

**REPORT OF THE COMMUNITY LED RESEARCH PROJECT FOCUSING ON:**  
“Investigating the extent and impact of isolation and loneliness amongst ex-service users and carers.”

**BY: THE WILTSHIRE TRUST (Registered Charity: 1064979)**  
**COMMUNITY IN: Southampton, Hampshire, South East**

**AUTHORS:** Caleb Alfred Brewah, Gregory Richards, Phil Simmons, Nor Gure

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The Centre for Ethnicity and Health, University of Central Lancashire.



## The following people were involved in the development of this project

**Caleb Alfred Brewah** – 27 years old. I am a black male from Sierra Leone, West Africa and attending Eastleigh College presently studying plumbing whilst working as a ‘researcher’ for the Wiltshire Trust. I feel this project will give me the opportunity to help identify problems facing black and minority ethnic people in mental health services. This project will improve my prospects to gain a qualification and experience but most of all keeping my options open for future job opportunities.

**Gregory Richards** – 48 years old. I am a black male originally from the Caribbean, came to England in 1966 and settled in Birmingham. At present, I work for a Housing Association as a project worker, supporting service users who have mental health issues. It has been a mission of mine to work in any capacity with people from black and minority ethnic communities. Now I have been given the chance, I am really enjoying the challenge of being part of a research team. It has helped me to develop new skills and also to gain one of three qualifications that are recognised nationally through the University of Central Lancashire for Ethnicity and Health.

**Nor Gure** – 36 years old. I arrived in the UK 8 years ago and now live in Southampton. I am actively involved in my community and in building bridges between all cultures. I am Chair of the Hampshire Somali Welfare Society and take part in a number of other forums. I am presently studying for a Certificate in Community Mental Health at Southampton City College and it is a great opportunity to enhance my qualifications. I am actively participating in raising awareness of the positive contribution refugees can offer to society.

**Phil Simmons** – 49 years old. Lead ‘researcher’ and co-ordinator of this Research Team. My main asset which I brought to this team was my experience working with the Wiltshire Trust since 1996, and was instrumental in our two previous pieces of research; Black Survivors – “Hear my cry” 1998 and “Is anyone listening” 2003. My greatest wish is for this research to help alleviate the underlying problems, which are associated with isolation and loneliness on the wards and within the BME (black and minority ethnic) communities’ mentally ill clients and carers.

## ACKNOWLEDGEMENTS

We would like to extend our sincere thanks to the ex-service users, carers and those from the service providers sectors (strategic personnel, statutory, clinical) and voluntary sector services who gave up their time to be respondents in this research.

### Special thanks go out to:

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- Poppy Jaman, our South East Race Equality Lead
- Beverley Meeson, Focussed Implementation Site’s Co-ordinator
- Norman Powell and Anthony Kollie, our Support Workers from University of Central Lancashire, Centre for Ethnicity and Health
- Solent Mind and Wendy Kennard for the accommodation for the research group and a venue for the respondents
- The Project’s Steering Group ~ ‘Satisfaction with services’ Sub Group to the Focussed Implementation Site, Hampshire Partnership NHS Trust
- Southampton Public Health Primary Care Trust

- East Hants Fareham and Gosport, Hampshire Partnership NHS Trust and Portsmouth PALS (Patient Advice and Liaison) Services
- Portsmouth Race Equality Network Organisation
- Portsmouth Race Equality Lead, Isle of Wight Race Equality Lead
- Adult Community Services - Isle of Wight,
- Bangladeshi Welfare Association – Portsmouth
- Empathy – Southampton.

We are grateful for your dedication and time spent on this community engagement project.

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## Executive Summary

### Introduction

Research over the past three decades suggest many black and minority ethnic people suffer from deprivation and poor follow up care after hospital admissions and are more likely to be admitted to psychiatric wards following contact with the police, (**according to Bebbington *et al* 1994, Bhui *et al* 1998, Pakman *et al* 1997 and Rogers and Faulker *et al* 1987**).

Many are likely to be admitted to compulsory detention under the Mental Health Act through the judicial system (**Takei *et al* 1998**) and (**Department of Health Home Office 1992**). We were researching the association with the much-documented high rates of psychiatric admissions and compulsory detentions of black and minority ethnic people to psychiatric inpatient units in Southampton, Hampshire.

