse group.
Parallel to the development of our own work we have extended our external involvement across a number of strategic forums relating our service provision for BME women. We have representation on the BME Key Strategic Partnership, The Health & Well Being Key Strategic Partnership, a developing Equalities Key Strategic Partnership, Doncaster Strategic Partnership, and the Multi-Faith Network. We are also extremely well connected into a range of statutory providers and other voluntary sector deliverers.

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[6] www.ywca.org.uk/
[7] www.nimhe.csip.org.uk/our-work/-Black-minority-ethnic-mental-health.html
[8] www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4100773
[9] www.uclan.ac.uk/facs/health/ethnicity/communityengagement/nimhe.htm

We currently employ a person with specific responsibility for partnership work development around contracts and commissioning who will have responsibility for ensuring that the findings of this research are fed into the appropriate health and social care leads across Primary Care Trusts and the Local Authority.

Doncaster (context)

Doncaster is situated in South Yorkshire, northern England and covers a total area of 57,000 hectares, of which approximately 23,000 hectares are Green Belt. Doncaster's total population is approximately 289,600 with an available workforce of around 120,000. The population density is 5.1 people per hectare with 118,699 households with residents and an average household size of 2.38 (Doncaster Metropolitan Borough Council, 2007).

Black and Minority Ethnic groups in Doncaster

Black and Minority Ethnic people (BME) comprise 3.5% of the population of Doncaster local authority area: see the table below for details (Office for National Statistics, 2001). This is lower than the national (England) average of 9.1%.

Ethnic Group (KS06)	Count	%
All People	286,866	
White: British	276,828	96.50
White: Other White	1,920	0.67
Asian or Asian British: Pakistani	1,503	0.52
White: Irish	1,491	0.52
Asian or Asian British: Indian	1,247	0.43
Mixed: White and Black Caribbean	827	0.29
Black or Black British: Caribbean	736	0.26
Chinese or other ethnic group: Chinese	523	0.18
Mixed: White and Asian	444	0.15
Mixed: Other Mixed	285	0.10
Asian or Asian British: Other Asian	262	0.09
Black or Black British: African	229	0.08
Chinese or other ethnic group	224	0.08
Mixed: White and Black African	203	0.07
Black or Black British: Other Black	84	0.03
Asian or Asian British: Bangladeshi	60	0.02

One reason for a low BME relative population may be the relative recent migration. Gus John in his report to Doncaster Metropolitan Borough Council (John, 2002) states that men from BME communities came relatively recently to Doncaster as migrant workers to join the coal mining and railway industries from the 1940s onwards and settled in the city with their partners and other family members. In the late 1990s, refugees and asylum seekers primarily from Kosovo and Turkey were housed in Doncaster under the UK Government's dispersal programme.

Doncaster Metropolitan Borough Council set up a Commission of Inquiry into the needs of BME people in Doncaster in response to statutory requirements under the Race Relations (Amendment) Act 2000 to promote race equality. The subsequent report of the Inquiry (John, 2002), while providing clear evidence of the difficulties experienced by BME communities in Doncaster, gave little attention to the additional

social isolation and disadvantage experienced by women from these BME communities.

It is our inference that many BME communities are explicit and scrupulous about gender roles - how men and women should be seen to behave - and endorse the constrained public responsibilities of women. In 2005, when YWCA Doncaster made an application to be part of this NIMHE project, it was our view that barriers of language and culture, especially expectations of gender roles, had resulted in the exclusion of BME women from services in Doncaster; as well as their exclusion from studies and surveys to determine service provision.

Our experience has shown that women from BME communities experience gender-specific barriers that warrant a single-gender focus for this research, as women are less visible and active in formal arenas than their male counterparts.

Women with asylum-seeking and refugee status have very often presented at YWCA services with identifiable mental health needs as a direct result of the trauma they have experienced which led them to leave their country of origin. Their need for contact with female practitioners, for cultural appropriateness, has often meant that they were unable to access specialist help and support from statutory health provision.

We believe that this research, placed within a women-only organisation gives an important, focused assessment of BME women's needs made in a manner and environment where women are able to speak freely and inform the steps needed to improve both their access to, and satisfaction with, services.

In our work we have been guided by the Mental Health Foundation definition of mental illness: '*a transient or long-term disruption of usual thoughts, perceptions and feelings which can cause difficulties in personal and social relationships, self-care, decision making and judgement' We* appreciate that diagnosis is made on largely on the basis of people's descriptions of their own experiences, how they behave and on other people's accounts of them, leading to different interpretations of mental illness. We have considered the following as mental illness: anxiety; mood disorders (depression, manic depression); schizophrenia; addictions; eating disorders; organic disorders (dementia, memory loss, depression through underactive thyroid).

It has been identified that at present there are no services for BME, asylum seekers and refugee communities in Doncaster that specifically offer culturally-sensitive services around mental health issues.

Methods

Recruitment

We recruited the volunteer researchers from our existing contacts held on our database. These were women who are currently using services at YWCA Doncaster Women's Centre who have been identified through their Individual Personal Plans engagement with us that would span the lifetime of this research to ensure maximum potential for retention. We ensured that all aspects of this research would be conducted in an ethical manner, adhering to national YWCA England & Wales procedures for risk assessment to guarantee good and safe practice.

Eleven researchers, including translators to represent the different communities, were recruited to the research in June 2006. Over the course of the research, volunteer researchers, translators, YWCA project workers and managers became the Community Research Group. We were all engaged in the process of enquiry and learning about BME, asylum seekers' and refugee women's experiences of mental health services in Doncaster. Thus the Community Research Group comprised volunteers, YWCA staff and self-employed translators. The research group became ten when the Home Office repatriated Sabir Yuksel, one of the volunteer researchers.

The research group

We 11 researchers (Randhawa *et al*, 2007) could be considered to represent three circumstances within BME communities:

- born or came as children to Doncaster with parents or family seeking new opportunities
- came as adults, from our home country, seeking refuge from war, conflict, or persecution or
- came as adults with husbands working in professional occupations in the UK, following our spouse.

These differing circumstances give very different experiences and may give rise to differing views and needs of mental health services. They influence our approach to the research, our learning and interpretation of the findings. They are a key part of understanding race equality and preserving diversity. We value our differences while at the same time cherishing our connectedness, throughout this report of our work and when we give our individual voices.

The Community Research Group met regularly between June 2006 and May 2007 (see Appendices for our timetable of activities). We had several trips as a group travelling together to University of Central Lancashire (UCLan) workshops and to networking events with other research groups, group learning, development, training, advancement, accreditation and recognition. The group processes followed a pattern similar to that seen in co-operative inquiry (Lavie-Ajayi, 2007). At the start, co-researchers came together to agree the focus and develop questions and agree a format for gathering and recording data from the experience. As the research progressed, co-researchers in the research group also became co-subjects as we each observed the process and outcomes of our own and each other's experiences. Finally, the data we collected from the research were analysed and shared to construct our recommendations to promote change.

We learned individually the procedures and protocols of academic research during the workshops held by UCLan, how research sets out the logic of your enquiry. We followed these steps in designing our research together.

Training and support

Through the workshop training by UCLan spaced over seven separate days in the summer of 2006 we were given many questions to aid our initial thoughts around our research: who will do it? Who are the targets of the research? How much data? How much time? How will I maintain anonymity?

We considered the following key stages of a research project to assist planning:

- Deciding on a project, to choose a topic, especially for women and service users
- Deciding on the research tools: our team decided to design a questionnaire
- Selecting samples. We decided to do focus groups, questionnaires, one-to-one structured interviews to select samples.
- Collecting data. There are two types of data: qualitative data, from which you can get information, meanings, feelings and impressions; and quantitative data, from which you can get numeric data through computation, charts, graphs etc.
- Analysing data
- Writing a report
- Disseminating findings, present our findings to audiences.

The main function of our research was to explain how to find answers to research questions.

The researchers decided that they would use postal questionnaires, one-to-one structured interviews and focus groups, to which the researchers' knowledge would be added. The researchers had strong links with their communities and with YWCA Doncaster Women's Centre, which proved an advantage as all three methods of research were successful. Two hundred postal questionnaires were posted out with stamped addressed envelopes, out of which fifty-eight were returned. The numbers that we received was a cause for celebration, as the purpose was to reach out to women who for whatever reason were unable to access the services at the YWCA Doncaster Women's Centre. It ensured that even these women could have a voice on proposing change for implementation across services provided around mental ill-health.

When the researchers carried out the one-to-one structured interviews, they fully informed the participants about the Community Mental Health Research Project, what the research involved and what its aims and objectives were. The researchers ensured that all participants completed a confidentiality statement and assured the participants that the information given would not be used for anything else. The information for the one-to-one interviews was recorded and taken in note form, as was the information from the focus groups, where additionally the flip chart was also used to record discussion. Before any of the one-to-one structured interviews, focus groups were held or postal questionnaires sent out, the questionnaires had to be piloted. This was very useful, as some of the wording on the questionnaires had to be

simplified because we needed participants to understand the questions. The postal questionnaire was translated into Turkish, Punjabi, Hindi, Urdu, Albanian and Arabic. Participants were sent this questionnaire in their mother tongue which was identified through our database.

Steering group

A multi-agency steering group was formed which included people involved in mental health services and from organisations providing support to BME asylum seekers or refugee women. The purpose of the steering group was:

- Monitoring
- Support
- Development
- Inform commissioning

The steering group met at regular intervals during the research and they participated in the formulation of the postal and structured one-to-one interview questionnaires, consent forms, focus group questions and ground rules. The volunteer researchers took the final decision about how the research tools (e.g. questionnaires) were formulated, even though the steering group requested these documents in a more complex format. It was felt that this would prove difficult for BME, asylum seekers and refugee women to understand, as language had already been highlighted as a barrier.

We had regular meetings with our Race Equality Lead (REL), Selina Ullah, who we met every eight weeks. We also gave regular feedback to our local Focused Implementation Site (FIS), through meetings and presentations. The steering group was clear that it had a responsibility to manage the ethical issues that may have arisen from this project and to support the project throughout its duration.

Data collection tools

Our aim was to gather as much information as we could from our various communities in the time available. We spent many weeks from July to September 2006 discussing the method of data collection, its applicability and suitability to our situation, and the problems and limitations associated with it (Kumar, 2005). Nadia Ahmed, our support worker, assisted us with this. We also learned about data collection methods in our UCLan workshop training and reading.

First of all our group designed a structured questionnaire and formulated questions to gather information about women's experiences of mental health services in Doncaster, their understanding of mental wellbeing and experiences they had of mental ill-health. The questions we used in the questionnaire informed the question schedule for focused discussion in the five ethnic/culturally-specific groups. See the Appendices for the questionnaire and focus group schedule. We (YWCA workers and community researchers) facilitated discussion in the groups, and we all acted as translators and note-takers for the groups.

We anticipated that quantitative information on health service access and experiences would be derived from the structured questionnaires.

We compiled letters to inform people about the research and produced forms to obtain written, recorded consent from the people who agreed to take part. Respondents were asked to sign and tick a box to confirm they understood the nature and purpose of the interviews and questionnaires, and that we would keep all matters confidential. Where participants wanted their names to appear with the research, we obtained specific prior consent from them for their names to appear in reports. See the Appendices for the consent forms and information sheet.

The main reason we used three methods for data collection was to give women a choice about how to take part in the research. By using questionnaires and focus group discussions, we gave opportunities to be part of the project to women who might not otherwise have taken part: women unable to leave the house; those who feel confident in a group setting; and those who prefer one-to-one interviews with a known friend or acquaintance.

A subset of questionnaires was completed with members of communities during discussions lasting 60 to 100 minutes, in one-to-one interviews with researchers.

Accessing communities

In the end data were obtained using all three methods: focused discussion in ethnic/culturally specific groups and written structured questionnaire. The questionnaire was administered in two ways: in one-to-one interview by researchers who spoke the same language as the interviewee; or in common interest groups, either through interpreters or same-language facilitators.

We each sought views and collected data from our own families, friends and immediate community (Asian Punjabi, Asian Hindu, Turkish, Arabic and Kosovo) using research tools and methods devised by the group. We also invited all BME women who use the range of services at YWCA Doncaster Women's Centre, particularly asylum-seeking and refugee women and their families. We also researched ourselves through discussions in our research group of 11 (subsequently ten) community researchers, throughout the project and particularly as we met to analyse and make sense of the data collected from questionnaires and focused discussions.

YWCA Doncaster Women's Centre has experience in the past of successfully consulting with a wide and diverse range of groups on a number of different issues using interviews, focus groups, workshops, seminars, questionnaires and anonymous comments slips. The Centre contracts interpreters to work with women who are more comfortable speaking in languages other than English, and this ensures that women are not excluded through language. On-site childcare with culturally-appropriate childcare workers enables the meaningful participation of women who have young children.

Questionnaires were distributed to all existing users of YWCA Doncaster Women's Centre. Also we, the researchers, delivered questionnaires in our own communities. By the same mechanism we invited women to take part in one of five focused discussions held at the Centre in September and October 2006. We decided to concentrate on five focus groups, as we wanted to represent all of the six communities that we the researchers belong to: Albanian, Turkish, Arabic, Pakistani, Indian and African.

Mehmooda described how she interviewed people she knew from her community to collect data using the structured questionnaire:

> *'I think I learned quite a bit about other people. Basically when I meet them socially they're quite different people. And actually when you say okay, I'm doing serious research and I'd like a little bit of information, is that okay with you, and I think you have to draw them out a little bit when talking to them – how much help you give them, if we know about all this. And when they started talking about them I thought a lot of people had similar - not problems, but they were going through the same sort of things in their lives'*

Confidentiality

Volunteers at YWCA Doncaster Women's Centre signed a confidentiality agreement to confirm that all information gathered in the course of the research would remain confidential (a copy of this agreement is in the Appendices). Facilitators of the focus group discussions explained the importance of confidentiality and trust to participants, and all participants agreed to respect the conditions of taking part in the group. The only exception to this procedure for confidentiality was if researchers came across information, which led them to believe that there was a child protection issue, or harm to self or others, or an act of terrorism. Then they would have no option but to report it to their project co-ordinator who would take further action through the appropriate authorities.

Data from the questionnaire were analysed and presented in such a way as to ensure that it was not possible to attribute any particular response to any specific individual. The completed questionnaires were locked away and stored securely so that only members of the research team had access to them. Completed questionnaires and notes and digital recordings from focus group interviews were handed in to Ninda, the project co-ordinator, as soon as possible after the interviews were completed. Care was taken not to leave data in cars or any other unsecured spaces. Data input onto the computer were stored in Microsoft Word, Excel files or SPSS files with password protection. Only YWCA staff and volunteers working on the project had access to any of the information produced.

Contact details (names and addresses) of researchers and interviewees were stored separately and securely from research responses. Only information that is anonymised will be shared with other agencies and it will be shared only for the purposes of improving the provision of mental health services for BME women. The research team received ethics training and all members had clear guidelines provided by UCLan on maintaining confidentiality.

Safety

When planning the research we considered the personal safety of us as researchers and the safety of respondents. Ninda and Diane carried out risk assessments in accordance with YWCA procedures for work and put in place prior support mechanisms. Counselling and one-to-one support was available throughout the project. Respondents and researchers could end interviews and questionnaires at any time if they wished. There was a minimum of two researchers present at the focused discussion groups. A copy of our ground rules used in the group sessions is included in the Appendices. Although we did not anticipate that we would encounter

angry or violent incidents, all our venues have adequate security for respondents and volunteers. Respondents and researchers were informed that if they felt under threat the interviews would be terminated immediately. This was not necessary at any time during the research. In group discussions respondents sometimes cried when recounting experiences and other group members listened. Researchers received training in interview techniques and body language. During interviews we did not give out any personal advice to respondents.

Results

A total of 165 women and 13 men took part in the research, including the 11 community researchers.

A breakdown by ethnic group of the 167 people in either the focus groups or who completed the questionnaire is shown in the table below, together with a breakdown of the Doncaster population by ethnic group for comparison.

Population group	Doncaster	Sample
All people	286,866	167
White: British	276,828	6
White: Other White	1,920	38
Asian or Asian British: Pakistani	1,503	27
White: Irish	1,491	1
Asian or Asian British: Indian	1,247	39
Mixed: White and Black Caribbean	827	0
Black or Black British: Caribbean	736	5
Chinese or other ethnic group: Chinese	523	0
Mixed: White and Asian	444	2
Mixed: Other Mixed	285	10
Asian or Asian British: other Asian	262	6
Black or Black British: African	229	20
Chinese or other ethnic group	224	8
Mixed: White and Black African	203	0
Black or Black British: Other Black	84	4
Asian or Asian British: Bangladeshi	60	1

The table gives an indication of the groups represented in the research sample, and those absent.

The research aimed to look particularly at the mental health needs of women who are asylum seekers and refugees. There were 25 refugees and 30 asylum seekers reporting their status who took part in the research. Not all respondents declared their citizenship status (21 missing values out of a total of 167 respondents).

Core data

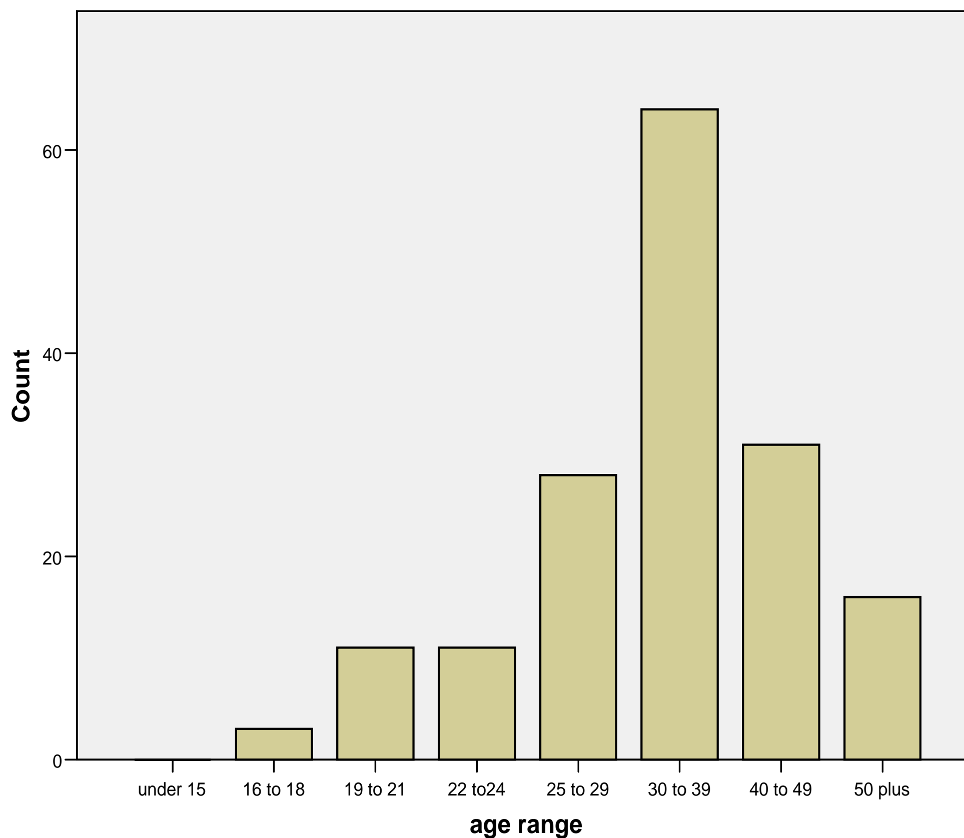
Core data for all 167 participants who took part either in the focus groups or by completing the questionnaire, are shown in the following tables or illustrated in Figures 1-5.