We investigated to argument the Delivery Race Equality two characteristics:

- A reduction in the rate of admission of people from BME communities to psychiatric inpatient units;
- A reduction in the disproportionate rates of compulsory detention of BME service users inpatient units;

**Aim:** To investigate the extent and impact of isolation and loneliness on inpatient wards and the communities and to look at ways to reduce it.

**Objective:** To identify the needs of black and minority ethnic service-users so that their experience of using mental health services can be improved leading to reduced isolation/loneliness and an improvement in their mental health well being.

## METHODOLOGY

### RECRUITMENT

The recruitment of the researchers was made by advertising for the positions through the black and minority ethnic ex-service users and carers groups around Southampton and Hampshire. Four researchers were recruited, one ex-service user, a supportive housing care worker, a Somali part-time student and another from the voluntary sector.

### TRAINING

Training arrangements were compulsory and provided by the University of Central Lancashire personnel. There were seven workshops delivered, focussing on giving participating groups vital information on delivering race equality in mental health practices, mental health polices, research methods and analysing data between June and November 06. This process was linked with an accreditation in a University Certificate Level 1 qualification after attending workshops.

### SUPPORT

The researchers were supported by the support workers system at the University of Central Lancashire on a fortnightly basis. The Steering Group of the project, Focussed Implementation Site's 'Satisfaction with services', group also gave us support and guidance.

## STEERING GROUP

The Steering group was made of a number of organisations from the statutory, mental health care trusts and voluntary agencies from Southampton, Portsmouth and Hampshire and the Isle of Wight.

## CSIP (Care Service Improvement Partnerships) National Institute for Mental Health in England (NIMHE) involvement

The South East Development Centre in Guildford through our Race Equality Lead supported this research project by giving us the opportunity when we presented our preliminary work to the “New ways of working” conference attended by Dr David Sallah (Delivering Race Equality programme Lead) back in November 2006. The National Institute for Mental Health in England funded the project.

## RESEARCH DESIGN

We used an independently designed semi-structured questionnaire formulated by members of the research team. The questionnaire was made up to investigate the following areas, which we placed under following areas:

### AREAS INVESTIGATED

- ✪ Adding activities on wards.
- ✪ Combating isolation and isolation on the wards
- ✪ Spiritual needs for wards to help in-patients.
- ✪ A ward scheme to enhance social interaction
- ✪ A black and minority ethnic support group for ex-service users
- ✪ A targeted information service for the wards and communities
- ✪ Accessing voluntary service after leaving the in-patients' wards
- ✪ Enhancing cultural and diversity training for staff

TWT Research Team, Southampton CE Project 06

The ex-service users and carers' questionnaire had 8 areas with 39 questions and the service providers' questionnaire had 7 areas (research team felt the support group area should be answered by the ex-service users and carers) with 23 questions (**see both in Appendix 10 and 11**).

## PARTICIPANTS

We asked a sample of 52 participants from ex-service users/carers groups and service providers (20 ex-service users, 10 carers and 22 service providers). The sample looked at people between the ages of 16 to 50+ for participation in the survey. We had 20 males and 32 females, which took part in the research into isolation and loneliness.

## PLANNING

The researchers brainstormed the specific areas around isolation and loneliness on in-patient wards and in the communities. In total 8 areas were identified to investigate, 4 within the wards and another 4 within the communities. Questionnaires were formulated with list questions for respondents' views.

## ETHICAL APPROVAL

The research tool's Performa was formulated using the University of Central Lancashire's guidance document supplied in our handbook. We registered the survey with the Hampshire

Partnership NHS Trust's Research and Development for 'a service evaluation of staff associated with in-patient wards' it was obtained in November 2006.

## INVITATION

This was carried out by an invitational letter sent out to sets of groups, (i) ex-service users (ii) carers and (iii) service providers for acceptance to partake in the research.

## INTERVIEWING PROCESS

All interviews were conducted between 9-5 p.m. at an office at Solent Mind. Interviews were arranged through lead researcher and appointments finalised to suit ex-service users or carers. The core data form elicited information concerning age last birthday, gender, ethnicity, were they born in the United Kingdom, length of time lived here, resident status, first language spoken/written, first language fluent spoken/written, religion, sexuality and disability status.