There were 13 men (8%) and 153 women (92%). The focused discussion groups were women-only groups, with a total of 49 women joining the discussions.

Sex of research participants		Frequency	Percentage	Valid percentage
Valid	Male	13	7.8	7.8
	Female	153	91.6	92.2
	Total	166	99.4	100.0
Missing	System	1	0.6	
Total		167	100.0	

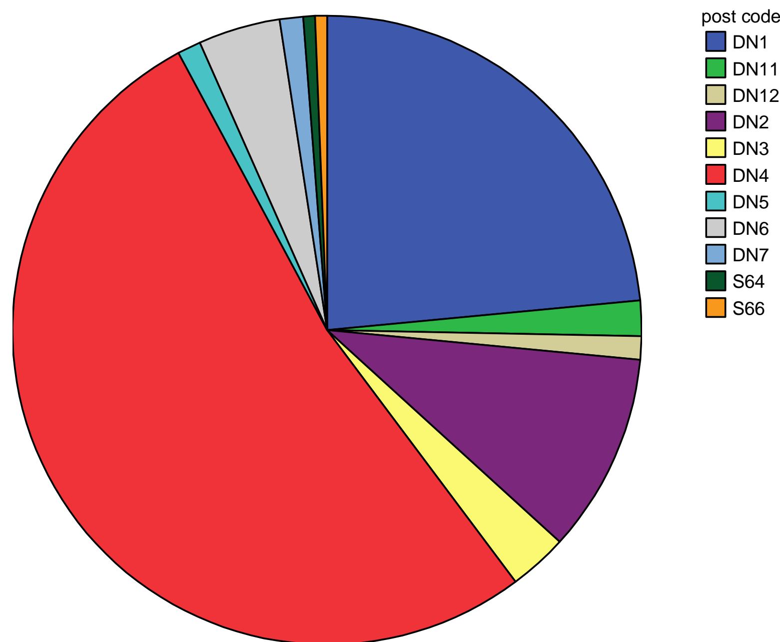
39% of participants were aged 30-39 years. The majority (75%) were aged between 25 and 50 years with 15% under 25 years of age (Figure 1).

Figure 1: age of participants



Just over half (52.4%) of the participants lived in postcode area DN4 and almost a quarter (23.5%) in DN1. The majority were local to Doncaster, with a total of 86.1% living in DN1, DN2 and DN4. Two participants lived outside the Doncaster postcode area, in Mexborough and Rotherham.

Figure 2: residence of participants by postcode



Participants indicated their ethnicity by ticking one of 17 groups used in the National Census 2001. These groupings are tabled below. The groupings vary slightly from those shown in the table comparing Doncaster population with the research sample.

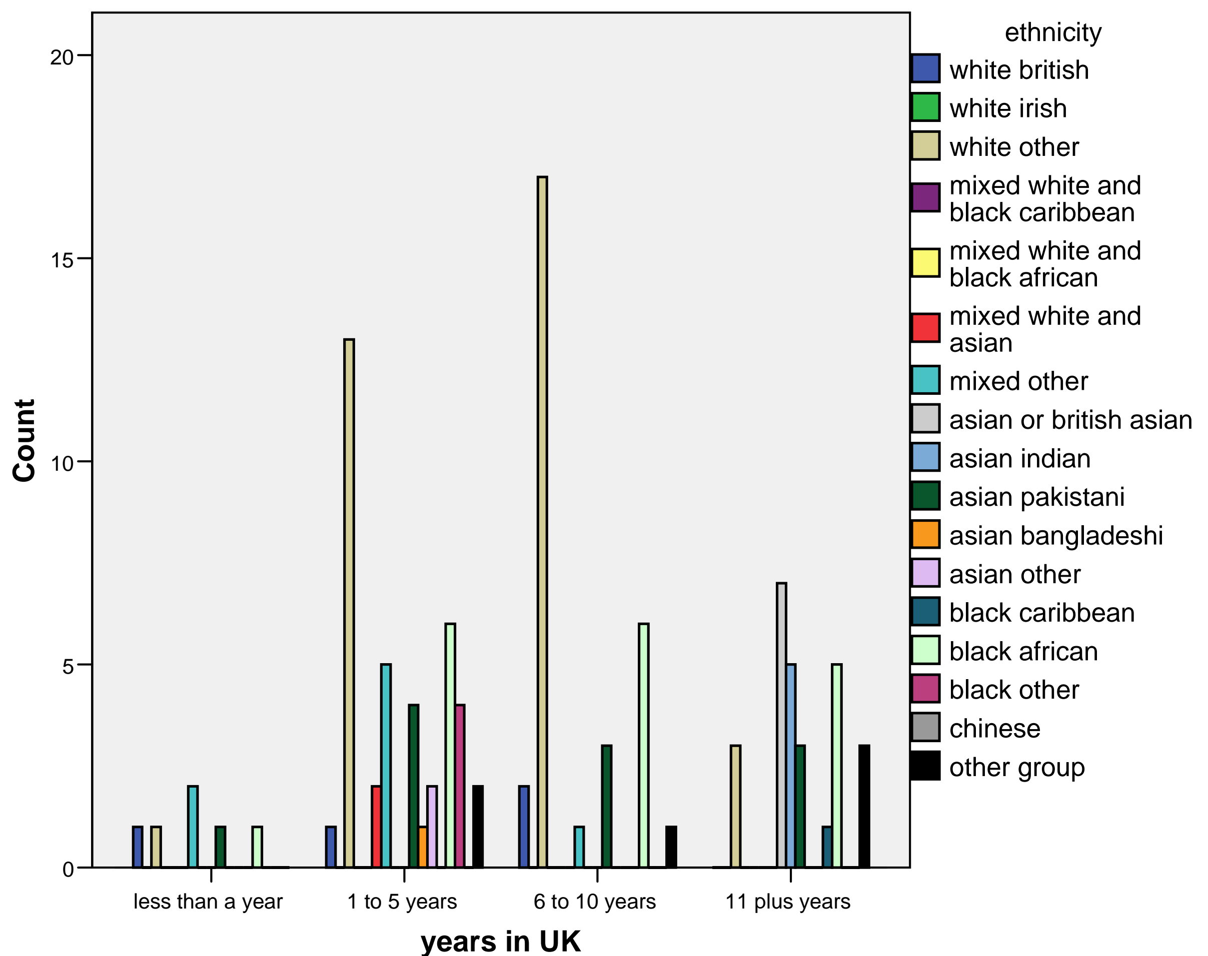
Ethnic group	***Frequency***	***Percentage***
White Other	39	23.4
Asian Indian	39	23.4
Asian Pakistani	27	16.2
Black African	20	12.0
Mixed Other	10	6.0
Other group	8	4.8
White British	6	3.6
Asian Other	6	3.6
Black Caribbean	5	3.0
Black Other	4	2.4
Mixed White and Asian	2	1.2
Asian Bangladeshi	1	.6
Total	**167**	**100.0**

17% of participants were born in the UK, the rest were born outside the UK. Of those born outside the UK 55% had been resident in the UK for six years or more.

Years in UK	***Frequency***	***Percentage***	***Valid percentage***
Less than a year	6	4.3	5.8
1 to 5 years	40	29.0	38.8
6 to 10 years	30	21.7	29.1
11 plus years	27	19.6	26.2
Total	103	74.6	100.0
missing	35	25.4	
Total	138	100.0	

Residence in the UK by ethnic group for those research participants who were born outside the UK is illustrated in Figure 3.

Figure 3: years in UK by ethnicity



58% of all research participants had British citizenship status. A breakdown of status by ethnicity is tabulated below.

ethnicity * citizenship status Crosstabulation

			citizenship status				
			British	Refugee	Asylum seeker	No status required	Total
ethnicity	white british	Count	5	0	0	1	6
		% of Total	3.3%	.0%	.0%	.7%	4.0%
	white other	Count	4	13	16	5	38
		% of Total	2.6%	8.6%	10.6%	3.3%	25.2%
	mixed white and asian	Count	0	0	1	0	1
		% of Total	.0%	.0%	.7%	.0%	.7%
	mixed other	Count	2	7	0	0	9
		% of Total	1.3%	4.6%	.0%	.0%	6.0%
	asian or british asian	Count	8	0	0	0	8
		% of Total	5.3%	.0%	.0%	.0%	5.3%
	asian indian	Count	31	0	0	0	31
		% of Total	20.5%	.0%	.0%	.0%	20.5%
	asian pakistani	Count	20	0	3	3	26
		% of Total	13.2%	.0%	2.0%	2.0%	17.2%
	asian bangladeshi	Count	0	0	1	0	1
		% of Total	.0%	.0%	.7%	.0%	.7%
	asian other	Count	4	0	0	0	4
		% of Total	2.6%	.0%	.0%	.0%	2.6%
	black caribbean	Count	5	0	0	0	5
		% of Total	3.3%	.0%	.0%	.0%	3.3%
	black african	Count	6	1	5	0	12
		% of Total	4.0%	.7%	3.3%	.0%	7.9%
	black other	Count	0	0	4	0	4
		% of Total	.0%	.0%	2.6%	.0%	2.6%
	other group	Count	2	4	0	0	6
		% of Total	1.3%	2.6%	.0%	.0%	4.0%
Total		Count	87	25	30	9	151
		% of Total	57.6%	16.6%	19.9%	6.0%	100.0%

Five participants indicated they had a disability, which included: heart problem; back pain; and unable to use arm. 97% of participants stated they had no disability.

One-third of all research participants did not answer the question on sexuality. Of those who did respond, all except two stated they were heterosexual.

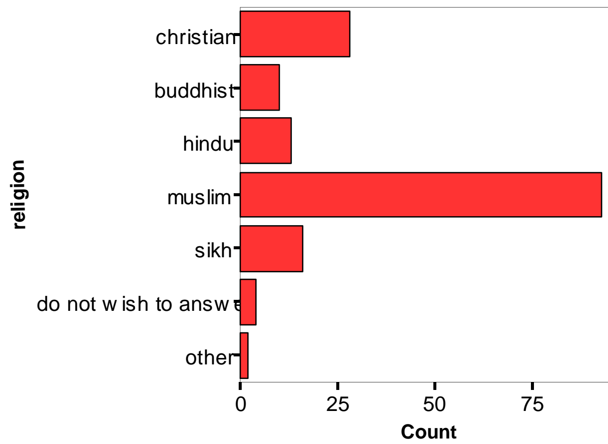
Sexuality	***Frequency***	***Percentage***	***Valid percentage***
Heterosexual	110	65.9	74.8
Bisexual	2	1.2	1.4
Do not wish to answer	35	21.0	23.8
Total	147	88.0	100.0
Missing	20	12.0	
Total	167	100.0	

The first language of the research participants included twenty-two different languages. These are tabled below.

First language	***Frequency***	***Percentage***
English	35	21.0
Urdu	31	18.6
Turkish	22	13.2
Albanian	17	10.2
not stated	14	8.4
Arabic	7	4.2
Hindi	7	4.2
Kurdish	5	3.0
Punjabi	5	3.0
Sinhala	5	3.0
French	3	1.8
Ibo	2	1.2
Luganda	2	1.2
Shona	2	1.2
Somalian	2	1.2
Bangladeshi	1	0.6
Dary	1	0.6
Edo	1	0.6
Gujarati	1	0.6
Portuguese	1	0.6
Slovak	1	0.6
Spanish	1	0.6
Thai	1	0.6
Total	**167**	**100**

More than half the research participants were Muslim.

Figure 4: Religion



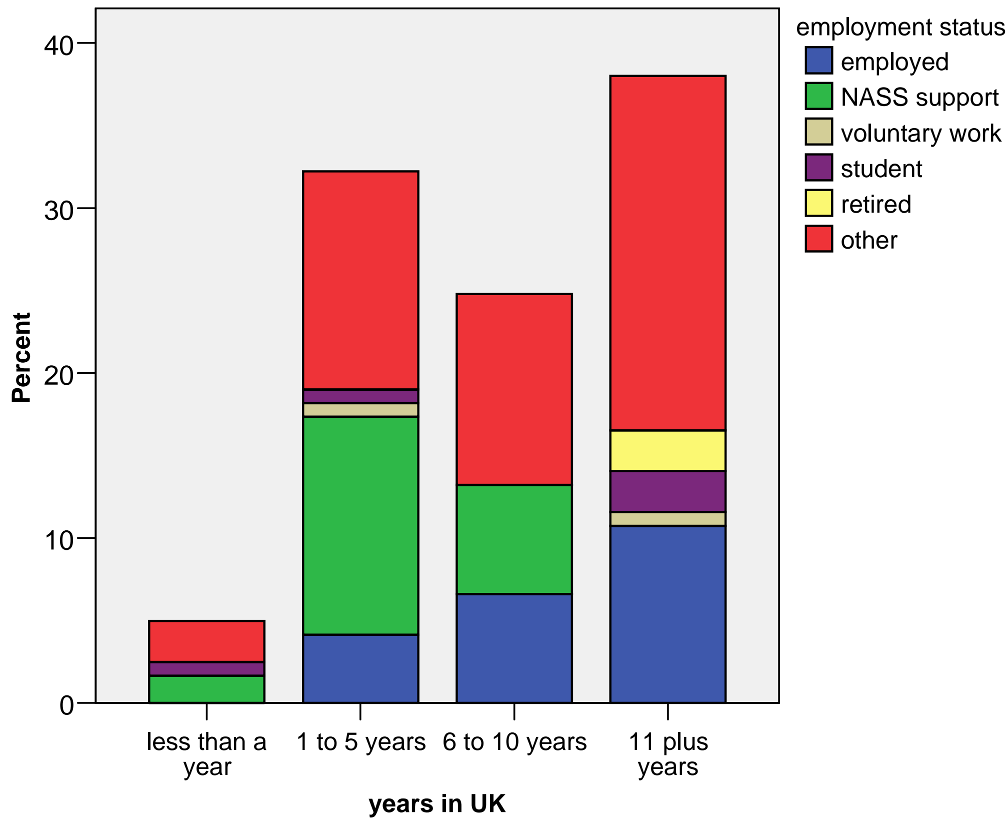
17% were Christian with 10% Sikh; 8% Hindu and 6% Buddhist.

The diversity of Muslim participants can be inferred from the range of first languages spoken, as shown in the table below.

First language	*Frequency*	*Percentage*
Albanian	17	18.3
Arabic	6	6.5
Bangladeshi	1	1.1
Dary	1	1.1
English	5	5.4
French	1	1.1
Kurdish	5	5.4
Punjabi	1	1.1
Somalia	2	2.2
Turkish	16	17.2
Urdu	28	30.1
not stated	10	10.8
Total	**93**	**100.0**

The employment status of participants changed according to the length of time they had been in the UK.

Figure 5: employment status and time in UK



24% of all research participants were in receipt of NASS[10] support; 18% were employed; 8% were students; 2% retired; 2% doing voluntary work; 46% gave some *'other'* employment.

The full list of *'other'* employment is detailed in the Appendices. It included 17% work in the home; 10% unemployed and receiving benefits; and 3% either self-employed or owning their own business.

[10] NASS National Asylum Support Service
www.ind.homeoffice.gov.uk/applying/asylumsupport/

Focus groups

A total of 49 women aged between 19 and 59 years took part in five discussion groups held at YWCA Doncaster Women's Centre during autumn 2006. Groups varied in size: four groups had between five and nine participants each and one group had 24 participants. The average age of the women was 36 (ranging from 19 to 59 years). Other characteristics of the women, including area of residence in Doncaster, ethnicity, citizenship status and religion, are tabled below.

Postcode	n
DN1	8
DN11	2
DN12	1
DN2	7
DN3	2
DN4	28
missing	1
Total	**49**

Ethnicity	
Asian Indian	11
Asian other	4
Black African	2
Black other	2
British Asian	7
other	1
Pakistani	10
Turkish	5
White British	2
White other	5
Total	**49**

Employment status	
House worker	17
Income support	2
NASS support	18
Retired	2
Student	6
Unemployed	4
Total	**49**

Religion	
Buddhist	4
Christian	2
Hindu	3
Muslim	36
Sikh	3
Missing	1
Total	**49**

First language	
Albanian	5
Arabic	2
English	9
French Arabic	1
Turkish	5
Urdu	16
Missing	11
Total	**49**

Citizenship status	
Asylum seeker	7
British	32
Refugee	4
Turkish	1
Turkish Kurdish	2
Pakistani	2
Missing	1
Total	**49**

Notes taken during the Turkish women's group discussion are reproduced below as an example of the discussion written up by facilitators directly after the focus group. Notes from other workshops taken from digital audio records of the sessions are reproduced in the Appendices, together with notes recorded on flip charts at the time of the group discussion.

Notes from the Turkish Women's Focus Group

What makes you feel good?
Being a Muslim, to be able to talk to family and friends back home, having happy and healthy children, children attending good school. Cooking together with husband. Feel good if children are successful in education. Feel very good to receive status in this country.

Mental ill health.
Tired always worried about children, listening to bad news about racism, comfort eating. Sometimes not wanting to wash and dress in a morning, feeling angry about all the bad news and antisocial behaviour. Shaking and nervousness, alcohol or smoking, not feeling happy. Bullying and living in a bad and depleted area. Having financial problems, no jobs, discrimination when applying for jobs, language barrier, cultural misunderstandings and loneliness.

Woman no. 1 said she had not seen her daughter for many years leaving her family behind. Her mother died of cancer but she was not able to go and see her when her mother was ill, and even now she has not been able to see her daughter who she left behind when she was only a baby, losing freedom to travel to see family, leaving family behind it was not worth coming here.

Woman no. 2 her son experienced violence and racism in school, she had to change school to protect her son.

Woman no. 3 said her sister was sent back home after living here four years - this was very distressing.

Woman no. 4 described living in fear, someone had set fire to a car in front of her house, the police were called, they were very pleasant but not really listening to what she was saying. The neighbour of ours did not want to say they had witnessed anything. The family left that house, very soon after they had left the house was burnt down, this made her very depressed. Some women found the police and people very supportive when they had been attacked by racist people.

The effect of 9-11: many people found it difficult as a Muslim to be out in public places; many people seem to be looking at you in a strange way, almost as if they were accusing you of what happened.

Some women found the language barrier a great problem because trying to explain English was difficult and people do not have patience to listen, they do not want to know, they seem to assume that you they think they know what you are saying. Many services are not helpful when language is a problem.

Did you experience any of these in your own country?
Violence, torture, money issues, sexual abuse, war, murder

Have you used mental health services in Doncaster?
Doctors, nurses, they found they did not have enough time to explain their problems and were put on medication without being offered support or any other therapy. They felt having support would have helped to come out of depression. Seeing people and talking helps, not tablets.

What services would you like to help you out of depression?
They said they would like a centre for only women, welcome and respect and a sense of security. They would like a place for counselling with confidence. They all said the focus group was a very useful way of helping them to recognise the issues their community is facing, they found the discussions were very reassuring that there are people who are wanting to help. The women would like to have this type of gathering more often.

Oral translations recorded at the time on the flip charts have been analysed and general themes emerging from the five groups on the discussion topics: positive wellbeing; mental ill-health; poor experiences before and since living in Doncaster; knowledge, use and barriers to use of mental health services in Doncaster; and views and recommendations for improving services are described below.

Positive wellbeing
Things that gave participants ‘good feeling’ included:

	giving good feeling	**examples**
1	family and friends	being in contact with family and friends abroad; nice company children’s achievements, education, success, happiness; when they are respectful and healthy *‘going out to eat with my husband’* nice company
2	being active	shopping; cooking; travel to visit friends and relatives; gym, salsa, helping others; busy painting ‘*being in control’* *‘I dance’*
3	being physically healthy	fit; wellbeing; deep sleep;
4	attitude and status	*‘my attitude’*; ‘*making the most of what you’ve got’*; having permission to stay in UK; ‘*being myself’* ‘*Me I don’t have any problem, just the Home Office’*
5	religion	*‘if she start reading the Koran and this make her feel better […] she read the holy books and pray this make her forget a little bit ’*
6	house and home	happy at house; cooking with husband; *‘when I have a clean and tidy house’*
7	good weather	when not raining; sunny days

One group participant said *‘Nothing makes me feel good’.*

Views of mental ill-health
Views and discussion around mental ill-health covered:

	mental ill-health	examples
1	symptoms	headache; shaking hand; body twitching; stress worry, unable to work, having no focus, waking up upset, gaining weight, not sleeping, being tired and having no energy
2	emotion	emotional pain; unhappy; worry; feeling down; suicidal thoughts; depression; homesick; loneliness; angry; crying; *'bad news'*; '*feel bad when I think of the past'*; sorrow at the suffering of others at home
3	behaviour	creating impressions we are coping; hiding feelings; can't hide your feelings; not bothered about yourself; don't want to see anyone; being bullied; fighting with my children; eating a lot; not eating; drink more; smoke more; self-harm; not getting dressed
4	loss and not having	many events led to mental ill-health, including: death of loved one and separation from children; and many negative examples using 'not' and 'no': not wanted; not settled; no peace of mind; no choices; not knowing; no place; no solutions to too many problems; not sociable; no employment; not being listened to; not appreciated

Poor experiences
Participants were asked about any poor experiences prior to coming to Doncaster (in their country of origin and elsewhere in the UK) and any poor experiences they might have had in Doncaster. Poor experiences centred on war, trauma, violence and loss in their countries of origin and violence, loss and homelessness in Doncaster. Examples of these are tabled below:

	poor experiences in country of origin	poor experiences in Doncaster
war	trauma; *'murder, my son shot in front of my eyes'*	
violence	sexual abuse; racism; torture;	physical violence; broken windows, graffiti, religious harassment, burning house down, racial discrimination, burning car port, throwing eggs and wood, fire bombed, husband tied up; verbal abuse,
loss	death of child, husband, loved ones,	death of loved one, illness in family, no place, no home, no money, poor housing, no independence, no job, no help

Sharing and listening to stories of these experiences had clear emotional impact on participants including facilitators. This was particularly so when participants told of harrowing incidents of racism they experienced since coming to England and in Doncaster, such as the two incidents experienced by an Arabic women in Birmingham and Doncaster re-told below:

'She used to live in Birmingham and when she, they moved from here in the beginning then they can't find for her a proper property and the people they used to abuse and her kids. Throwing the egg on her. At ten o clock in the [night] they knock the doors and they throw things on the windows. Knocking all the windows for her until the morning the police involved. And they told her everything was happy so they didn't try for her. So there she is.
She said they give them this like the bag to put the paper in, this in Doncaster. They put fire on it and put it through the window for them. And her husband try to put down the fire. Oh gosh! but they throw wood as well on her head. Her husband try to put out the fire but at that time they keep throwing the eggs and the wood on her head straight away. So they call the police. The police they never did nothing.'

Another woman observed, after listening this story of neighbourhood aggression, tried to give solace saying that initial hostility from neighbours was transient: *'I think when they know you; they can't say anything. Because when you come somewhere new, everybody they look at you. But when they're used to you: where you go, where you come, and they see, they can't say anything. They say 'hello!''*

Coming to Doncaster for one participant was a *'broken dream* […] *haven't found anything I was looking for, people don't care about each other'*. Another commented that *'life is a monotone'*. Other women spoke of the *'kindness by others'* and how their English neighbours were supportive.

Knowledge and use of mental health services
While a number of women in the groups did not know about mental health services in Doncaster, others knew of counselling; General Practitioner (GP or doctor); YWCA; Community Psychiatric Nurse (CPN); Psychologist; Sure Start; Home Start; and Health Visitor.

When they wanted help with mental ill-health, many women mentioned talking to friends, family, mum and dad and reading the Koran.

The women had used their General Practitioner with varying levels of satisfaction, from *'happy excellent', 'my doctor is a nice person'* to *'can't get GP appointment'*, '*lack of understanding and support at GP'*. A number of women stated that their GP did not spend enough time with them and others preferred British female doctors to Asian male doctors who felt the latter did not listen to them.

'I used to sit at home and eat, eat, eat. Then I came to the GP's centre, changed my life for the better.'

The women reported that talking; sharing stories and experiences helped them.

'I felt better when I talked about my issues and didn't need anti-depressants.'

'*The women's centre we feel secure here and it's the people like you who make us that way. We feel more confident, share experiences'*.

Views on barriers to using services
The women talked of barriers to their use of mental health services as features of the services they would like improved, included or changed rather than barriers. These are reported below.

Aspects of service provision mentioned specifically as barriers included: language, lack of money, not enough time from service providers, unable to trust health professionals and male doctors lacking understanding or empathy.

There were a number of features that focus group participants raised about the barrier of communication. These included: the insecurity some felt by their not understanding when others are talking around them; the inability to communicate their symptoms and their needs to health professionals; the dangers of not understanding when receiving instruction about medication; and the multiple responsibilities taken by interpreters when translating for patients.

> LM *'It's because you don't know the language you don't understand what they say you feel they are talking about you. You feel that way. You do feel that way. Its not may be they have nothing to do with you they don't even look at you. But you feel that way.'*
>
> *EB 'I think this depends on what the person himself feels, because this things didn't mean only the language. Even now all of us we speak English, if now I whisper something would you feel it is about you? It is something what you feel inside'*

Interpreters were very aware of the roles they take on for their client, and the responsibilities and pressures associated with these roles.

> LM '*You have to treat them* [the client] *with respect'*
> GK *'I translate literally because it is very important that every word they say has meaning to my client and if I summarise it because I have next appointment. This is what happens in interpreting business. They have another appointment so they cut it short so they can get to another appointment. But that is not what we are there for. We are there to help say their words to professionals. So that professional will understand them. I do not make it short. So professionals hear their words. I try to say it client's level. I try to say their words, their sentences.'*

The same interpreter also highlighted difficulties of communication between interpreter and client when the level of comprehension differs between speakers of the same language.

> *'We are dealing with the clients their education level is really, really low. We need to make it so simple for them so they can communicate.'*

Participants who did not speak English explained the anxieties and uncertainties they experienced when faced with a situation of having to communicate with English-speaking professionals without the services of an interpreter. They had many stories of taking prescribed medication incorrectly due to misunderstanding.

> *'You know I got my Aunty ten years she hasn't got children. Ten years and she went to IVF and it was okay and they gave her a medicine; it is very small tablets supposed to put in the vagina and the translator she said 'take them three times a day'. And she swallowed them. After fifteen days she got bleeding and this is the problem.'*

Suggestions for improving mental health services included changes to the current service given by health professionals, in particular more time for discussion with translation and more respect; culturally specific or sensitive and women only services; more community based services; and services that addressed their spiritual needs. These are listed in the table below with examples:

	Recommendation	Examples
1	Change in service from health professionals	*'Health professionals that will listen'; 'It is insulting, doctor does not have half an hour for you'; 'We want doctors to listen to us not get pain killer' 'Be able to trust our own doctor'; 'Some professionals should recommend alternatives'*; respect and good welcome
2	Women-only	*'they will attend if opportunities in YWCA, women-only environment'*
3	Culturally specific	should be staff in mental health services whose first language is the client's first language
4	Community-based	*'I think there is a need for community-based mental healthcare, to go back to wellbeing, and things like projects around wellbeing and centres could run that with linkages to doctors'* '*more centres (may not be doctor)'*; Well-women support and clinic at YWCA; support groups; handling stress; smear tests, massage, make-up, dance; relaxation;
5	Meeting spiritual needs	spiritualist services; traditional music teaching, a big centre

Structured questionnaire

104 women and 13 men completed written responses to the questionnaire to yield a total of 118 responses (sex missing in one) that were analysed and the results presented here. The questionnaire is appended.

Postcode	
DN1	31
DN11	1
DN12	1
DN2	10
DN3	3
DN4	59
DN5	2
DN6	7
DN7	2
S64	1
S66	1
Total	**118**

Age range (years)	
16 to 18	3
19 to 21	5
22 to24	8
25 to 29	23
30 to 39	44
40 to 49	23
50 plus	10
missing	2
Total	**118**

Employment status	
Employed	29
NASS support	21
Voluntary work	3
Student	7
Retired	2
Other	54
Missing	2
Total	**118**

Born in the UK	
Not born in UK	91
Born in UK	26
Missing	1
Total	**118**

Ethnicity	
Asian Bangladeshi	1
Asian Indian	20
Asian or British Asian	1
Asian other	2
Asian Pakistani	17
Black African	18
Black Caribbean	5
Black other	2
Mixed other	10
Mixed white and Asian	2
Other group	7
White British	4
White other	29
Total	**118**

Years in UK	
Less than a year	6
1 to 5 years	38
6 to 10 years	24
11 plus years	40
Missing	10
Total	118

Citizenship status	
British	55
Refugee	21
Asylum seeker	23
No status required	4
Missing	15
Total	**118**

Disability	
No disability	111
Disability	5
Missing	2
Total	**118**

Sexuality	
Heterosexual	61
Bisexual	2
Do not wish to answer	55
Total	**118**

Religion	
Christian	26
Buddhist	6
Hindu	10
Muslim	57
Sikh	13
Do not wish to answer	4
Other	2
Total	**118**

Respondents lived in Doncaster with 23% born in the UK. 21 from the total of 118 respondents were receiving NASS support and 21 had refugee status. 48% were Muslim; 22% Christian; 11% Sikh, 8% Hindu and 5% Buddhist. Ages ranged from 16 to over 60 years with 76% aged between 25 and 50 years. More than 22 ethnic groups represented among the respondents.

First language	
Albanian	9
Arabic	4
Bangladesh	1
Dary	1
English	26
French	3
Gujarati	1
Hindi	7
Ibo	3
Kosovan	3
Kurdish	5
Luganda	2
Portuguese	1
Punjabi	5
Shona	2
Sinhala	5
Slovak	1
Somalian	2
Spanish	1
Thai	1
Turkish	17
Urdu	15
Missing	3
Total	**118**

Spoken language	
Albanian	9
Arabic	3
Bangladeshi	1
Dary	1
English	24
Fiveny	1
French	3
Hindi	9
Ibo	1
Kosovan	2
Kurdish	6
Luganda	2
Portuguese	1
Punjabi	9
Shona	2
Sinhala	5
Slovak	1
Somalian	2
Spanish	1
Thai	1
Turkish	19
Urdu	14
Missing	1
Total	**118**

Written language	
Albanian	9
Arabic	3
Bangladeshi	1
Dary	1
English	34
French	3
Hindi	6
Ibo	3
Kosovan	2
Kurdish	4
Luganda	1
Portuguese	1
Punjabi	4
Shona	2
Sinhala	5
Slovak	1
Somalia	1
Spanish	1
Thai	1
Turkish	19
Urdu	12
Missing	4
Total	**118**

Positive wellbeing
The questionnaire asked respondents for their opinions on mental wellbeing and about their experiences of mental ill health.

What makes you feel good about yourself	%
Good relationships	71
Able to communicate with others	69
Fresh in the morning	64
Eating well	59
Watching a film	57
Cope with life’s ups and downs	56
Energy to do things	54
Other	37

On being asked to tick a list of things that made them feel good about themselves most respondents (about 70%) ticked having good relationships and being able to communicate with others. See table above. More people recognised these social aspects of mental wellbeing (how good relationships and communication with others made them feel good about themselves) than recognised the individual aspects (about 60%). Overall the 13 men surveyed indicated less that any of these things make them feel good about themselves, most particularly that eating well made them feel good.

33 respondents gave some indication of the *'other'* things that made them feel good (see Appendix HSQ 16). These included being happy, shopping, being a mum, helping others, being active, having permission to be in the UK and having time to pray. These *'other'* things that were mentioned could be grouped as matters about **self** (happy me, having control, knowledge, fun); **contributing**, (being able to work, happy children); and **consumerism** (spending money, eating); as well as duty and relationships.

> *'Being me'*
>
> *'Being able to work in the community to bring about better understanding; to have my family near me; to see them happy to feel well'*
>
> *'Being helpful, able to help others; having time to do my prays in a relaxed way; having time to read and gain knowledge'*
>
> *'Shopping, travelling, buying and wearing new clothes & wearing the latest fashions'*
>
> *'Be a good Muslim; having time for herself; able to carry out all her Islamic duties as a mother and wife and daughter would make her feel complete'*

One-third of respondents giving *'other'* things that made them feel good wrote about the self and one-third wrote about contributing. Respondents were inclined to write either about the self or about contributing; not both. Only three respondents wrote about duty and what they wrote tended to be more holistic, covering all matters.

Views of mental ill-health

Responses to a list of ways to describe mental health are tabled below

How do you describe mental ill-health?	%
Depressed	79
Emotional pain	59
Stressed	58
Suicidal thoughts	57
Tired	56
Unable to cope	56
Physical pain	51
Anxiety	51
Other	18
Text response	17

Women respondents agreed more with all these ways of describing ill-health. In particular proportionately fewer men would describe mental ill-health as tired or physical pain.

19 respondents wrote about *'other'* ways to describe mental ill health (see Appendix HSQ 15); these included

'Nobody cares, alone in the world'

'When you've lost it'

'Feeling of being useless'

'Guilt'

'Arguments with her husband about his gambling habit affect her mental health'

'Feeling of being useless'

'Over eating'

Where as most respondents acknowledged that good relationships make them feel good about themselves mental ill-health was described by most respondents (80%) in terms of depression and the self, a personal rather than social description. Only four respondents mentioned other people when describing mental ill-health and these are quoted below:

'Loneliness'

'Suicidal thoughts when she has too many problems she does not know how to solve'

'Arguments with her husband about his gambling habit affect her mental health'

The questionnaire asked about respondents own experiences of mental ill health.

In the following list, please tick any feelings that have affected you	%	Have you ever been ill with any of the following? %
Depression	61	64
Emotional stress	52	45
Anxiety	33	18
Mood swings	26	19
Poor concentration	22	14
Physical stress	22	13
Guilt	20	17
None	17	16
Memory loss	12	8
Worthless/suicidal	11	7
Nightmares	11	10
Hallucinations	5	3
Alcohol abuse	4	1
Self harm	4	3

Men were proportionately more likely to have been affected by nightmares and physical stress and less likely to have been affected by poor concentration, guilt and emotional stress. Women were proportionately less likely to have been ill with any of the conditions listed and in particular less likely to have been ill with memory loss, nightmares and suicidal feelings.

Respondents were invited to explain any experiences if they wanted (Appendix HSQ 15). 14 respondents did so and a few examples are given below:

> *'She has arguments with her husband. She has attempted suicide once. She smokes 20 cigarettes a day and lost a lot of weight like 3 stones.'*
>
> *'Loneliness and longing to have good relationship with her family'*
>
> *'I want to walk in front of the cars at the traffic lights'*

Most (about four-fifths) of the explanations of respondents own experiences of mental ill-health described painful or unsatisfactory relationships with others.
Three people wrote about fear of deportation, two about addiction and the thoughts of suicide quoted above were the exception.

Poor experiences
The questionnaire also asked about bad experiences they might have had in Doncaster and prior to coming to Doncaster. Results in the tables are given as percentages of responses.

Did you experience any of the following in your country of origin (before coming to UK) or during your stay in the UK?	before	during	Since living in Doncaster, have you experienced any of these issues?	
	%	%		%
Death of loved ones	37	27	Racism/discrimination	50
War	26	2	Racial abuse	44
Violence	23	2	Language barriers	38
Persecution	22	1	Inequalities by services	34
Family problems	20	27	Illness	28
Torture	19	1	Finance or debt issues	26
Illness	18	22	Social exclusion	25
Finance or debt issues	15	22	Unemployment	23
Domestic violence	14	3	Poverty	22
Detention at refugee camp	12	7	Family problems	18
Sexual assault	11	2	Homelessness	10
			Domestic violence	9
			Violence	7

Between a quarter and a third of all respondents had experienced death of loved ones, war violence or persecution before living in Doncaster. Women were proportionately more likely to have experienced sexual assault and less likely to have experienced torture and war.

Since living in Doncaster a half had experienced racism and racial abuse. Less than 10% had experienced violence since living in Doncaster.