## ANALYSING RESEARCH DATA

All questionnaires were analysed by thematic content analysis (**Krueger R.A. 1994**) as suggested by our University of Central Lancashire tutors. We circulated all transcribed comments from respondents to our Steering Group to get peoples' suggestions on possible themes.

## RESULTS

In total there were **52** respondents in this piece of research looking at the impact of isolation and loneliness in the BME (black and minority ethnic) on the in-patients wards and the communities in Southampton, Hampshire. The following is a summary of the core data, questionnaires results from the ex-service users, carers and service providers:

- ✪ 20 ex-service users, 10 carers
- ✪ 22 service providers

### CORE DATA RESULTS

Respondents	n=52					
<b>1.1 Age groupings</b>	16 - 18	-	-	25 - 29	3	6%
	19 - 21	-	-	30 - 39	9	17%
	22 - 24	-	-	40 - 49	25	48%
	50 +	15	29%			
<b>1.2 Gender</b>	Male = 20		38%	Female = 32		62%
<b>1.3 Ethnicity</b>	White British			11	21%	
	Irish			2	4%	
	Other			0	-	
<b>Mixed</b>	White and Black Caribbean			1	2%	
	White and Black African			0	-	
	White and Asian			0	-	
	Other			2	4%	
<b>Asian or Asian British</b>	Indian			9	17%	
	Pakistani			3	6%	
	Bangladeshi			0	-	
	Other			0	-	

<b>Black or Black British</b>	Caribbean	15	29%
	African	4	8%
	Other	0	-
<b>Chinese or Other Group</b>	Chinese	0	-
<b>1.4 Born in the UK</b>	Yes = 27	52%	No = 25
			48%
<b>If no length of time here</b>	Less than 1 year	0	-
	1 – 5 years	1	1%
	6 – 10 years	1	1%
	11 years or more	23	44%
<b>1.5 Citizenship</b>	British Citizen	49	94%
	Refugee	1	1%
	Asylum seeker	2	3%
	Other	0	-
<b>1.6 First Language</b>	Spoken = English	42	81%
	Written = English	50	96%
<b>1.7 Language fluent in</b>	Spoken = English	34	65%
	Written = English	40	76%
<b>1.8 Religion</b>	None	10	19%
	Christianity	23	44%
	Buddhist	0	-
	Jewish	0	-
	Sikh	5	10%
	Other	3	6%
<b>1.9 Sexuality</b>	Lesbian or gay woman	0	-
	Homosexual or gay man	0	-
	Heterosexual or straight	46	88%
	Bisexual	0	-
	Do not wish to answer	5	9%
<b>1.10 Had a disability</b>	Other	0	-
	Yes	15	29%
	No	37	71%

### Main points from the research into isolation and loneliness

- ⊕ No respondents from the 16-24 year grouping
- ⊕ 3 of those invited were serving criminal custodial sentences between 12 to 40 months.

75% of respondents thought a scheme for the wards were inevitable to reduce isolation and loneliness on the wards.

“The befriending scheme is vital for relieving isolation and loneliness I believe some progress has been made by the Health Service...” **Carer Female**

### THEME 1. Spirituality and mental health care

- \* “Identifying their cultural and religious needs is first thing .....” **Ex-service user Male**

- \* “Everyone has spiritual needs even if they do not identify themselves with any particular faith group therefore any activity which raises self-esteem..” **NHS Worker Female**
- \* “In-patients may find respite and comfort in the practice of religious traditions or in activities with a spiritual content.” **NHS Worker Female**
- \* “The church needs to be more involved in understanding and reducing isolation and loneliness. Community needs to understand what it means to be lonely.” **Carer Female**

## THEME 2. Staff on psychiatric wards

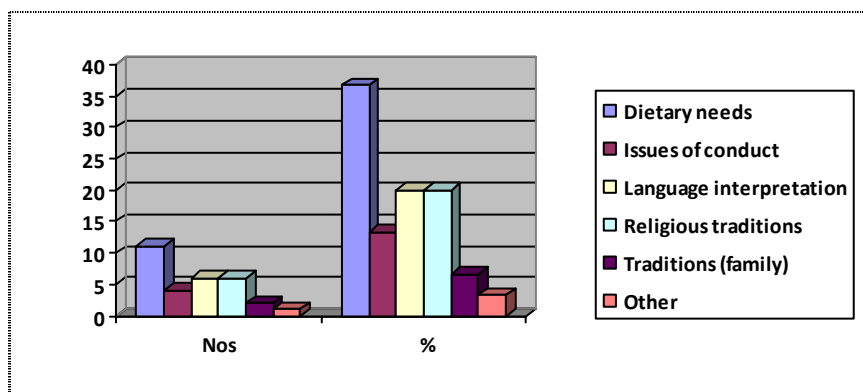
- ☛ “Staff should not be blamed, is Managers and people higher up! Resources are scare on the wards but I think appliances can be better...” **Ex-service user Male**
- ☛ “I would like to see more staff around when you visit wards, more staff should be in the appropriate place when you need them because they are hard to find.” **Carer Female**
- ☛ “A lack of understanding culture and cultural needs can make a person isolated and lonely...” **Ex-service user Male**
- ☛ “Better interaction between staff and patients....” **Ex-service user Male**

## THEME 3. Activities on wards

- ❖ “Involving more activities, people are not confidence, doing some kind of voluntary work will definitely help to relieve isolation and loneliness.” **Ex-service user Female**

## THEME 4. Cultural awareness training for in-patient ward

“Areas do you think clinical staff needs cultural awareness training?”



- 93% of respondents felt religious and cultural training would be beneficial for ward staff
- 93% felt cultural awareness training would contribute to identifying isolation/loneliness
- 36% of ex-service users and carers thought staff needed training about dietary needs
- 34% felt the potential benefits of having culturally trained would make communication better

## RESULTS OF INVESTIGATED AREAS

<p><b>1. Adding activities to wards to relieve isolation and loneliness</b></p> <ul style="list-style-type: none"> <li>▪ 88% of respondents felt staff should try to prevent isolation on wards</li> <li>▪ 77% felt more contact with staff would alleviate loneliness on in-patient wards</li> <li>▪ 50% of ex-service users and carers felt counselling and psychotherapy staff would help in reducing isolation on wards</li> <li>▪ 34% of respondents thought community visitors from same ethnic group would reduce isolation</li> </ul>
<p><b>2. Combating isolation and loneliness on the wards and communities</b></p> <ul style="list-style-type: none"> <li>▪ 80% of respondents thought employment agencies would help to alleviate stigma</li> <li>▪ 32% felt more local people working in mental health setting would combat isolation</li> <li>▪ 30% thought they would promote self help groups through community gatherings</li> <li>▪ 25% felt working in partnerships ~ inpatient, staff, secondary and primary care</li> <li>▪</li> </ul>
<p><b>3. Spiritual needs to reduce isolation and inspire inspiration</b></p> <ul style="list-style-type: none"> <li>▪ 82% of respondents felt staff should develop links with the local diverse communities</li> <li>▪ 50% of ex-service users and carers thought spiritual needs contributes to well being</li> <li>▪ 40% felt their spiritual needs would be met daily or weekly</li> <li>▪ 32% thought staff should be aware of religious significant dates</li> </ul>
<p><b>4. A scheme for wards which enhances social interaction and friendships</b></p> <ul style="list-style-type: none"> <li>▪ 75% wanted a befriending or buddying scheme for in-patients wards</li> <li>▪ 88% felt the scheme would function in a psychiatric setting</li> <li>▪ 42% thought the scheme would be introduced through the voluntary sector</li> <li>▪ 21% of ex-service users and carers felt the scheme would reduce isolation and loneliness</li> </ul>
<p><b>5. A BME (black and minority ethnic) support group</b></p> <ul style="list-style-type: none"> <li>▪ 97% of respondents thought a support group would be useful</li> <li>▪ 40% of ex-service users and carers wanted the scheme linked to the Care Programme Approach process where applicable</li> <li>▪ 36% felt the support group would meet every week</li> <li>▪ 33% thought a day centre would be the appropriate place for meeting</li> </ul>
<p><b>6. A targeted information service for the wards &amp; the black and minority ethnic communities</b></p> <ul style="list-style-type: none"> <li>▪ 92% of respondents felt there was a need for a targeted information service</li> <li>▪ 90% felt the service would be led by ex-service users and carers</li> <li>▪ 30% thought the wards was the most effective place to be seen</li> <li>▪ 100% wanted an A-Z of items in the information service</li> </ul>
<p><b>7. Accessing voluntary services after leaving the in-patients wards</b></p> <ul style="list-style-type: none"> <li>▪ 89% of respondents felt voluntary services were beneficial for ex-service users</li> <li>▪ 73% of ex-service users were not offered voluntary services after leaving the wards</li> <li>▪ 38% felt their key worker was the best route to accessing voluntary services</li> <li>▪ 25% thought their approved social worker was appropriate for contacting services</li> </ul>
<p><b>8. Enhancing cultural and diversity training needs for clinical staffs</b></p> <ul style="list-style-type: none"> <li>▪ 93% of respondents felt religious and cultural training would be beneficial for ward staff</li> <li>▪ 93% felt cultural awareness training would contribute to identifying isolation/loneliness</li> <li>▪ 36% of ex-service users and carers thought staff needed training about dietary needs</li> <li>▪ 34% felt the potential benefits of having culturally trained would make communication better</li> </ul>