Men were proportionately more likely to have encountered racial abuse and women more likely to have experienced racism/discrimination. Women were proportionately more likely to have experienced inequalities by services. Only one man from the total of 13 men indicated that he had received an unequal service, whereas 36 women from a total of 97 women (37%) indicated they had received an unequal service.

Fourteen people gave written examples of their poor experiences before coming to Doncaster. These comprised racism, bereavement, trauma, addiction and family break up (Appendix HSQ 19). Examples of other poor experiences in Doncaster included racism, where statutory services were particularly mentioned, family problems and frustrations with being unable to work as an asylum seeker (Appendix HSQ 20).

'When the police may you feel different when you are not white'

'Yes, in my GP, I was not finished but my GP & my interpreter were finished with me, I was still sitting down, they were already standing up. I mean they don't give you enough time.'

'Bus driver never stopped'

One respondent wrote about very kind British people.

Knowledge and use of mental health services

Most respondents (70%) indicated they would go to their friends and a GP if they needed help with mental health problems. A lot fewer (20%) would consider going to either friends or the GP if they wanted information about mental health.

Where would you go if you needed help or information with mental health problems?	Help %	Info %
General practitioner (GP)	70	22
Friends	70	18
Telephone helpline	48	13
Spiritual	40	13
Hospital	35	18
Family	35	14
School	29	8
Other	16	4
Text response	15	3
Library	13	7
Internet (world wide web)	6	11
College	5	4

Men were proportionately more likely than women to get help from the family and internet and women proportionately more likely to seek help for friends.

Other places where respondents would go for help with mental health problems included religious institutions (temples, gurdwara, and mosque), statutory services such as SURESTART and the Red Cross (Appendix HSQ 21).

81% of respondents did not know about mental health services in Doncaster.

know about services

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	no	85	72.0	81.0	81.0
	yes	20	16.9	19.0	100.0
	Total	105	89.0	100.0	
Missing	System	13	11.0		
Total		118	100.0		

Proportionately more men stated they knew about mental health services in Doncaster than women stated they knew about the services.

sex * know about services Crosstabulation

			know about services		Total
			no	yes	
sex	male	Count	4	5	9
		% of Total	3.8%	4.8%	8.7%
	female	Count	80	15	95
		% of Total	76.9%	14.4%	91.3%
Total		Count	84	20	104
		% of Total	80.8%	19.2%	100.0%

However, the numbers of men completing the questionnaire were too few to make a valid comparison of this difference. See Chi Square test below for testing responses to know about services by sex.

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	8.370[b]	1	.004		
Continuity Correction[a]	6.005	1	.014		
Likelihood Ratio	6.591	1	.010		
Fisher's Exact Test				.012	.012
Linear-by-Linear Association	8.289	1	.004		
N of Valid Cases	104				

a. Computed only for a 2x2 table

b. 1 cells (25.0%) have expected count less than 5. The minimum expected count is 1.73.

Because of the small number of responses from men in the sample (13), all other responses have not been analysed for differences between men and women. Statistical results are presented for all respondents, as the exclusion of men makes no difference. Where responses from men have a tendency to differ these are noted, as previously.

experience of services

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	excellent	5	4.2	13.9	13.9
	good	17	14.4	47.2	61.1
	poor	7	5.9	19.4	80.6
	very poor	6	5.1	16.7	97.2
	other	1	.8	2.8	100.0
	Total	36	30.5	100.0	
Missing	System	82	69.5		
Total		118	100.0		

Of the 36 respondents who had used mental health services in Doncaster, half had a good or excellent experience and half considered their experience to be poor or very poor. Five women considered the service they had received as 'excellent' where as men only rated it 'good'. There were only three written comments (Appendix HSQ), which are all reproduced below:

My brother used mental health services and had a bad experience

I started to receive much better service with my second nurse because she is consistent

Confidential

Three-quarters of respondents thought that counselling, therapy and medicine were the help people needed when they had mental health problems. This, of course, implies that a quarter of respondents thought that counselling, therapy and medicine were not the type of help people with mental health problems needed.

What help do you think people need if you think they have mental health problems?	%
Counselling	76
Therapy	76
Medicine	75
Spiritual	64
Other	12

Men were proportionately less likely than women to think that any of the types of help listed were what people needed if they had mental health problems. However, they were just as likely as women to favour therapy and medicine.

About two-thirds of respondents thought spiritual help was needed. These were overwhelmingly women respondents as only one man thought spiritual help was needed.

Other types of help cited (Appendix HSQ 221) were the support of family and friends, including a good marriage, GP community mental health home visits and yoga.

Most respondents (94%) had used their GP and two-thirds had used YWCA Doncaster Women's Centre. Fewer than 10% had used the mental health team, MIND, RETHINK or a Counsellor.

Have you used local health services?	%
Used GP	94
Used Women's Centre	62
Used mental health team	9
Used counsellor	9
Used Home Start	7
Used MIND	6
Used RETHINK	5

Women were more likely than men to have used their GP

Views on barriers to using services

What do you think would prevent you from going to and using mental health services in Doncaster?	%
Stigma of mental health	78
Cultural differences in illness	78
Don't know about mental health	74
Discrimination/prejudice by staff	73
Providers don't speak language	64
No one to look after the children	62
Don't know the services available	47
Other barriers	42

People were only slightly more likely to indicate that things about their knowledge and cultural attitudes towards mental health prevented them from using mental health services (74-78%) than indicated that it was aspects of the service that prevented them (64-73%). It was more likely for women to indicate that care of the children prevented them.

Half of the respondents felt that not knowing about the services available prevented them from using them. Women were much more likely than men to consider any and all of the list as barriers, in particular the stigma of mental health and discrimination or prejudice by staff.

Other barriers (Appendix HSQ27) included lack of resources such as money for travel and bus fares; aspects of the service particularly poor treatment of women and language difficulties; and lack of information.

Improvements to mental health services in Doncaster

One respondent poignantly and tragically describes how in her experience, health services currently do not reach out to people who are isolated and desperate:

> '*My friend died from suicide she was so depressed, she had young children; there was nobody that came out and gave her any help – she needed help in the community. No nurses, nobody helped her. She should have been encouraged by the health people to come to centres like the women's centre then perhaps she might have been here today. Nobody needed to suffer like she did.'*

The majority of respondents (54-69%) reported that, community networks, culturally appropriate services, better information, multilingual staff, spiritual support counselling and services in informal settings would all improve current mental health services to Black and minority ethnic women. See table below.

What would you like to see that would improve mental health services in Doncaster?	%
Other	70
Other text	70
Culturally appropriate	69
Spiritual support	68
Community network	67
Better information	66
Counselling	62
Multi-lingual staff	59
Informal settings	54
Therapy	17

Women were proportionately more likely than men to indicate the need from improvement by any and all of these means. In particular women, more than men indicated that they wanted spiritual support, culturally appropriate services and especially services in informal settings. 55 women from a total of 94 respondents thought that services would be improved through delivery in informal settings, whereas only two of the 13 men indicated this.

The questionnaire gave space for respondents to write their own recommendations for service improvement. Seventy of the 118 respondents made use of this opportunity to describe how they saw improvements might be made, of whom 47 or 67% specifically mentioned the need for women-only services (Appendix HSQ 28).

> *'Women only services like the women's centre, when I feel down I came to the centre - used the well women's clinic'*
>
> *'We have been treated badly by health services. We need a centre for women only where we can go and we can then get to know staff and trust them'*

One respondent described how women need help and support at particular times, such as after childbirth and at menopause and when setting up home in a new country. (Appendix HSQ 28 * 13).

> *'More awareness of mental health, people often do not know or recognise the systems of mental ill health. Young women specially after having a baby they need help and support which they do not receive and often suffer from depression or going through menopause. People or women who have left their family behind and come to Britain after getting married have a difficult time settling into their new surroundings, they need support and understanding which they have no access to. A centre which is can give women friendly and confidential support and the centre should be well publicised and women should have easy access to.'*

Another mentioned help with children;

> *'I need support with my children when I feel very low or if I need to go to hospital'*

Five respondents wrote how they would like to see involvement of religious institutions in mental health services.

> *'Need to work - Person liaison Services (PALS) Need leaflets in local languages explaining how to access services. Need to involve places of worship (religious groups)'*

Six respondents mentioned they would like outreach services and community groups. Others would like services to be more understanding and considerate especially to black people.

> *'Community outreach to find out what's happening and more community workers (Black & ethnic group) to enable [people] to open up'*
>
> *'Consideration of religious background. Stop stigmatising colour of individuals. Involvement of families if any problems'*

And one suggested training for service providers.

> *'To train up ethnic minority staff who are sensitive to cultural differences, to [en]sure cultural sensitivity training. Institutional structure of the Mental Health are quite rigid and should be made more flexible to other cultural backgrounds.'*

Questionnaires completed through one-to-one interview of participants and a community researchers yielded stories of experiences from interviewees that were remembered and re-told by researchers in our research group meetings.

From these many stories, our community research group identified three stories, which we feel encapsulate matters of particular significance to the inquiry.

The first illustrates the importance of a listener.

I I started to speak to her about how she was feeling and everything

M – One particular person I remember quite clearly that had a problem, and she's quite a young person, she's got two boys and one of them is ill. And last time I saw her she was actually quite well built and everything and then she actually lost a lot of weight, and I asked her, 'what's the matter'? In fact I did one of these questionnaires with her, and I asked her 'what's the matter?' Why she lost so much weight? And she's basically saying: Because I meant to lose this weight. And I say, okay, but why so much weight, because she looked really drained and everything – and I said okay, and I started to speak to her about how she was feeling and everything.

And she said sometimes she gets up in the morning and oh, there's a problem on my mind, and it gets just bigger and bigger and bigger, and by the evening I'm feeling so bad about it I don't know what to do with myself. So she said, I go to sleep with this problem in my head, and I don't sleep very well; in the morning I get up and there's something else in my mind and it sort of goes on more or less every single day. And she would go out, you know, to get rid of this thought in her mind, and she doesn't – you know, it brings her down, makes her feel bad, and everything. And I said, well, have you told your doctor about it? And she said, no, I don't think its anything to do with that really. She's not recognising basically that maybe its possible that her son who is very ill.

And they have to visit the hospital I think its every month or something, to give him treatment and things like that, and so she's going through an awful lot in her mind, in her life. I don't know whether the doctor is actually speaking to her about her own health or not. But I think she is suffering quite a lot, and the only thing I could sort of help her with is, okay, you know, if you need any help from me, talk about things.

I often phone her, and she phones me, and we talk about things. But I think she's going through a problem that needs solving and I thought that affected me quite a lot. [It affected me] in the sense that I felt that this person is going through so much, and as a result of her son's problems she is actually thinking ahead as well: how is life going to be further ahead. And I'm thinking, you know, how is this going to be solved, basically. I feel a little bit responsible because I know about it.

I think knowing something about someone gives you a little bit of a responsibility. At least, I feel that it does.

The second story is one of many that could be told of the trauma and suffering experienced by asylum seekers that caused them to seek asylum in the UK; and how these past ordeals still affect them today.

This is Sanije's story.

II For me very, very bad

S - Before I have seven years I have big problem… for me, very, very bad

L – I'll translate it. She just wants to explain how she's been affected with her mental health, especially during the war time.

Actually the Serbian Army, well you can't say Army or Police because you know it was a war, they burn her house down. I stayed at the relatives'. Later on, they arrest her husband. They put him in prison. She didn't know anything about him for months - r if he'd been killed or whether he was in prison. She didn't have any information at all about him.

She had three sons; the youngest was two years old. Every day she was asking and crying, crying, what had happened? After six, seven months, the Red Cross – they helped him to get out of prison, and they suggest him to come to England because he has been very, very brutally, you know… they broke his ribs and everything. So they suggest him to come to England to get some help because he has been brutally, brutally….

She was crying every day, she was trying to support her children, and she didn't know really what to do because she didn't have a clue what had happened to him. She didn't have any support, you know, didn't know where to go and get help, where everybody was looking for help. The children were crying all the time, asking after their dad.

After six, seven months a friend of his rung them and told them about him. He's alive, he's in England. Because somebody had told her, you know, two months ago before she heard the news, told her he's been killed. She does say she's quite happy she's here now and her family has been saved, but I've been through a lot, and it did affect me a lot actually. But things have changed, things have changed, but now you know it's seven or eight years since that happened and sometimes for her husband when he sees things on television …it does affect him… its kind of like it was coming back.

It does happen to me, when I see something, in the television or I hear something it is just straight away, you know, I'm back where I was. And actually I know deep down all the people who've been through that have been affected. It does, yes, she says, it did affect me, especially when doing the questionnaire, it was bringing me back. Actually, she's saying that you don't have to say much, you know, if somebody's been through something like that you don't have to say much in order to bring the memory back.

S2 – I remember first time we come, Sanije and three boys and my mother in law, everybody happy for Sanije and she go to bedroom cry. Everybody, people happy. English people help Sanije

S – Yeah, I have too many friend, English . They will come in my home to help me

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Sanije's story is one she told to us often during our time together in the research group. She obtained relief in telling her story as we shared the anguish of her experiences with her. It is one of many stories of the brutality and violence suffered by asylum seekers fleeing war zones.

The third story is one of racist aggression in the UK and the effect it has on the recipient's mental health.

III To tackle it would make violence involved in it

M – I spoke to one person briefly, I don't know her very well, but through this research I've got to know a little more about her. They had a newsagent shop, and what was happening was young boys would come in a group and somebody would buy something small and the rest would sort of take things off the shelf and so on, and she was getting more and more upset about this and she couldn't cope with this. And her husband would be there and he also felt that to tackle it would make violence involved in it.

CJ – Were these white boys?

M – Yes. And so several times police were phoned but they didn't respond to it. And this is about four or five years ago they had this shop. They sold the shop as a result of what happened at that particular time; she is actually still suffering.
I went to see her, she doesn't go out very often, she keeps her house absolutely, you know, spotless. She spends all her time – if you go to her house, she'll give you a cup of tea and make everything just so, and its part of I suppose being lonely. She will not mix with a lot of people, and recently we had a group set up for us to get together and do some learning and she was attending that and then she stopped coming. And so we inquired about, you know, what was the matter, and she was saying she had to go to the hospital because of her condition and everything and I said, well, you know, you shouldn't stop coming, it will help you. Being with people and so on. So she started coming again, but she is being treated for that, she is actually in a situation where she feels frightened in going out, she doesn't feel comfortable in going out.

CJ – How is she being treated medically?

M – Medication – basically medication. You know, she says she has a lot of shaking and she imagines that – you know, she's got two children, one son and daughter and they're both away so there's just husband and wife at home, and she feels basically that, you know, the thing that she was describing to me was the fact that she had a sense of being alone, nobody with her. And physical pains in her body. She actually feels that she's ill. And she said she sometimes feels that she's terribly ill but the doctor is not telling me about it, which is not the case, as far as I know.

All three stories illustrate the value of sharing problems and communicating emotions.

Discussion

Carrying out this research we learned about mental health and we learned about conducting research. We were able to reflect on our own mental health. We collected views and experiences of BME women and men on mental health services in Doncaster and we learned about the experiences of women from BME communities other than our own. Those of us who have never experienced war and fighting were shocked and disturbed by the suffering of those from countries in conflict.

We learned from the people we interviewed and the stories we told each other. Not all our learning has been captured and reported here. We are surprised how much detail is lost in data collected using a structured questionnaire and how the immense emotions we all felt as we heard and repeated stories of tragedy, loss, bereavement, resilience, survival, injustice, brutality and violence shrink on the pages of this report.

Despite this, using the questionnaire as a tool and prompt for inquiry has made us realise all the problems that people have experienced. When you listen to somebody's problems you start to feel a little bit responsible and want to help them in some way. People suffer silently until someone is able to talk to them and encourage them to open up. The questionnaire has brought about a realisation of the problems that people are facing. It makes you feel stronger about your own mental health and realise that you are a stronger person than you originally thought.

Although people have unique experiences and problems of their own we heard stories of similar experiences and how people have experienced the same things as ourselves, even when they have come from different cultural backgrounds. People tend to worry a lot about their children, even when their children are older. Parents worry constantly and this can cause them tension and anxiety. On a religious level, older generations consider spiritual help to be more important while younger people seek a quicker solution, preferring to seek medical help from their doctor.

Psychological wellbeing and social support

The majority of those taking part in this research identified how important good relationships with others was for their mental wellbeing. Where these relationships were inadequate or hostile, their mental health deteriorated.

We heard many stories of racism, particularly hostile, aggressive and violent behaviour by white English neighbours towards newly arrived asylum seekers. Persistent hostility and racism, low-level non-violent aggression, can lead to deterioration of people's mental wellbeing such as the case of the shopkeeper who became afraid to leave her house due to her experiences of white boys stealing constantly from her shop. She is being treated with medication but has a sense of being alone, has physical pains and feels she is terminally ill but her doctor is not telling her.

It is well recognised that racism leads to a decrease in psychological wellbeing. *'The perception of self and the perception of community may affect an individual's self esteem and their ability to live a healthy lifestyle and to support others in a health-promoting lifestyle'* (Kamaldeep 2002)

We also heard heart-warming stories of how white English neighbours and friends had helped and supported the women, their families and their children.

The importance of social care as well as clinical provision for those with mental health problems was identified in a systematic review of home treatment (Burns *et al*, 2001). In this review health and social care integration was one of sixteen items rated by the Delphi method as essential components of community based services.

Hosin (2001), writing on refugee families, also recommends that '*specialised treatment recognises the role of current stresses, relieving some symptoms by medication and also helping individuals to get the social, emotional and financial support that they need*'.

We found that through our interviews with participants we contributed to this social support. Social support is also provided by neighbours and friends, community groups and centres. Established groups and centres can encourage and promote social support to isolated groups and individuals and ease the harm of racism. Community leaders and representatives should take action to combat racism and work positively and collaboratively with the police to act humanely and effectively to incidents of racism.

Age

'And I think it depends on what age group you are actually dealing with because in our society basically once you grow up you are not actually responsible for the children anymore. You feel more responsible for them, and so it becomes more, you know, not a burden but more something that people as parents are continuously thinking of and trying to sort out.'

'So I think support for good mental health depends on the age group that you are looking at, and for me I think it was the same sort of thing people were going through – worry about the children, about this, and that was causing them a lot of tension, a lot of worry.'

'As far as religiously they were concerned, I think my age group of retired folk seek more of that than younger people do. People over sixty would rather to go to a religious side of trying to get better and go into there, sort of, do meditation and pray – things like that. Rather than go to a doctor and say, I'm suffering with this tension, this problem, whatever. And I think the younger people feel it would be better to go to the doctor and basically seek something, you know, a quicker solution to it.'