## Recommendations

### Hampshire Partnership NHS Trust ~ Focussed Implementation Site

- We recommend the Steering Group of the site use the groups' resources of its membership and the CDWs (Community Development Workers) to develop a strategic work plan around the report's findings and recommendations. Primarily, to reduce the disproportionate numbers of black and minority ethnic people which end up on the psychiatric wards.
- To oversee the implementation measures and to facilitate greater awareness of the importance of the impact of isolation and loneliness on the BME (black and minority ethnic) ex-service users and carers in the communities.
- To audit the work plan after six months and thereafter on the anniversary of the report's launch to measure achievements and outcomes.

### Hampshire Partnership NHS Trust ~ In-patient wards

**TRAINING MODULES:** Research data suggests the following should be taken on board for future training modules:

- Cultural awareness training to identify isolation and loneliness in black and minority ethnic in-patients.
- To include **dietary, religious and cultural customs** as part of training practices.
- To ensure appropriate staff becomes acquainted with **religious significant dates**.
- ⊕ To urgently seek to establish a **befriending/buddying scheme** to reduce isolation and loneliness suffered by in and out patients on the wards and the communities.
- To establish a protocol for staffs to familiarise themselves with a **pathway introduction** to the proposed (befriending/ buddying) scheme on wards.
- ⊕ To use available resources within the black and minority ethnic communities to introduce a black and minority ethnic **support group** for reliving isolation and loneliness.

### Southampton Local Implementation Team

- \* To start future commissioning service provision preparations for funding to establish the befriending/buddying scheme and to ensure it's sustainability in the foreseeable future.

### Southampton City Primary Care Trust

- ❖ To highlight greater working partnerships between primary and secondary to influence more appropriate and responsive services.
- ❖ To develop targeted appropriate information for service users, carers, the secondary services and the voluntary sector for greater accessibility of primary and secondary care services.

### Solent Mind ~ voluntary services sector provider

- \* To primarily look at improving the way the organisation advertises its' available services to the diverse black and minority ethnic communities in Southampton.
- \* To embark on a drive which looks at promoting access of available services on offer to black and minority ethnic outpatients clients and carers in the communities.

**Other voluntary agencies:** To organise a service which would be able to operate within the in-patient wards for visiting people who are hospitalised from their own ethnic group.

## **INTRODUCTION**

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

#### **Background**

We often hear the following words or phrases:

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

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

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

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

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

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

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

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

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

## **The Key Ingredients**

According to the Centre for Ethnicity and Health model, a Community Engagement project must have the community at its very heart. In order to achieve this, it is essential to work through a **host community organisation**. This may be an existing community group, but it might also be necessary to set a real or virtual group up where one does not exist already. The key thing is that this host community organisation should have good links to the target community<sup>1</sup> (whoever

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<sup>1</sup> 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)

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

<b>A Host Community Organisation</b>	With Good Links To The Target Community	To Provide Basic Infra-structure For The Project (Recruit And Co-ordinate Project Team; Provide Office Space, Phones And Computers; Look After The Finances)	To Recruit A Number Of People From The Target Community To Do The Work
<b>A Task</b>	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
<b>Support</b>	Financial (Typically Up To £20,000)	Training And Workshops; On-Going Support And Guidance; Personal Tutor	Statutory Partnerships; Steering Groups; Sustainability

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

The final ingredient, according to the Centre for Ethnicity and Health’s model, is the provision of appropriate **support** and guidance. We do not expect community groups to become involved for nothing. Typically we would make in the region of £15-20,000 available to the host organisation. We would expect that the bulk of this money would be used to pay people from the target community as community researchers<sup>2</sup>. 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

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or by some other label that people can identify with or rally around (e.g. victims of domestic violence, sex workers).

<sup>2</sup> 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.

workshops give participants in the project a chance to gain a University qualification whilst they undertake the work. The support workers will also assist the group to pull together a steering group for the project<sup>3</sup>. The steering group is an essential element of the project: without one, it is difficult to see who the community are engaging with and it is unlikely that anything out of the project will be sustained in the longer term. The group will be doing a needs assessment or a consultation exercise, but for what purpose? It is the role of the steering group to ensure that the work that the group undertakes sits with local priorities and strategies, and that there is a mechanism for picking up the findings and recommendations that the group may make. It is also their role to help to pick up the key individuals who are developed through the project process to help them to take their 'next steps'.

### The Community Engagement Team

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

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

### Programme Outcomes

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

<sup>3</sup> 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.

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

### **The focus of this particular report**

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

❖ The views expressed from this point in this report are those of the Wiltshire Trust's researchers group, which undertook this work, and are not necessarily those of the Centre for Ethnicity and Health at the University of Central Lancashire.

In-equalities in Britain today are centred on people from the black and minority ethnic communities because of many factors including poor housing, in-adequate health standards, access to an appropriate and sensitive mental health service provision and educational attainment in schools. Research over the past three decades suggest many black and minority ethnic people suffer from deprivation and poor follow up care after hospital admissions and are more likely to be admitted to psychiatric wards following contact with the police, (**Bebbington et al 1994, Bhui et al 1998, Pakman et al 1997 and Rogers and Faulker et al 1987**).

Many black and minority ethnic people are likely to be admitted to compulsory detention under the Mental Health Act through the judicial system (Takei et al 1998 and Department of Health Home Office 1992). Well documented pieces of other research points to many being violent and detained on locked wards including medium secure and higher secure mental health institutions, (Cope 1989, Commander et al 1997, Commission for Racial Equality report of 1995). Mc Govern, D (1987) found there was compulsory detention of African-Caribbean young men in particular and this was prevalent throughout the United Kingdom.

Further research indicates a key factor of an adverse pathway (police involvement Section 136) and compulsory admissions, is not ethnicity but an absence of family, social support and primary care prevalence, (**Cole et al 1995 and Davies et al 1996**). There are compelling similarities which contributed to isolation and loneliness:

- ❖ There were high proportions (25%) of all African-Caribbean in-patients with severe mental illness living alone, were unemployed and lived in single accommodation, (**Birchwood et al 1992, Bhugra et al 1997, Bowls and Barnes 1990, Littlewood and Lipsede 1988 and Mc Govern et al 1994, 1991**).

Similarly, research suggests community and secondary care fail to provide appropriate preventative and supportive care at an early stage to inhibit crisis, (**Bhui et al 1998, Bowls and Barnes 1999, Cole et al 1995, Commander et al 1997 and the Commission for Race Equality 1995**).

### **PUBLIC POLICY**

The Government Service Standards Agreement strategy 2005-08 sets out to reduce inequalities in public sector services and to monitor the progress of minority ethnic communities as they interact with public sector services. This work we carried seek to inform communities, statutory and voluntary services about the gaps in services and ways in which isolation and loneliness would be reduced leading to more appropriate and responsive services.

Community Engagement primarily looks to improve responsive services, to help and increase community renewal. "Put another way community engagement has the potential to improve the quality of service supplied, but it can improve the opportunities and capacities of those who rely on services so lessening the need for them." Rodgers and Robinson 2004

In a major push to reduce in-equalities, the National Health Service has introduced the Delivering Race Equality framework, a five year action plan for 2010 to reform and improve mental health services, providing appropriate and responsive services which meet the needs of the black and minority ethnic communities.