Trauma, conflict and violence

Many asylum seekers and refugees who took part in this research had witnessed and experienced physical assaults, displacement, suffered loss and endured trauma. When they see things such as war on the television they are affected because it brings back terrible memories of sufferings in their home country.

Other people do not have to say much to trigger these memories in them and for the experiences once more to be brought to the surface. The husbands of some of the women asylum seekers had suffered brutal treatment in war and conflict and, it was

inferred, had symptoms of post-traumatic stress disorder (PTSD): loneliness, depression, irritability.

Sharing experiences through group discussions, such as the research group, the focus groups and with our own friends and family is helpful to those who have suffered, as we discussed when compiling our thoughts for this report:

EB -You know when we did the Turkish group focus group, a lot of people after they've discussed their feelings and everything, at the end of it they said, if only we could help these groups more often. Because sharing the feelings, sharing the experiences, helped them. Helped quite a lot. And a lot of them said if it was possible to have groups like this more often so we could exchange experiences.

CJ -Does it help to share?

SN - Yes. Some people leave it inside. I no leave it inside. Just cry.

LM - It does help, yes.

EB - Yes, it helps when you get someone sharing the same thing, it helps.

LM - It does help a lot because I remember, I lost my mum, and I was only fourteen years old.

Remembering and talking about people that you have lost can also bring relief, especially when you remember the happy times. Not everything is discussed though. Some of the refugees from Kosovo told how they do not like to think about the war because they do not like to remember seeing those who have suffered. Hosin (2001) considers the value of debriefing as a treatment approach for survivors of traumatic events citing Yule's study where debriefed individuals showed '*lower levels of distress, particularly in relation to intrusive thoughts.'*

Inhumane policy

The distress of people seeking asylum in the UK is compounded by inhumane policy, centrally determined and condoned by Government. Many people, especially refugees and asylum seekers, find that one of the most depressing aspects of their lives is the fact that they are not allowed to work. In particular, those people who are used to working very hard, and those who have been in highly qualified professions are devastated by their predicament. This pressure is very destructive and many begin to suffer mental disorders, and the whole family suffer

The solution to this would be a way of helping them to use their abilities to benefit them as well as the host community. Create schemes that give a service, use their ideas and make them feel respected and useful instead of making them feel useless and a burden to society.

From the research we have done so far, we have come across many incidents where the treatment of refugees and asylum seekers has been so inhumane that they are

suffering so much and they do not have a voice or any rights, nor do they have anyone they can complain to. This causes them anxiety and helplessness and suffering. When they need to use the services, all the problems associated with going for help and not being understood or being made to feel second-class makes them not want to put themselves in a situation where they feel looked down upon. This becomes even more depressing. Please put yourselves in their position and think what is happening to them: separation from family; homelessness; no control over finances; no work; insecurity – can be sent back at anytime. Nothing to do but sit and think of their predicament is bound to have an effect on their mental health and consequently on the wellbeing of their family. The review of migrants and public services in the UK by Arai (2006) indicated that refugees and asylum seekers are '*particularly vulnerable to the effects of social isolation.'*

Supportive relationships and sharing experiences

Sharing your experiences with other people is a positive thing. Emtiaz told us a story of salt water when we were discussing the importance of telling other people your experiences. Emtiaz said

> '**You know, I think sharing is something very good**…….'There is a short story about a lady who lost her son, and she was crying and crying and crying, and she can't be patient [peaceful].
>
> So she met a man, she is asking him, 'How can I be patient, how can I forget? How can I be fine?' He said, okay, just bring salt, mixed in water, and drink it. You will be fine. She said it's easy.
>
> But he said 'No, this salt, you need to take it from someone. Don't buy it. Take it from a neighbour or friends'. Again the women thought but this it's easy, salt is something very cheap. Everyone has salt.
>
> Again the man said 'but remember, this salt you're supposed to take from someone who hasn't never, ever lost anyone who they loved'. So the woman. she asks everyone, 'Have you lost someone?' 'Oh yes, I've lost my mother, my father, I lost my friend'.
>
> So, she got herself exactly the same with everyone. So this makes her feel happy. This is a short message that you are not alone, that you are like everyone.'

When people do not speak about their problems, their problems tend to get increasingly bigger and people become down and feel bad about them selves. They can lose a lot of weight because they become overcome with worry. Mehmooda writes:

'I learned that people suffer silently. I feel that a lot of people suffer and they don't show their own selves to people, unless you actually give them compassion, and sit with them and make them feel that talking to you as a friend to help – not to help, but be part of what you're going through, sort of thing. Help in that manner, if you

understand what I mean, if my sister and I, we talk about our day to day lives, we talk so that we sort of share information about life, you know. 'Is it the same with you? Are you suffering, or are you having a good time?' Sort of, sharing feelings, I suppose. And I think that by doing this research, talking to people has helped me in realising what other people are going through basically.'

When presenting the early work of the research group to the Doncaster FIS mental health BME implementation group, Mehmooda explained how she came to realise through interviewing people in her own community that she herself can make a difference, by listening and comforting. It was through this chance of the research that Mehmooda came to this awareness of the positive role she could play.

Mehmooda described how the teachings of Islam on bereavement recommend sharing experiences to relieve grief.

'You know in Islam if somebody close, somebody you know, has lost a loved one, it is recommended you go and visit that person for the first three days and try and talk to them.
And so many people visit that every time a new person comes to visit them they talk about their experience, what has happened. And I think it's a good thing. But at the end of those three or four days you've more or less said everything that you want to say about what's happened. And then you settle down, and it's recommended that you look after that person as much as possible.
But it's recommended that you do this, you know, religiously. It's recommended that you do it for the first three days, but not to carry on. Because then it actually prolongs their agony, every time you go and every time you discuss. It's good just to get everything over and done with and start life again.'

Communication and the role of interpreters

In this discussion we have highlighted the importance of communicating with others, sustaining good relationships and the value of a sympathetic listener. English was not the first language of many of the participants in our research and much of the research was carried out with the use of interpreters. Interpreters and interpretation services are crucial to effective services and key to a supportive community.

Two members of the community research group were professional interpreters (Gulcan and Linditta). They confirmed the *'many roles of the interpreter: translation, cultural broker, cultural consultant, advocate, intermediary, conciliator, community advocate, link worker (sign posting), bilingual worker (clinical role)'* (Phelan 1995).

Tribe and Brunner (2002) advance the Audit Commission's recommendations that interpreting and communication resources should be available to all non-English-speaking service users, and promote a requirement for training, both for practitioners (clinicians) and interpreters.

Mental health services in Doncaster

Barriers affecting service access or use identified in our research were less than those for migrants accessing all public services in the UK shown to be prevalent in a recent review by Arai (2006). Findings from the questionnaire did indicate that

women were proportionately more likely than men to have experienced inequalities by services.

When we discussed, hypothetically, in our research group, what our advice would be to a friend who required mental health support, we all arrived at similar actions. We suggested that our hypothetical friend talk about their feelings and decide if they need any help. If they feel depressed, listen to them and suggest they go to a GP. The research showed that most people are aware of their GP and 94% have used the services of a GP.

If they do not want to do this then we suggested asking them if they would like spiritual help or introducing them to other people with whom they can speak. Friends and family were other people to whom respondents would turn when needing help with mental ill-health.

We also suggested that they try to involve them in something positive such as courses at the Women's Centre. Our findings show that people feel good about themselves when they are active.

Talk about their problems and advise them about counselling. Ensure them of your confidentiality and security and offer them friendship and support so that they do not feel like they are on their own. Advise them to go and see a GP or go to hospital. If a doctor has prescribed tablets, try and find out if the doctor had suggested anything else apart from tablets that could help, such as someone to talk to such as a counsellor. Whether the doctor suggests counselling, tablets or refers them to a consultant at the hospital, support them and try to talk to them and see if there is anything you could do for them. Try and listen.

As a group we thus developed an opinion of services allowing choice, being informative and being integrated and co-ordinated. We recognised the importance of friendship and community links and the part that we can play in supporting the mental health of others. Friendship and community links might be nurtured and supported for asylum seekers, refugees and migrants by the work of centres such as YWCA Doncaster Women's Centre and religious centres.

We also made an assumption of openness when talking about mental health issues with friends and of GP medical centres being welcoming to the BME community. Our research shows that while half were satisfied with their GP, half were not. So there is room for improvement. Poor GP services not only affect service users but also affects their family and carer. Newbronner and Hare (2002) highlight the importance that carers of people with mental health problems placed on the manner in which services are provided to service users.

Women-only services

Women-only services were essential to appropriate mental health services for 47 of the 70 respondents suggesting enhancement of current services from our research.

The Department of Health's report '*Women's mental health: into the mainstream'* (Department of Health 2002) advocates women-only community day services where women can 'meet with other women to share concerns and experiences'.

> *Women only services are highly valued by the women that use them. They can provide a non-stigmatising source of support and inspiration for a wide range of women. Some women speak of the sense of social isolation that they feel when they are at home with families, especially if they are struggling with mental ill health. […] By encouraging creativity, participation, learning and relaxation these services can help women increase their self-esteem and develop individual coping and protective strategies.*

The report stated that the majority of women-only day centres were provided by the voluntary sector (Keighley Women's Centre, and) and recommended that service development should '*build on these services where they exist.'*

Women taking part in this research confirmed the importance and effectiveness of YWCA Doncaster Women's Centre to women in Doncaster and the centre seems an obvious service to build on.

Black women's issues not taken seriously by service commissioners

A postal survey of 318 local mental health user groups in England revealed that women and black women in particular, do not report positive experiences of local groups taking up their issues (Wallcraft and Bryant, 2003).

During this research Doncaster West Primary Care Trust appointed three Community Development Workers to Delivering Race Equality posts. Service commissioners at the Primary Care Trust had consulted with members of our Community Research Group, who spoke of our finding that not offering women-only services prevented some women from communicating their needs and from accessing services. The appointment of three men to the three posts implies that women's issues were not taken seriously, in keeping with the findings of Wallcraft and Bryant.

The role of the voluntary sector

Kamaldeep (2002), in a study of mental ill-health in London, reported how different ethnic groups remain dissatisfied with their GP due to longer waiting times and the absence of same-sex GPs. He suggested that the voluntary sector had a role to play in the delivery of *'quality effective care'* and that the *'fragile position of voluntary sector organisations'* should be addressed. He also reported that the role the voluntary sector could play in addressing high levels of psychiatric disorders among refugees, where children are often neglected as a focus for therapeutic attention.

In their scrutiny of the comparative costs of in patient and community mental health services for BME and white individuals, SDMH (2006) suggested that there was *'scope for spending money differently'* and they recommended a role for the voluntary sector to *'influence the process of commissioning'*.

Thus it would seem that the voluntary sector has two roles it could play: in augmenting services provided by the statutory sector; and in commissioning.

Spiritual support in mental health

I (MH) believe that to have spiritual help and guidance when someone is suffering from depression or any kind of mental health problem, helps to strengthen one's inner self to be able to cope with the problems with a clear mind and gives a truer perspective on the issue. Islam teaches than when a soul is deprived of the belief in God, it suffers and therefore the whole body suffers and is unable to cope with stress or problems both mental and physical.

To have discipline in life is very important. The discipline in religion gives us structure in our lives and the skill of self control, which empowers a person to take hold of a situation and begin to turn it around. Many acts of worship are like meditation, in the sense that they help to cleat the mind of negative thoughts, put things into perspective and encourage people to think positively. However in times of stress, people tend to forget or neglect this self-discipline and worship or meditation. This is why spiritual advice at these times is even more important.

It is common in the Muslim community to support and advise people with problems in a way that is both practical and spiritual. For example, a person with a severe physical illness affecting their mental health might be encouraged to seek alternative medical help, but also advised to perform certain prayers and acts of worship to help strengthen their patience and resolve during a difficult time. Taking advice from an Alim or Alima, a qualified and respected person who has studied religion and faith in depth, would allow a Muslim to act with confidence and have faith in the support they were receiving.

More generally, to include all faiths, spiritual help would be advice from a person who has experience of life and a deeper knowledge of faith. Someone who has studied and is qualified to give advice, someone who is trusted and whose consultations would be completely confidential. Spiritual support will strengthen a person's confidence in their actins and their resolve to cope with their problems.

How we changed

'I think as far as I'm concerned […] First of all, for myself, I used to think I'm quite weak in certain situations, but after going through and talking to people and seeing how they've been coping with everything I felt I was quite strong in myself. I think that helps in a way because then you know, I know in myself I can do things – and everybody goes through a weak patch anyway. So basically that's what I felt' - MR

Through this research we have become more organised. We have learned to work as part of a team, improved our listening skills and have more respect for others. We have more knowledge about mental health services and can give more advice regarding mental health issues and can direct people to seek suitable help. We have gained a realisation of our own mental health and recognise the value of talking.

The research has improved our self-confidence and has given us the feeling that we have something to offer. It has brought about the confidence to do other things which before we would not have had the self-confidence to do.

We have learned to be more patient and understanding, some of us even with our own families and children. The research has encouraged other topics to be spoken about more openly such as alcohol and drugs which before we would not speak

about so much. It is important to understand these issues, which affect our lives today. It is no good to judge people; it is good to support them.

In carrying out the questionnaire we have been able to do something for ourselves and have enjoyed working within the team and meeting with the research group.

'I feel that I've got a little bit changed, you see. First of all I feel confident talking, not like before […] Really I gave a lot of experience and ideas I discovered. I told you before my community is completely different. I don't know what are the asylum seekers' problems, I don't know the refugees' problems, so I know the problems from this group actually from the questionnaire that my colleagues had, talking about asylum seekers and refugees.
[…]I have long time this country doctors are moving from place to place. Wherever I go, we meet colleagues; all of them are doctors sharing the same thinking, the same hopes, the same – everything we are equal on. Even the economical, you know, we are the same level – we're getting paid the same, everything is the same, our children the same. So really what I know, I have a lot of ideas, because I am very very limited. I'm very limited. I know only the doctors. So really, I've got a lot of experience now. I know what the world is.' - EB

What's next?
We would like to carry out more research about the community, particularly social aspects. Topics to be researched could include employers' attitudes towards Asians, children's education and study, racism and bullying in schools especially in the BME community.

Our reflections

We would like to thank the university for all the support we have been given. We are very positive about the tutors and all aspects of the course in general. We would however suggest that the workshops be staggered so that they are delivered when they are required rather than all at once. For example, the workshop on writing the report should take place just before the report needs to be written. We would also suggest that workshops are not organised during summer holidays because of potential childcare problems. Furthermore there should be more flexibility in gaining the qualification. Currently if workshops are missed it is not possible to obtain the qualification

It has been a good opportunity to be part of the research and it has increased our awareness of different cultures. We have also received good support throughout from YWCA Doncaster Women's Centre and have enjoyed celebrating International Women's Day.

Sanije 1
So far our group has achieved so many things. First we designed the questionnaire and focus groups, interviews and data collection. My contribution was to gather as much information as I could. This takes us hopefully to achieve better services for BME communities

My fears and concerns were how to have access with participants

What help did this enlist?
Better information

The data collection methods that our team used were:

- Participant questionnaires
- Interviews
- Focus groups

The advantage of the questionnaire is that it is less expensive. You do not interview respondents so you save time and human and financial resources. It also offers greater anonymity as there is no face-to-face interaction between respondents and interviewers.

The questionnaire also has several disadvantages. It is important to note that not all data collection using this method has these advantages. Also we should be aware that not everyone returned the questionnaires.

Sanije 2
During my time on this project I was part of the research team. First I attended two workshops on mental health issues then three workshops on the community. After all these workshops we started to meet every week with our team to complete the questionnaire. I was also involved with the focus groups and I gathered information.

I would like to be able to help people and support them and also be part of other projects. It is very important to me to be able to support people from my community. The reason for this is when people have got different issues I will be able to talk to them and to have confidence in myself. I would do this as soon as I can. My action is going to be to learn new things to be able to achieve this goal.

What obstacles did you have to get around?
Communication time and commitment: whether I would be able to do it or not as sometimes it is difficult to get in touch with people.

My main concern was whether I would be able to do the one-to-one interviews because people from my community may not understand about mental health. What action did you take? Help and support from our team and Nadia and through focus groups and interpreters.

What help did you enlist?
More information about mental health, I enlisted easily available information.

My personal skills are being able to communicate with different people and being part of this project. It is a very big thing because now I have strong confidence.

I have developed my communication with people, patience and how to organise within our team etc.

What this means to me now is to be involved in other projects in order to make a difference to my own community especially for women. My goals are to learn more new things, especially to improve the language to be able to help people.

Mehmooda
As a group we achieved many things, and the most important is the ability to work together as a team, recognising each other's skills and qualities and respecting each other's views.

We organised a steering group to help us with the questionnaire and we have put together the Ethics Form, which has been approved. We have devised a Consent Form to gain consent of participants. We have put together a Confidentiality Statement, assuring the participants complete confidentiality. We have devised a Covering letter to inform the participants of NIHME Mental Health programme.

We have piloted the questionnaire in a focus group and in one-to-one interviews. The questionnaire has been translated into many languages to have a wider involvement of the BME communities.

From the workshops amongst other things we have learned how to analyse data, compile a report and summaries and give recommendations.

My personal contribution is representing my own community. I have done one-to-one interviews and helped in focus groups to translate and scribe. I have translated the questionnaire into Urdu. I have contributed to the groups understanding of my community and helped to compile all the necessary forms.

The main obstacle was the Ethics Form, which we had to amend many times. We approached UCLan and argued our case that the fact if the Ethics Form in principle is right than the wording of it is the way the group has chosen. The Ethics Form has been approved.

Some of our researchers cannot speak English but wanted to take part in the research and represent their communities. We approached UCLan and persuaded them that it would be beneficial for the research if these members could take part with the help of a translator. They agreed.

Translating the questionnaire was helpful in accessing the people who normally would not have been able to participate. We enlisted the help of a stirring group, and the YWCA Doncaster was also helpful in accessing the BME community.

Determination, patience and self-confidence are certainly qualities I have developed during this research. Working on the questionnaire, Ethics Form, doing presentations, focus groups and one-to-one interviews have all helped to develop these qualities. Time management and efficiency are also skills I have developed during this research.

What this means to me now is I have become aware of my own abilities and feel committed to developing my learning skills and would like to do further research work.

Emitiaz
Things that our group has achieved so far in the project:

- Attending workshops

Was interesting being part of the project and important source of information collection, sharing ideas with others

- Attending conference

Have listened to different speakers, obtained broad ideas on mental health concept including participation in two workshops

- Devised a questionnaire

We had arranged the questionnaire many times until we felt that it was understandable to participants and would be helpful to our research

- Project plan

The contribution that I have made personally

- Made the questionnaire
- Did questionnaires face-to-face
- Involved in focus groups
- Participated in the workshop
- Represented the Arabic community by translating the questionnaire into Arabic.

Through discussions and my activities in the project I did reflect the Arabic community

As the phrase ‘mental health’ is still untouchable because of its sensitivity to the participants, they are very careful and when they were answering the questions they did not open their hearts as they were frightened of any misunderstandings that would make others think they are suffering from some mental illness.

Really it is not an easy job doing a questionnaire on such a topic that everyone avoids but I did my best to be very clear in explaining the aim of the research and how it is done and what action it will take etc. And I had to speak to each person differently depending on his or her way of thinking, age, culture etc

It requires a lot of patience with people who cannot understand the aim of the research clearly so I had to choose a good time and atmosphere and was very careful in the way I asked my questions.

I had improved my English language. Also developed confidence in speaking to an audience, sharing ideas with others.

What this means to me now is…Nothing is difficult in this life. The difficult thing is what we do not know, but after we know about it, it becomes easy and interesting.

Some goals I have for myself:
Goal 1 to avoid the fear and shyness of mentioning and discussing mental illness and speak about it normally.
Why – early awareness of mental illness avoids difficulty in treating the illness later. Focusing on the importance of mental health is an essential part of general health of the human being

Goal 2: To improve mental health service in Doncaster
It is important to me because I am living in Doncaster and no one can guarantee what will happen in the future. We may need this service.
The action I plan to take is to encourage people in the community of Doncaster to convince the health authority to improve mental health care.

Ninda Randhawa
The researchers as part of our community-based research have gained the ability to challenge, gain confidence, feel empowerment, raise self-awareness, the ability to work as a team (team work), mental health awareness, organisational skills. Most of all we as a team have gained skills on how to research.

My involvement and the contribution to the Project is , organisational skills, encouraging all researchers to work as a team, coordinating the Project, maintaining equality between researchers regardless of their status. Encouraging commitment, dedication and passion for the project to succeed through motivating and setting up support groups.

One of the obstacles that we had to face was around equality. Some of our volunteer researchers are asylum seekers and we cannot as an organisation offer them any cash incentives for expenses. This caused problems with the other researchers. To overcome these fears, with advice from the National Asylum Seekers Support Team it was decided that gift vouchers would be offered. The asylum seekers would be taken to the store of their choice and be offered to purchase goods to that value e.g. Sainsbury's. This was not welcomed by some of the researchers. But in order to maintain equality this was seen as the best way forward. Discrimination didn't arise as we were able to provide all the researchers with some form of incentive. I organised transport and ensured that full risk assessments were put in place for transport for the workshops, networking events and the time out session that was arranged for the researchers to evaluate the findings. Another obstacles that researchers faced was the use of the interpreters, this was a barrier that we overcome as we challenged the University. Another barrier that we faced was the time commitment of the researchers especially in the school holidays due to child care facilities.

My main concern was to ensure that everyone was treated the same and to ensure that equality was maintained, regardless of citizenship status. To ensure that the researchers were committed to the project and that they didn't loose interest. I organised meetings outside the school holidays, as meeting in school holidays caused friction within the families. I also managed the project on a daily basis and made sure that the researchers were supported emotionally due to the feelings raised by the research.

The personal qualities that I have developed through this project are the sense of the Project to succeed: being sensitive to the cultural differences of the researchers; ensuring that we gained consent from the families of the researchers with the regard to the childcare commitments. I have gained vast experience of how to gain ethical approval and how difficult it became when the Ethical Clearance form was being filled in incorrectly. This caused the researchers great distress and myself, however what we have learnt from this experience is a step forward if we ever needed to seek ethical approval in the future we would know the procedure. I have learnt so much about the different cultures and why each of their needs is different. Through self-determination and confidence, and patience these have been eliminated. The ability to challenge is a skill and quality that we have all achieved, as we challenged NIMHE when we were told the wording was incorrect on the Ethical Clearance Form to which the researchers responded that it should not need changing.

The skill that I have developed during this project is my research skill: my ability to conduct and facilitate focus groups and one-to-one structured interviews; to compile

a questionnaire, consent form, the importance of ground rules and the importance of ethics approval. Being able identify the advantages and disadvantages of each method of research and collating quantitative and qualitative data.

What this means to me now is the sense of achievement on how this community-based research can have a significant impact on local and national services in mental health for BME communities and making a difference. Many barriers were faced as a team, however with, good communication and understanding we were able to eliminate them.

The two goals that I would like to achieve for the future are:-

(a) To ensure that the launch of the final report is successful, to address some of the inequalities that women in Doncaster face by lobbying the recommendations in the report.
(b) To ensure that the Volunteer researchers have a voice on the local FIS, so that they can influence commissioners when developing local services for the BME communities that they represent.

I will help to promote the final report with local councils, health commissioners and FIS. The report will be promoted to many local community projects and to all participants who helped to compile it. I feel that this is a positive way forward as criticism we have received from participants consulted in the past is that they never receive feedback.

My second goal is to ensure that the Community Researchers have a voice on the local FIS and Health Commissioners. This Project has helped to build the confidence, self-esteem and empowered the researchers, I feel that this is the area where their experiences and knowledge gained will help them to further progress. To further develop themselves I will encourage the researchers to attend our leadership course, which looks at developing leadership, organisational skills. It also encourages chairing meetings, taking minutes and how to conduct presentations. My belief is that although some of our researchers do not speak English this is not a barrier. This can be overcome, through the support of translation; this can be achieved as this is clearly demonstrated, as many of the World leaders do not speak English,

Recommendations

We found that most of the BME people taking part in this research (81%) did not know about mental health services in Doncaster. Of those who had used mental health services, only half had a good experience. There is room for improvement; to design services that reach out and meet the needs of diverse BME groups in Doncaster, particularly women in asylum seeker and refugee communities.

Asylum seekers and refugees suffer deeply from material and emotional loss, loss of family, friends and support networks, culture shock with the sudden change in their circumstances and environment, isolation, lack of awareness of resources available to them in their locality, poor self esteem, self worth, and ultimately lack of confidence. Long periods of waiting, with uncertainty, for Home Office decisions on asylum cases cause great anxiety among asylum seekers and has resulted a direct impact on their mental health.

Our research and our recommendations form part of the Delivering Race Equality in Mental Health Care (Department of Health 2005) action plan and aspire to make a difference to BME, asylum seekers and refugee communities in Doncaster. The action plan aims to tackle discrimination based on three building blocks: appropriate and responsive services, community engagement, and better information.

Based on our work, we recommend the following:

More appropriate and responsive services

1) Interpretation services

Not speaking or understanding English was one of the barriers to service access. 64% of respondents (59 women and 6 men) indicated that service providers who don't speak their language prevented them from going and using the services.

> *'There were a number of features that focus group participants raised about the barrier of communication. These included: the insecurity some felt by their not understanding when others are talking around them; the inability to communicate their symptoms and their needs to health professionals; the dangers of not understanding when receiving instruction about medication; and the multiple responsibilities taken by interpreters when translating for patients'*

Resources for translation services, including training and support for interpreters, should be included in all mental health service budgets to provide an interpreter at the first point where non-English-speaking BME people access the service and medical consultation. Service budgets and practice should take account of additional service time to allow for translation; realistically this is four times the time with an English speaker.

2) Counselling outreach services

76% of respondents (72 women and 4 men) thought that people with mental health problems needed counselling and 62% (61 women and 5 men) thought that wider provision of counselling would improve mental health services in Doncaster.

'I felt better when I talked about my issues and didn't need anti-depressants.

Provision of counselling in informal, women-only settings would assist effectual delivery and use by BME women who do not wish to attend mixed-sex services. Outreach service is vital to help those who are trapped in their home.

'…she was so depressed, she had young children; there was nobody that came out and gave her any help – she needed help in the community. No nurses, nobody helped her. She should have been encouraged by the health people to come to centres…'

We suggest funding and supporting two posts working from YWCA Doncaster Women's Centre: a part-time counsellor and full-time outreach worker to deliver services to women in women-only settings in the Centre and other community settings.

3) **Female Community Development Worker**

The need for gender-specific workers was voiced in all discussion groups and written in questionnaires. Seventy of the 118 questionnaire respondents wrote how they saw service improvements, of whom 47 or 67% specifically mentioned the need for women-only services.

'We have been treated badly by health services. We need a centre for women only where we can go and we can then get to know staff and trust them'

Community Development Workers (CDWs) are fundamental to the Delivering Race Equality action plan and male CDWs compromise service equality aspirations for a significant portion of BME women. A female CDW is better placed to engage BME, asylum seeker and refugee women in planning services around sensitive mental health issues. We recommend the appointment of a female CDW in Doncaster.

4) Well woman clinic

Women who have difficulty using mainstream health services used YWCA Doncaster Women's Centre when it offered a Well Woman Clinic in the past. 62% of respondents (64 women) had used the Centre and described how they felt at ease to come and receive attention from women health professionals.

'Women only services like the women's centre, when I feel down I came to the centre - used the well women's clinic'

54% of respondents (55 women and 2 men) indicated they would like services in informal settings. We recommend funding for the establishment and running of a well woman clinic in safe women-only space at YWCA Doncaster Women's Centre, which encompasses a drop-in centre with a female doctor so that people can talk about menopause, get pregnancy tests and advice.

5) Same-sex appropriate and responsive services

Women were more likely than men to consider discrimination by staff as barriers to the use of mental health services. Women from the BME, asylum seekers and refugee communities often struggle through not knowing their rights and to make requests of service providers. We recommend that statutory mental health services should be pro-active in offering women the opportunity to see a woman professional such that it does not jeopardise the service offered. The local health service Trust should carry out an audit of staff to identify and address potential gaps in particular services when providing same-sex professionals.

6) Access to information and advocacy

47% of respondents stated that not knowing about mental health services prevents them from using the services and 74% stated that not knowing about mental health prevented them from using mental health services. 66% (65 women and 5 men) agreed that better information would improve the service. There is a range of information, which supports social inclusion of particularly asylum seekers and refugees, including health services, legal advice, immigration, housing, debt, poverty, reporting racial incidents.

Such an information and advocacy service can be, and is being, provided at YWCA Doncaster Women's Centre where women are able to access information on a one-to-one basis and in facilitated support groups in a women-only environment as well. We recommend this service is developed further and in other community settings.

7) Education: training service professionals in cultural sensitivity

Research participants expressed the desire to *'be able to trust our own doctors'* with many connotations on trust including to trust them *'to know about my culture'* and how culture impacts on treatment acceptability. 73% of respondents (70 women and 5 men) indicated that discrimination and prejudice by staff would prevent them from going to and using mental health services. 69% (67 women and 5 men) would like to see improvement through culturally appropriate services.

We recommend funding for a programme of education on the culture, customs and religions of different ethnic communities for all health professionals and workers who deliver services to BME people. The education programmes need to be made compulsory through the whole organisation, from managers to community workers, and to have a participative, reflective approach which analyses organisational structures as well as staff understanding and attitudes.

'Institutional structure of the Mental Health are quite rigid and should be made more flexible to other cultural backgrounds'

Standard 1 of the National Service Framework for mental health (Department of Health, 1999) requires health and social services to promote mental health for all and promote social inclusion. Within the National Service Framework, local BME communities need to be consulted and involved in the planning of services to ensure that they are culturally appropriate.

Community engagement

8) Spiritual and religious intervention

About two-thirds of respondents (68 women and 4 men) would like to see improvements in mental health services by the use of spiritual support. *'Need to involve places of worship.'* The respondents comprised many faiths.

We recommend that a spiritual and religious aspect be integrated with mental health treatment. For Muslims, integration can be achieved through well respected, trusted and qualified Imams who are paid for consultations and are on a list of people who can be contacted by the mental health services. If it is also possible to enquire about a knowledgeable Muslim woman who can, if required, help in cases where a woman feels she can only talk to another woman.

We recommend initiating consultation with religious and spiritual centres and mental health service providers and users to address how this support might be offered, supported and funded.

9) User involvement

Research participants stressed the desire for the patient and the patient's family to have some say in the decisions made about their treatment. There was a strong feeling in some of the focus groups that patients should be involved in consultations taking place with all the service providers about their case.

'The patients are people who should be respected and not be made to feel that they do not have anything of value to contribute... Family involvement allows the family to be aware of treatment and they can also help. After all they may know the person better than the service providers.'

We recommend health professionals take account of user desires for involvement in their own treatment.

10) Right to work

Asylum seekers and refugees spoke of pressures of not being able to work as employment is prohibited for asylum seekers. Hardworking people cannot sit at home having no aims in life and feeling useless and unable to provide for

their families. People who have been in highly qualified and professional jobs and have been used to a comfortable living feel this is a waste that they do not have a way of using their ability There is a feeling of shame and of not being in control and they do not know how long it is going to last. This pressure is very destructive and many begin to suffer from mental disorders, and the whole family suffers. The waiting time for a decision for asylum seekers directly affects a person's mental wellbeing.

We recommend help for asylum seekers to use their ability to benefit themselves and the host community. We suggest the creation of a local scheme that provides services, uses their ideas and makes them feel respected and useful.

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Appendices

YWCA Doncaster Women's Centre BME activities

In the year April 2006 to March 2007, 593 women from BME communities accessed YWCA's services. They attended ESOL and IT workshops and many other learning activities, spoke up in the BME women's voice group, volunteered in the centre, gained employment, accessed information through promotional events and attended local councillors' surgeries within the women's centre. Some also made use of the one-to-one support and drop-in support groups. All activities are listed below:

ESOL and IT Training provided:

- Three ESOL courses to 149 women from BME communities
- Eight IT courses to 46 women from BME communities

Workshops, focus groups and other activities:

- Four Assertiveness workshops
- Two Cancer Awareness workshops (30 women attended)
- Three Gender Equality Focus Groups (72 women attended)
- Three Race Equality Consultations (69 women attended)
- Four Learning and Leisure Focus Groups (70 women attended)
- Two Community Safety Information Sessions (41 women attended)
- Two Fire Safety sessions (36 women attended)
- One Road safety session(32 women attended)
- Street Law Plus delivered a workshop on Welfare Rights and Asylum Seeker Issues (30 women attended)
- A show case of employment and volunteering opportunities in our local area and one NHS consulted with with the women re the role of the BME Community Development Officers (Mental Health) (31 women attended)
- DMBC Consultation into the needs of Disabled People and their Carers (40 women attended)
- One workshop on drug and substance misuse (29 women attended)
- One sexual health workshop (15 women attended)
- One presentation from National Asylum Seeker Support (NASS) team (40 women attended)
- One presentation from Black Sisters on mental health issues in BME communities (42 women attended)

The following support groups have been delivered weekly during term time:

- 12 women regularly attended the Hindu women support group
- 12 women regularly attended the Arabic women support group
- 26 women regularly attended the Asian women support group
- 20 women regularly attended Turkish women support group
- 15 women regularly attended Albanian women support group

Courses completed and received: 356 certificates of attendance. 91 of those women received an accreditation from Open College Network (OCN) in the following subjects: Natural Health and Beauty; Citizenship; Henna Art; Crafts; Holistic Therapy; Conversational English; Healthy Cooking and Eating; Food Hygiene; First Aid; Keep Fit; Yoga; Garment making;

203 individual women received one-to-one support.

BME Women's Voice :

- 33 women attended the Introduction to Voice and Leadership Skills course
- 25 women attended the BME Women's Voice Group

19 women volunteered with the Women's Centre in the Café Crèche as Translators Reception/Admin and Marketing and Promotion of events.
Four women have been supported to volunteer in the local hospital

12 Women gained employment

- in DMBC's Translation Unit (8)
- Factory work (1)
- Community development work (1)
- Shop work (1)
- Cleaning(1)

833 BME women received information and signposting at promotional events, including:

- International Women's Day (250 women)
- Key Strategic Partnership Family Event (100 women)
- Cultural Festival in the Park (50 women)
- Arts and Cultural Festival in the Market Place (75 women)
- Women's Aid Conference (30 women)
- Publicity with the Local Judiciary Service (50 women)
- Launch event of the Mayor's White Paper (40 women)
- Official opening of the Sterling Family Centre (35)
- BME Community Health Awareness Day at the Doncaster College for the Deaf (20)
- Mayor of Doncaster's 'One Strategic Voice' White Paper for Ethnic Minority communities (90)
- 'Handful of Henna' – Drama performance by Sheffield Theatres (73)
- 'Lady In Red' drama performance by Doncaster College (30)

Community research programme 2006-2007

June 2006
Researchers ready to attend the first of seven workshops over the lifetime of the project.
12th June Team Building Session
15th June Introduction to the Project and the nominated support worker (Nadia)
22nd / 23rd June Community Mental Health Workshops
29th June Networking Evaluation – Selina Ullah (Racial Equality Lead)

July 2006
11th / 12th Research Workshops
17th July Planning Day with Nadia

August 2006
10th August Introduce Steering Group to Researchers
15th August Barnsley Networking, Selina Ullah
23rd August Portfolio's Action Plan, Ethics Application, Questionnaire

September / October 2006
6-week timeframe to distribute the questionnaire, capture the focus groups and undertake the fieldwork for the research.
The questionnaire will be distributed in 6 different languages: Turkish, Albanian, Hindi, Punjabi, Urdu, and Arabic.

Focus groups
The focus groups will consist of 5 different ethnicities.
Dates for the Focus groups:

- September 26th Arabic and Albanian
- October 2nd Hindi
- October 4th Asian
- October 5th Turkish

Workshops – Wednesdays 10.00 – 12.00
Shared Lunch 12.00, Tutorials with Nadia between 12.00 – 2.00
The workshop dates:

- 13th September with support worker
- 20th September
- 27th September with support worker
- **3rd October Steering Group Meeting (10.00 – 12.00)**
- 11th October
- 18th October
- 25th October with support worker
- 1st November
- 8th November with support worker
- 15th November
- 22nd November with support worker
- 29th November
- 6th of December with support worker
- 13th December

November / December 2006
Researchers undertake analysis of data in workshop sessions

January 2007
A final report will be submitted to NIMHE

February 2007
The report will be reviewed and any amendments undertaken and the launch date and disseminating dates for the findings will be finalised

Risk Assessment

(Page 1 of 2)

To eliminate/reduce anxieties which may arise as a result of the sensitive nature of the issues being disclosed/discussed in the research work.