**The Delivering Race Equality three building blocks are as follows:**

- Achieving more appropriate and responsive services
- Engaging black and minority ethnic communities in achieving effective services and
- Better information on service use, needs and knowledge of recovery enhancing environments and approaches.

In a final push to secure services which are appropriate, responsive and sensitive to meet the needs of the black and minority ethnic (BME) communities, Professor David Sallah, National Director of the black and minority ethnic mental health launched this programme in October 2005. The Focussed Implementation Sites through the Strategic Health Authorities, are the hot pots of good practice which would be orchestrated by the looking at the 12 National characteristics of the Delivering Race Equality (DRE) in mental health care.

**The twelve National characteristics are as follows:**

- less fear of mental health services among BME communities and service users
- increased satisfaction with services;
- a reduction in the rate of admission of people from BME communities to psychiatric inpatient units;
- a reduction in the disproportionate rates of compulsory detention of BME service users in inpatient units;
- fewer violent incidents that are secondary to inadequate treatment of mental illness;
- a reduction in the use of seclusion in BME groups;
- the prevention of deaths in mental health services following physical intervention;
- more BME service users reaching self-reported states of recovery;
- a reduction in the ethnic disparities found in prison populations;
- a more balanced range of effective therapies, such as peer support services and psychotherapeutic and counselling treatments, as well as pharmacological interventions that are culturally appropriate and effective;
- a more active role for BME communities and BME service users in the training of professionals, in the development of mental health policy, and in the planning and provision of services; and
- A workforce and organisation capable of delivering appropriate and responsive mental health services to BME communities.

This Community Engagement project was a Department of Health initiative, which focussed on Delivering Race Equality: A Framework for Action.

We were specifically looking at these two points from the National 12 Actions points on improving mental health services for black and minority ethnic in-patients and carers. The two main points were:

- **A reduction in the rate of admission of people from black and minority ethnic communities to psychiatric inpatient units.**
- **A reduction in the disproportionate rates of compulsory detention of BME service users in the inpatients units.**

The main initiative to bridge the gap between the Department of Health and the communities has been to introduce the CDWs (Community Development Workers) to look at services and the communities to find solutions and engender a community engagement approach which encompasses empowering them to look at strengthening peoples' role in decision making.

This research was specifically looking at the extent and impact of isolation and loneliness on inpatient wards and in the Southampton's black and minority ethnic communities. We were researching the association with the much-documented high rates of psychiatric admissions and compulsory detentions of black and minority ethnic people to in-patient units. **(Koffman et al 1997)** was one of the first research studies looking at the over-representation of these clients to units and found that the following was prominent in acute, low and medium secure units in the NHS (National Health Service):

- ❖ High proportion of the black population were admitted to psychiatric units
- ❖ Black and minority ethnic patients were more likely to be admitted under section
- ❖ Many were over-represented and situated on locked wards
- ❖ They were more likely to be diagnosed with schizophrenia
- ❖ General Practitioner's registration were not present in their history to psychiatric admissions

Research suggests in-patients detained under the Mental Health Act through the seventh Biennial Report of the Mental Health Act Commission were lacking proper care for patients from black and minority ethnic communities and their service provision remained basic, insensitive and inadequate leading patients feeling alienated and isolated, Warner et al 2000. The report stressed serious issues of inappropriate care and treatment for black and minority ethnic in-patients.

Nationally, our best guide to rates of admissions and compulsory detentions was through the **'Count me in' census 2006** and **'who's been sleeping in my bed'** documents. Figures from the national count me in Nationally, South East and Southampton's are as follows:

NATIONAL		SOUTH EAST		SOUTHAMPTON, HANTS	
ETHNIC GROUP		ETHNIC GROUP		ETHNIC GROUP	
British	78.3%	British	85.5%	British	92.43%
Irish	2.2%	Irish	1.2%	Irish	0.48%
White Other	3.2%	White Other	3.7%	White Other	1.93%
White and Caribbean	0.8%	White and Caribbean	0.4%	White and Caribbean	0.32%
White and Black African	0.2%	White and Black African	0.1%	White and Black African	0.16%
White and Asian	0.3%	White and Asian	0.2%	White and Asian	0.16%
Other Mixed	0.5%	Other Mixed	0.3%	Other Mixed	0.32%
Indian	1.4%	Indian	0.8%	Indian	0.48%
Pakistani	1.0%	Pakistani	0.5%	Pakistani	-
Bangladeshi	0.5%	Bangladeshi	0.1%	Bangladeshi	0.32%