Person(s) responsible for undertaking risk assessment:
Diane Derbyshire.
Ninda Randhawa

Person(s) responsible for implementing support mechanisms:
Ninda Randhawa
Louise Gover

Person(s) especially at risk:
Participants of research
Volunteer Community Researchers
YWCA Workers

Risk Assessment (page 2 of 2)

Risk Identified	What measures can be implemented to minimise the risk? Please tick when support mechanism introduced. (Information given)	Date	Signature of worker
Increased anxiety levels.	Provision of a safe enabling environment. Group Agreement to be developed within each focus group, to include: • Confidentiality • Participants only need to share what they are comfortable with • Participants made aware that information that is disclosed would be collated anonymously. No personal/specific information will be passes to Local Authority, unless there are issues of Child Protection or risk of harm to self or others. De-briefing opportunities after each session for Volunteer Community Researchers. Participants made aware that should they become distressed in the focus group or individual interview, it is okay to leave the room and a worker will be available to support them. Access to YWCA workers for counselling and/or support. **(Participants)** Access to external counselling. **(YWCA Volunteers)** Provision of Helpline for out of hours support Mon – Fri, 5pm - midnight		

Letter accompanying questionnaires

YWCA Doncaster Women's Centre, in partnership with the Centre for Ethnicity and Health (University of Central Lancashire), is undertaking research to look at the experiences of Black and Minority Ethnic community's access to mental health services, and how these services can be improved and made more appropriate and sensitive to the needs of the BME community both at a local and national level.

The following questionnaire will take approximately 15 –25 minutes. **The questionnaire is anonymous and confidential and you do not have to answer any questions that you feel uncomfortable with.** All interviews are anonymous and confidential – however confidentiality may be breached if information is received that suggest the informant or any other individual is at risk of serious harm, including child abuse.

The findings form this questionnaire will be written in a report and presented to Local Government and Nationally and disseminated to various health sectors across South Yorkshire. Your name will not be mentioned in the report and when we have completed the report all recordings will be erased and destroyed.

☐ **Please tick this box to confirm that you have understood what has been said to you.**

If you would like a copy of the Report or would like to attend the launch for this Report, please provide your address, a contact number or an e-mail address on a separate piece of paper.

If you would like further information on this project or have a complaint please contact Ninda Randhawa 01302 309825or Louise Gover 01302 309808 at YWCA Doncaster Women's Centre or write to us at YWCA Doncaster Women's Centre, 21 Cleveland Street, Doncaster DN1 3EH.

Your Views on Health Services in Doncaster

YWCA Doncaster Women's Centre
Community Research Group

About this questionnaire:

We would be grateful if you could answer all our questions. All answers will be confidential and used for research purposes only. You do not need to write your name, and all your views are anonymous.

Section 1: About you

1) Please enter your postcode

____

2) What is your gender?

a ☐ Male
b ☐ Female
c ☐ Transgendered or Transsexual

3) What was your age on your last birthday?

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

4) What is your ethnicity?

a ☐ White: British
b ☐ White: Irish
c ☐ White: Other (please state)
d ☐ Mixed: White and Black Caribbean
e ☐ Mixed: White and Black African
f ☐ Mixed: White and Asian
g ☐ Mixed: Other (please state)
h ☐ Asian: Indian
i ☐ Asian: Pakistani
j ☐ Asian: Bangladeshi
k ☐ Asian: Other (please state)
l ☐ Black: Caribbean
m ☐ Black: African
n ☐ Black: Other (please state)
o ☐ Chinese
p ☐ Gypsy/Roma/Traveller
q ☐ Other group (please state)

5) Were you born in the UK?

a ☐ Yes b ☐ No

6) If you weren't born in the UK how long have you lived here?

a ☐ Less than 1 year
b ☐ 1 to 5 years
c ☐ 6 to 10 years
d ☐ 11+ years

7) What is your citizenship status?

a ☐ British
b ☐ Refugee
c ☐ Asylum seeker
d ☐ No status required
e ☐ Awaiting appeal

8) What is your *first* spoken language?

9) Which languages do you speak fluently?

10) Which languages do you write fluently?

11) What is you religion?

a ☐ None
b ☐ Christian
c ☐ Buddhist
d ☐ Hindu
e ☐ Jewish
f ☐ Muslim
g ☐ Sikh
h ☐ Do not wish to answer
i ☐ Other (please state)

12) What is your sexuality?

a ☐ Straight/ heterosexual
b ☐ Lesbian/gay
c ☐ Bi/ bisexual
d ☐ Trans/ trans gendered
e ☐ Do not wish to answer
f ☐ Other (please state)

13) Do you have a disability?

a ☐ Yes   b ☐ No

If yes, please explain

14) What is your employment status?

a ☐ Employed
b ☐ Nass support
c ☐ Voluntary work
d ☐ Student
e ☐ Retired
f ☐ Other (please state)

Section 2: Your opinions and experiences on mental wellbeing and mental ill health

15) Please tick any feelings that have affected you from the following list::

a ☐ Depression
b ☐ Guilt
c ☐ Anxiety
d ☐ Mood swings
e ☐ Feeling worthless e.g. suicidal
f ☐ Nightmares
g ☐ Poor concentration
h ☐ Memory loss
i ☐ Hallucinations
j ☐ Alcohol
k ☐ Emotional stress
l ☐ Physical stress
m ☐ Self harm
n ☐ None of the above

Please explain any experiences

16) What makes you feel good about yourself?

a ☐ Fresh in the morning
b ☐ Energy to do things
c ☐ Eating well
d ☐ Watching a film
e ☐ Good relationships
f ☐ Able to communicate with others
g ☐ Able to cope with life’s ups and downs
h ☐ Other (please state)

17) How do you describe mental ill health?

a		Stressed
b		Depressed
c		Tired
d		Emotional pain
e		Physical pain
f		Unable to cope
g		Suicidal thoughts
h		Anxiety
i		Other (please state)

18) Have you ever been ill with any of the following?

a		Depression
b		Guilt
c		Anxiety
d		Mood swings
e		Feeling worthless e.g. suicidal
f		Nightmares
g		Poor concentration
h		Memory loss
i		Hallucinations
j		Alcohol
k		Emotional stress
l		Physical stress
m		Self harm
n		None of the above

19) Did you experience any of the following in your country of origin (or before coming to the UK), or during your stay in the UK?

		Home country	UK
a	Violence		
b	Torture		
c	War		
d	Sexual assault		
e	Domestic violence		
f	Persecution		
g	Death of loved ones		
h	Detention at refugee camps		
i	Family problems		
j	Illness		
k	Financial/debt issues		
i	Other (please give details below)		

20) Since living in Doncaster have you experienced any of these issues:

a	☐	Homelessness	h	☐	Domestic violence
b	☐	Family problems	i	☐	Racism/Discrimination
c	☐	Poverty	J	☐	Language barriers
d	☐	Racial abuse	k	☐	Domestic violence
e	☐	Violence	l	☐	Illness
f	☐	Unemployment	m	☐	Financial/debt issues
g	☐	Social exclusion	n	☐	Inequalities e.g. by police, service providers, transport

Please explain any bad experiences

Section 3: Your experiences – where would you go if you needed help?

21) Where would you go if you needed help or information with mental health problems? Tick all that apply:

		Help	Information
a	Family		
b	Friends		
c	Telephone help line		
d	Internet (world wide web)		
e	Hospital		
f	General Practitioner (GP)		
g	School		
h	College		
i	Library		
j	Spiritual		
k	Other		

If other please describe where you would go

Section 4: Mental health services

22) Do you know about mental health services in Doncaster?

a ☐ Yes b ☐ No

23) What help do you think people need if you think they have mental health problems? Tick all that apply:

a ☐ Counselling

b ☐ Therapy
c ☐ Medicine
d ☐ Spiritual
e ☐ Other (please state)

24) Have you used mental health services?

a ☐ Yes   b ☐ No

If yes, why?

25) If yes, what was your experience of the mental health service in your community?

a ☐ Excellent
b ☐ Good
c ☐ Poor
d ☐ Very poor
e ☐ Other (please state)

Section 5: About local health services

26) Which of the local health services have you used in Doncaster?

a ☐ General Practitioner (GP)
b ☐ Mental health team
c ☐ Counsellor
d ☐ MIND
e ☐ RETHINK
f ☐ Home start
g ☐ YWCA Women's Centre

Section 6: Accessing Services

27) What would prevent you from going to and using mental health services in Doncaster? Tick all that apply:

		Yes	No
a	Stigma of mental health illness in the community		
b	They don't know what services are available		
c	They don't know about health and mental ill health		
d	The discrimination/prejudice by service staff		
e	Cultural differences in understanding illness		
f	Service providers do not speak the language		
g	They have no one to look after children		
h	other barriers		

28) What would you like to see that would improve mental health services in Doncaster? Tick all that apply:

		Yes	No
a	Spiritual and religious support		
b	Community network and help		

c	Culturally appropriate services		
d	Counselling services		
e	Better information easily available		
f	Link workers particularly multi-lingual staff		
g	Services in formal community settings		
h	Therapy		
i	Other recommendations		

If other please describe

Please use this space to tell us about anything else you would like to know about mental health services

Thank you for sharing your opinions and time in completing this questionnaire.

If you need more information please contact YWCA Doncaster Women's Centre Community Research Group.

NIMHE DRE community research: Focus Group Topic Guide

Eight questions with prompts

1. **What does Positive wellbeing mean to you?**
   Prompt: Fresh in the morning
   Energy to do things
   Eating out
   Watching a film
   Able to communicate with others
   Able to cope with life's ups/down
   Sustain positive relationships

2. **How do you describe mental health?**
   Prompt: Fresh in the morning
   Stressed
   Depressed
   Tired
   Emotional pain
   Physical pain
   Unable to cope
   Suicidal thoughts
   Anxiety
   Unable to sustain positive relationships
   Overeating/Loss of appetite

3. **Did you experience any of the following in your country of origin, or during you stay in the UK?**
   Prompt: Fresh in the morning
   Violence
   Torture
   War
   Sexual assault
   Persecution
   Death of loved ones
   Detention at refugee camp
   Illness
   Finances/debt issues

Focus Group Topic Guide (continued)

4. **Since living in Doncaster have you experienced any of these?**
   Prompt: Homelessness
   Family problems
   Poverty
   Racial abuse
   Violence
   Unemployment
   Social exclusion
   Domestic violence
   Racial discrimination
   Language barriers
   Illness
   Inequalities e.g. by Police
   Finance/debt issues

5. **Do you know about the mental health services in your community?**
   Prompt: General Practitioner
   Mental Health Team
   Counsellor
   Mind
   Rethink
   Home Start
   Others

6. **Have you used mental health services?**

   If yes what was your experience of the mental health service in your community?

7. **What do you think are the barriers for people going to and using mental health services in Doncaster?**
   Prompt: Stigma of mental health illness in the community
   They don't know what services are available
   They don't know about health and mental ill health
   The discrimination/prejudice by service staff
   Cultural difference in understanding illness
   Service providers do not speak the language
   They have no one to look after their children
   Are their any other barriers?

8. **What would you like to see that would improve mental health services in Doncaster?**

Notes from focused discussion groups

Hindu Women's Support Group

The needs of the community is a community centre
Our duty is expected of us it to look after the elders, as we don't put our elders in homes.
The need for gender specific services – a lot of people from our cultures do not want to go to places that are mixed they like to go to women only centres where they can provide crèche. If it is mixed the women mostly are dominated by men. We would like a Hindu mandir so that we can have our cultural events as in Leicester they have lights on. The spiritualist needs would be met. We feel that there are no services for the Hindu community in Doncaster. Activities specifically for BME communities are spiritualist needs, culturally appropriate workers from similar backgrounds. We need funding for the Hindu community, as we need a base.

We are made to feel welcome at the women's centre, we are listened to, if we need to use mental health services we will use it, but where are the services? Language is a major problem. We need more counselling at the women's centre. When we go to the doctor's we ask for a tablet because that is what is available, what else is there? We want more consultations, we want to do more discussions in the support groups, and if this can be arranged we will all come.

Recommendations for implementing services

Well woman clinic so that if they need to they can come for a full health check. They would like a GP to come at least every month and it to be run by health professionals, health visitors, and midwives, nurses, on a possibility of a walk in centre basis. To be able to have access to repeat prescriptions and other medication available. A service for women to access regarding smear tests. This service would run with a no appt system as with the GP sometimes it can be two weeks before there is an appointment available. Cultural activities- this would enable us to learn about different cultures. To be able to have access to alternative therapies, non- medical alternatives. The need for bi-lingual staff, as this would then we would not need translators. Counselling services specifically for BME Women, we need BME Counsellor

Turkish Women's Group

Present: Mehmooda, Louise, Ulviye, Gulcan

Feeling good – what makes me feel good?

Nothing makes me feel happy, eating out. If my children are happy then I am happy. I am worried about status in this country. Talking to family abroad makes me feel good

What about when you're not feeling good – mental ill health

I feel tired. I suffer a lot of racism. I feel stressed. There is too much anti-social behaviour in Doncaster. When I'm not feeling good about myself I don't want to talk to anyone. I then smoke more, drink more

People with mental health are not happy, People who are stressed have mental health, it could be that they are bullied. Not having a job for us is a major problem; we cannot go out to work so we get very depressed. We feel we are telling you about our problems as we feel that none listens to us. Loneliness in our community is a major problem. Since coming to this country I have not seen my daughter for seven years I left her when she was two years old, hopefully when she is ten I shall see her. Since being in this country my mother died from cancer and I was unable to see her before she died. People think it is easy for Asylum seekers they just don't realised how difficult our lives are?

How do you see your lives in Doncaster?
We get up in the morning; we eat and then in the evening go to bed. One woman said we have no problems. With the doctors we are treated well and it is ok. Doncaster is a good place. I have heard of no racism in Doncaster. If I knew that by coming to this country I would not be able to see my daughter I would never had come here. The reason why we had to leave Turkey is because my husband was persecuted and we had to leave the country, but since coming to Doncaster it has been no different we have faced racism, my son is always being beaten up. Since coming to Doncaster my daughter has faced many difficulties through racism and bullying she has changed schools three times, she still is finding it hard to settle. Because of this we have big life style issued; nobody cares about us we could die tomorrow, who cares about us? My house got burnt down in Doncaster through racism; I then decided to move to London. The situation in London is far worse than Doncaster so me and my family have decided to come back. Another woman said that there are too many drugs in Doncaster. I used to live in Balby with so much racism they tried to burn my house when we were asleep, there were thee people involved nothing was done to them, nobody helped us as they left at the back of the house. Because of this and our lives were at risk the police gave us an escort until it was safe for us. Another woman said that while living in Balby she face many racism a neighbour who was English helped me, even though I have moved way this British neighbour still keeps in touch she comes to us at Christmas with presents and card. There was a hit and run where one of children were hurt and the neighbours gave us lots of support, they always check us if we are aright. One woman said that when she was pregnant a neighbour took her to hospital. The problem is that Muslims did the bombings but we shouldn't be blamed for being a Muslim, if we go for a bus the driver drives off. What people don't realise is that in Islam murdering is a sin. I see that there is so much racism within the health services the doctors, nurses and the GP'S are all the same. One woman said that racism is a personal thing. These professionals show so many prejudices if they can't speak English. Sometimes they will try to listen some will give you the time others won't. I will give you an example I went to the train station to buy tickets this lady could see that I could not speak English and she shouted at me as if I was stupid, she kept shouting and shouting and I just left. Soon as the health professionals know we don't speak English they tend to ignore us.

Did you experience any in your country of origin?
Some of have not experienced torture but we know of many of the Turkish community that has been. Some of us have been sexually abused that is why we left our country. Since coming to this country things have not been any different I was sexually abused on the bus, this was when I was taking my son to school, and I hate the whistling.

Have you used mental health services in Doncaster?
We all have used the mental health services in Doncaster and we have used medication. I was so bad I had to go to the GP to go for a tablet, and the reason why I go there is because I feel that they really help me. What other help is there, where else can I go for help. When I go to the doctors I feel that they don't have any time for us, the new doctors who are young show no compassion however the older ones seem to care. Nobody wants to be depressed and once you have been told you suffer from depression you become a label. People treat you different if they know that you are depressed. When I am at home I just eat and eat, my life changed when I came to the women's centre, I started meeting people doing things sharing experiences, which has helped me to become confident and I have done many courses. I have gained so much with coming to the women's centre, without the women's centre I would be in a bad way, as I feel that depression is a label.

What services would you like to be put in place in Doncaster?
More places like the women's centre
Women's only centres
Spiritualist needs
Alternative therapies easily available (free)
I would be totally on my own if it wasn't for the women's centre
Well women clinic, the one that we had at the women's centre needs to be started again.
We know this centre is safe, we trust everyone here. It's the people that make this centre, people like you, if it wasn't for people like you then we would not come, we are made to feel very welcome.

Text responses from questionnaires

HSQ 27 accessing services: what prevents you from going and using mental health services?

*8	Women are badly treated and we need services that are for women. These services should be provided at the women's centre
*9	My family would disown me if they thought I had mental ill health they would think I was going mad, what would the community think.
*10	My family, I would bring shame on the family if I had mental health
*13	No information, no easy access, family pressure, not knowing that I need any treatment. During PMT no knowledge of what I was feeling. Menopause difficult to explain feeling so felt better trying to deal with it myself and finding it very difficult
*16	Transport
*31	money
*32	need spiritual needs for black people
*36	money – travel
*37	I need help with travel costs
*40	language barriers
*63	Ignorance of quality service. Fear of being put on dependency drugs
*74	well woman clinic at Doncaster Women's Centre
*76	cost of travel
*77	money, bus fares
*78	money, family
*79	money/travel
*81	money
*83	language barriers
*87	Ignorance. Not aware of counsellors role. BME (They don't know counsellors, only listen not judge) Re-educate role of counsellors
*88	Information 4 awareness, community perception of mental health, social exclusion
*91 – 96	(group discussion) GP 'lack of understanding and support like "what do you want us to do?" 'It is insulting, doctor does not have half an hour for you'
*102	Service providers don't speak my language but I have an access to a qualified interpreter
*118	no thing

HSQ 15 opinions and experiences on mental ill health: describe mental ill-health

*3	Nobody cares, alone in the world
*8	When you've lost it
*13	Feeling of being useless
*14	Loneliness
*17	Mood swings
*23	tension
*41	none
*82	Self harm
*84	Over eating
*87	Psysocial aspects of life. Mood disturbance

*88 Emotional instability
*91 – 96 (group discussion)
Suicidal thoughts when she has too many problems; she does not know how to solve
Stressed out
Stressed because others she knows in Kosovo suffer (can't afford food)
I can see if someone has a mental health problem
You cannot see if someone dressed up, wears make up, but feels worse inside
I wake up upset and not want to see anybody
When I think about the past I feel bad
*102 Guilt
*115 Arguments with her husband about his gambling habit affect her mental health

HSQ 15 Explanation about feelings that have affected you

*17 Loneliness and longing to have good relationship with her family
*21 When my parents died I went through emotional stress
*23 Communication difficulty – recommended by Dr. to have counselling.
*63 The media made me feel like an intruder that was unwelcome when I came to the country as an asylum seeker
*101 I hate anyone who touches me
*102 I want to walk in front of the cars at the traffic lights
*103 Fear of deportation
*108 I am missing my family. I haven't seen them for 4 years. We are talking on the phone but this is not enough (not aloud to visit during waiting for asylum).
*110 Fear of deportation
*111 Fear of deportation
*112 Heart operations
*113 She has arguments with her husband. She has attempted suicide once. She smokes 20 cigarettes a day and lost a lot of weight like 3 stones.
*114 Smoking is not a feeling
*115 My husband has gambling problems

HSQ 21 Where else would you go if you needed help?

*4 temple
*6 gurdwara
*9 gurdwara
*17 She feels by praying and seeking help through her religious believes is the beat way
*38 Red cross, Solicitor
*50 MEXBOROUGH – CHILDREN CENTRE SURE START
*56 Mosque
*57 Mosque
*91 – 96 (group discussion)
Family (mum and dad) GP for medical solution 'safe with doctor'
Sue start (all) GP
*102 I call my interpreter for emergency help so she can communicate with crises team for me to explain my needs
*108 My friends come to me for help and advice because they think I am older and wiser
*114 Stop smoking sessions failed

HSQ 28 What would you like to see that would improve mental health services in Doncaster?

*1	well women clinic at Doncaster women centre
*2	women's only services like the women's centre, when I feel down I came to the centre – I used the well women's clinic
*3	For GP's to have time to listen & women services – women's centre
*4	The women centre is good, that's what we need.
*5	well woman clinic at women's centre
*6	women's centre – for women only
*7	women's centre, for women only. Well women clinic
*8	We have been treated badly by health services we need a centre for women only where we can go and we can then get to know staff and trust them
*9	Women's only services that are confidential
*10	Women's only services
*11	My friend died from suicide she was so depressed, she had young children there was nobody that came out and gave her any help – she needed help in the community. No nurses, nobody helped her. She should have been encouraged by the health people to come to centres like the women's centre then perhaps she might have been here today. Nobody needed to suffer like she did.
*13	More awareness of mental health, people often do not know or recognise the systems of mental ill health. Young women specially after having a baby they need help and support which they do not receive and often suffer from depression or going through menopause. People or women who have left their family behind and come to Britain after getting married have a difficult time settling into their new surroundings, they need support and understanding which they have no access to. A centre which is can give women friendly and confidential support and the centre should be well publicised and women should have easy access to.
*17	To have services such that one can use them independently to access them without needing someone help
*25	more help for black people as we are blamed for everything
*26	more support groups
*27	when I feel depressed I go to church
*28	more help form the church
*29	Better services for black people
*31	Better services for black people as black people are always stigmatised having mental illness
*32	more spiritual needs for black people
*33	Better services for black people
*34	More help form mosques
*35	I like coming to the women's centre
*36	more services at the women's centre
*37	women's services
*45	a women's centre
*46	well woman clinic at Doncaster women's centre
*47	well woman clinic at Doncaster women's centre
*48	Well Woman clinic at Woman Centre YWCA
*49	"Well Woman Clinic" at Women's Centre YWCA
*50	Well Woman Clinic at woman centre YWCA

*51 Well woman Clinic at women's centre YWCA
*52 Well Woman Clinic Women's Centre YWCA
*53 Well woman clinic at women's centre YWCA
*54 well woman clinic at women's centre YWCA
*55 well woman clinic at women's centre YWCA
*56 well woman clinic at woman centre YWCA
*57 well woman clinic at women's Centre YWCA
*58 well woman clinic at women's centre YWCA
*59 well woman clinic at women's centre YWCA
*60 well woman clinic at woman centre YWCA
*63 Exploration of alternative therapies & encouragement of community/cultural informal networks where applicable
*64 WELL WOMAN CLINIC AT WOMENS CENTRE
*65 well women clinic at Doncaster women's centre
*66 well woman clinic at Doncaster women's centre
*67 Well woman clinic at Doncaster women's centre
*68 Well women clinic at Doncaster women's centre
*69 well woman clinic at Doncaster women centre
*70 Well Woman Clinic at Doncaster Woman Centre
*72 well woman clinic at Doncaster women's centre
*73 well woman clinic at Doncaster women's centre
*74 well woman clinic at Doncaster Women's Centre
*75 well woman clinic at Doncaster Women's Centre
*76 Women's centre
*77 Women's Centres
*78 Women's centre
*79 I think there should be a centre where you can have a full medical
*80 women's only services
*81 women's centre
*82 women's centre
*83 Community outreach to find out what's happening and more community workers (Black & ethnic group) to enable people to open up
*84 Education of people – workshops, seminar – opportunities for employing BME staff to Mental teams
*86 Consideration of religious background. Stop stigmatising colour of individuals. Involvement of families if any problems
*87 Need to work – Person liaison Services (PALS). Need leaflets in local languages explaining how to access services. Need to involve places of worship (Religious groups)
*88 To train up ethnic minority staff who are sensitive to cultural differences, to sure cultural sensitivity training. Institutional structure of the mental health are quite rigid and should be made more flexible to other cultural backgrounds
*89 Avoidance of long waiting time in accessing services e.g. counselling. Religious Support from individual's religion.
*90 More awareness of services to the people. Accessibility of Services
*91 – 96 (group discussion)
A lot more support and time with patient
Some professionals should recommend alternatives
*100 I wish I could access to a doctor who speaks Turkish, much better help for me
*101 We want constant help anytime please
*102 I need support with my children when I feel very low or if I need to go to hospital

*108	More activities like crafts and practical English to improve us as independent individuals
*109	Firstly we need to become more knowledgeable and make aware of mental health problems and needs. We need easily available Turkish information. We can't express ourselves.
*113	Marriage counselling for foreign males
*115	Help with addiction problems like gambling and alcohol

HSQ 21 What other help do you think people need if they have mental health problems?

*13	Helping friends and Relatives also information from GP
*14	family and friends
*21	Family & Friends support
*22	Family Support
*23	good friends
*39	GP
*63	YOGA REFLEXOLOGY
*64	church
*102	Home visits from CMH
*108	I have not offered any other service but just medication
*112	Friend
*113	Good marriage

HSQ 13 Disability

*75	I have heart problem
*101	I a m suffering from back pain for seven years
*109	Yes I can't use my arm

HSQ 14 Employment

*2	Housewife	*37	Housewife	*76	Housewife
*5	Housewife	*39	Unemployed	*77	Housewife
*9	Housewife	*40	Housewife	*78	Unemployed
*10	Housewife/shop owner	*48	Unemployed	*79	Housewife/mum
*11	Shop Owner	*53	Unemployed	*80	Housewife
*12	Housewife	*54	Unemployed	*91	unemployed
*13	Housewife	*56	self-employed	*92	unemployed
*16	Housewife	*57	self employed	*94	income support
*18	Part-time	*59	unemployed	*95	income support
*19	Self employed	*61	unemployed	*96	unemployed
*20	Housewife	*66	housewife	*100	housewife
*21	Housewife	*67	housewife	*104	housewife
*22	Housewife	*68	Housewife	*105	Housewife
*23	House wife	*69	House wife	*112	Housewife
*32	Unemployed	*70	house wife	*113	Housewife
*34	Benefits	*71	unemployed	*115	Mother
*35	Unemployed	*72	Housewife	*117	Housewife
				*118	Housewife

HSQ 4 Ethnicity

*35	Thai	*55	Sri Lanka	*106	kurdish
*38	Kosovan	*56	Pakistan	*107	Turkish
*39	Kosovo	*59	Afghanistan	*109	Turkish
*40	Kosovo	*66	Iraq	*110	Kurdish
*43	Kosova	*67	Iraq	*112	Turkish
*49	Latin American	*68	Iraqi	*115	Turkish
*51	Europe	*69	Iraqi	*116	Turkish
*52	Turkey	*70	Sri Lanka	*117	Arab
*53	Sri Lanka	*71	Arabic	*118	Arab
*54	Sri Lankan	*72	Arabic		

HSQ 20 Experiences since living in Doncaster

*8 When the police may you feel different when you are not white
*9 bullying at school
*10 Bullying at school, being treated unfairly
*22 Feeling out of place in public places, a sense of not belonging here because of people's attitudes
*91 – 96 (group discussion)
Very kind British people during stay in refugee camp (Finningley Doncaster)
Homelessness and financial support stopped: husband is heart patient, their case closed and evacuated from their home; husband went to hospital (upset)
*99 Bus driver never stopped
*101 As asylum seekers employment is prohibited; my husband is at home all the time this creates arguments
*102 Mental Health Problems
*108 Yes, in my GP, I was not finished but my GP & my interpreter were finished with me, I was still sitting down, they were already standing up. I mean they don't give you enough time.
*109 GP's are not sensitive, they don't listen just medication
*113 They don't take prams to the bus. It is very difficult to travel with two kids
*115 After my daughter force to have second baby

HSQ 19 Experiences at home/ and in UK before coming to Doncaster

*13 Death of my parents
*91 – 96 (group discussion)
Albania/Kosovo refugee camp (very good)
Death of loved ones
Trauma
I have lost my independence because of moving away from family
*100 I have been in detention refugee camp for 9 days. They gave me very little milk for my baby and I didn't have nappies. It was very difficult
*102 Drug addiction in Turkey
*103 Racism (UK)
*108 Racial abuse in the UK: They have broken our windows. They have written swear words on our walls. My 21 years old son has beaten up.
*110 Racism (UK)
*113 This is my second marriage, I wish I could divorce
*117 People trying to take off my scarf in the street

HSQ 16 What makes you feel good about yourself?

*2 Happy
*3 Being me
*5 Good relationships with my children. Being alive
*9 I like shopping and wearing nice clothes, spending money
*10 Shopping, travelling, buying and wearing new clothes & wearing the latest fashions
*11 about being able to be me
*13 Being able to work in the community to bring about better understanding. To have my family near me. To see them happy. To feel well.
*16 shopping
*17 Be a good Muslim. Having time for her self. Able to carry out all her Islamic duties as a mother and wife and daughter would make her feel more complete
*21 Helping others. I feel good when I have fulfilled my religious duties
*22 Being helpful, able to help others. Having time to do my prays in a relaxed way, having time to read and gain knowledge
*23 good weather
*26 being able to work
*27 feeling healthy
*28 gardening
*29 I like going for walks and gardening
*31 Being myself
*32 I enjoy sleeping
*33 I like shopping
*37 I like to be a mum. I like to shop
*45 I like eating
*79 I like to have fun
*80 I like shopping
*82 Reading
*91 Good health (physical). Children happy and successful and respectful
*92 Children happy and successful and respectful
*93 Travel, visit, communicate with family abroad
*94 Travel, visit, communicate with family abroad
*95 Permission to stay in UK
*96 Being in control
*100 I want to meet other people
*102 If I don't meet any Turkish people I feel good
*113 Good husband

HSQ 11 Religion

*2	Catholic	*28	Catholic
*27	Catholic	*32	Catholic

HSQ Experience

*33 My brother used mental health services and had a bad experience
*102 I started to receive much better service with my second nurse because she is consistent
*113 confidential

Publicising our research

Research Project based at YWCA Doncaster Women's Centre

"WOMEN FROM BME COMMUNITIES GET THEIR VOICES HEARD"

In December 2005, YWCA Doncaster Women's Centre were successful in securing funding from the National Institute for Mental Health and the University of Central Lancashire to conduct a research project in Doncaster into "The barriers women from Black and Minority Ethnic women experience in relation to accessing statutory mental health provision."

What we aim to achieve through involvement with CVS's Spotlight in Info is an opportunity to share the experience as widely as possible on a regular basis. We want to keep you informed on activities planned, provide you with information on how you can become involved and participate in the experience with us to have your voices heard in the endeavour to be part of improving services. **We are inviting you to:**

- Share in the story of the journey the research is taking
- Receive updates on what is happening that may be of interest to some of your service users
- Provide an opportunity for as many women from BME communities to participate in the work

THE STORY SO FAR

In June 2006 the community researchers we recruited from our existing work with BME women were poised to engage with a series of seven workshops to equip them with research skills and mental health awareness. Some of the researchers are going onto achieving formal qualifications as community researchers which can contribute to a degree in community research. This is the timetable for activities:

- June 12th – Team Building session
- June 15th – Introduction to Nadia Ahmed the support worker from the National Institute for Mental Health
- June 22nd/23rd – Community mental health workshops for researchers
- June 29th Networking event with other research projects
- July 11th/12th – Research methods workshops for community researchers
- July 17th Doncaster's research project planning day with Nadia
- August 10th – Researchers introduction and meeting with the project Steering group
- August 15th - Networking event with other research projects
- August 23rd – Portfolio's action Plan, Ethics application, Questionnaire

SIX WEEK TIME FRAME
Over the next six weeks we are conducting the questionnaire survey, holding focus groups and carrying out fieldwork out in the community by the community researchers.

If your organisation would be interested in hosting a meeting let us know. Our researchers would be happy to work with you!

The questionnaire will be distributed to women on our database which totals in excess of 650 women from BME communities and will be available in 6 languages:

- Turkish
- Albanian
- Hindi
- Punjabi
- Urdu
- Arabic

The focus groups will be made of 5 differing ethnicities and be conducted within a support group setting at YWCA Doncaster Women's Centre. These groups will be facilitated by the community researchers supported by translators and scribes. Refreshments will be provided and all participants will receive a gift voucher as a token of our thanks and appreciation for their involvement.

FOCUS GROUP DATES

- October 2nd Hindi
- October 3rd Arabic and Albanian
- October 4th Asian
- October 5th Turkish

During November and December 2006, the researchers will undertake an analysis of all data collected with the final report being submitted to The National institute for Mental Health in January 2007.

We hope you have found this article to be informative and if you are interested in finding out more about this exciting project or feel that you would like to be involved please contact Ninda Randhawa or Louise Gover on 01302 309808 or 309825.

Specification for women-only community day services

Outline service specification for women only community day services

This specification should be considered in conjunction with the sections describing the development of gender sensitive services (see sections 5 to 11).

Service design principles

Women-only community day services should:

- be staffed by women
- aim to promote self-esteem and empowerment
- be flexible and responsive – to the range of women's needs and at times that are convenient for them
- be safe and confidential
- allow open access
- be supportive and welcoming
- have an holistic approach to health and wellbeing
- use appropriately trained staff and volunteers, with mental health focused training programmes for volunteers and paid workers
- take account of women's parenting
- responsibilities, e.g. consider the need for crèche or childcare facilities
- be accessible to all women by taking account of diverse needs of race, culture, religion, age, disability, sexual orientation, where they live and their caring responsibilities
- maintain strong links with primary care, community mental health teams and other voluntary/statutory agencies

YWCA Doncaster Women's Centre's proposal for a part-time counsellor

The current BME Women's Project at YWCA Doncaster Women's Centre has been developed initially from a very small pot of funding from the Healthy Living Fund. With further contributions from the Healthy Living Fund and the Big Lottery Fund, the Project has now developed in size to approximately 100 women per week from 26 different countries of origin. There is currently a high level of partnership working in place.

Since March 2006, the women on this project have been involved in a community engagement research programme with support from the University of Central Lancashire and the National Institute for Mental Health in England. This project was involved in researching the experience of BME women accessing mental health services and how services could be improved to facilitate a more appropriate and sensitive approach to the needs of BME communities both locally and nationally. This research is due to end March 31st 2007. A number of priorities, identified needs and themed issues are currently being acknowledged through this research.

A consultation was held with approximately 60 women from differing BME communities with the local councillor Glyn Jones, Elaine Spiby and Anne Kingswood from the Social Inclusion and Equalities Team where a number of specific issues were raised by the women in relation to their health.

The research undertaken highlighted the following as specific issues, which have a profound effect on their mental health

- Experiences around fleeing from war zones
- Rape and sexual crimes
- Depression and anxiety
- Poor housing
- Isolation and loneliness
- Poor health
- Domestic violence
- Stress
- Forced marriage issues
- Racial hatred
- Practical issues associated with living within a westernised society – e.g. understanding procedures involved in accessing services, particularly health services
- Fear of stigma associated with mental health issues
- Barriers of communication when attending GPs due to time constraints and language issues, e.g. even if these women have learned English language it is often difficult to express emotions/feelings when not using their native language
- Pressures around talking to health professionals who have no understanding of their cultural values and beliefs
- Coping with loss/bereavement

This list is not exhaustive and many of the above issues have a direct impact on mental health and there is an association between the likelihood of mental ill health

and social and economic issues such as poverty, poor education achievement, unemployment and social exclusion. Racism and discrimination, as well as family and social support networks can also affect the course of mental ill health.

Over the last 4 years it has become apparent to us that women from BME communities do not fully engage with local mental health service provision or YWCA counselling services. This may be due to the stigma that women face when accessing these services. This has highlighted the need for a specialist BME worker to work closely with these women offering one-to-one counselling as well as group sessions around areas of identified need, such as: post-traumatic stress; domestic violence; rape and sexual abuse; anxiety and stress.

With our current funding we are unable to meet these complex issues. Therefore we are seeking additional funding to employ a part-time counsellor who will be able to deliver one-to-one counselling and group work with a therapeutic and culturally sensitive approach specifically for BME women. This would be a pilot project in which to explore innovative and creative ways of working with BME women. We aim to provide an evaluation of our learning at the end of the project.

Estimate of costs for the pilot project

Counsellor 20 hours per week *	£ 20,647
Translator £10 per hour x 12 hours per week x 48 weeks	£ 5,760
Staff clinical supervision	£ 600
Travel and Expenses - Staff	£ 100
Photocopier Expenses	£ 100
Postage	£ 100
Stationery	£ 100
Telephone Expenses	£100
Refreshments	£ 50
Participants Travel	£ 1300
Electricity, Gas and Oil	£ 200
Resources and Materials	£ 100
YWCA Support Costs 15%	£4,373
Total	**£ 33,530**

* The number of hours this service provides could be increased or decreased depending on funding available.