Other Asian	0.8%	Other Asian	0.5%	Other Asian	0.48%
Caribbean	4.3%	Caribbean	1.5%	Caribbean	0.81%
African	2.0%	African	1.3%	African	0.48%
Other Black	1.8%	Other Black	0.3%	Other Black	0.16%
Chinese	0.2%	Chinese	0.2%	Chinese	-
Other	1.1%	Other	0.7%	Other	0.97%
Not stated	1.3%	Not stated	2.6%	Not stated	0.48%
	100.0%		100.0		100.0%

Source: "Count me in" 2005 Healthcare Commission report

There have been numerous studies, which made cases for the need for better community engagement with people from the black and minority ethnic service users and carers. Black and minority ethnic communities find it hard to access mainstream services as a consequence of a number of factors.

Isolation and loneliness is defined primarily as:

- (1) "A separation between persons or groups"
- (2) "A feeling of being disliked"

### Psychiatric definition

(3) "A defence mechanism in which memory of an unacceptable act or impulse is separated from the emotion originally associated with it." This gives a vivid imagination of what isolation and loneliness can bring to individuals, carers, families, communities and the social care network.

In doing this community engagement research we were looking at providing some solutions to the surmounting issues which are centred on in-patient wards and finally how individuals are able to function in the communities.

### AIMS

The research's aim was to investigate the extent and impact of isolation and loneliness on inpatient wards and the communities and to look at ways to reduce it.

- ▶ To explore key issues such as isolation and loneliness that black and minority ethnic service users experience in mental health provision.
- ▶ To identify gaps in service provision and suggest more effective ways on how clinical staff and other professionals could meet the diverse needs of their local communities thereby delivering race equality in mental health services.

### OBJECTIVES

To look specifically at the reduction of black and minority ethnic people to in-patient units to augment the Delivering Race Equality two action points:

3. The disproportionate rates of admission of black and minority ethnic patients to psychiatric wards.
4. The disproportionate rates of compulsory detention of black and minority ethnic communities' people to in-patients wards.

### COMMUNITY of research project

Southampton is situated south of London and resides in Hampshire, South East with a population of 222,000, Source: National Statistical Office – mid year 2005. Southampton's black and minority ethnic population stands at 7.6% in the 2001 Census figures. The city covers 51, 47 km and is the largest city on the south coast of England. The city was a landing port for West Indian migrants in the 1950s aboard the Empire Wildrush vessel looking for new jobs in the United Kingdom.

In the 1950s and 1960s there was an influx of black and minority ethnic groups prominently from the West Indies, India, Pakistan, Bangladesh, Hong Kong and China. In the 1960s we saw a migration flow from the East African nations. In the 20<sup>th</sup> century with the advent of conflict and strife in various parts of the world other groups have joined the population in the United Kingdom as refugees or asylum seekers settled here. Many were mainly Albanians, Bosnians, Iraqis, Iranians, Kosovans, Kurds, Serbs, Somalis and Tamils. The European Union Accession states have followed and presently there are large settlements of migrants from Poland in Southampton.

The city spans between SO14-SO19 and many black and minority ethnic groups have settled here in the city and are mostly centred in the urban central SO14 area. The ethnic grouping profile of Southampton is as follows:

### **SOUTHAMPTON'S population of ethnic groups**

<b><i>Ethnic group</i></b>	<b><i>Percentage</i></b>
White	88.75
Irish	1.06
Other White	0.33
White & Asian	0.49
White & Caribbean	0.46
White & Black African	0.22
Indian	2.17
Pakistani	0.80
Bangladeshi	0.44
Other Asian	0.38
Black Caribbean	0.48
Black African	0.48
Other Black	0.07
Chinese	0.75
Other ethnic group	0.55

Source: Office for National Statistics ~ Census 2001

The city is very diverse and has a cosmopolitan mix, which boasts as having 40 languages spoken around. British Asian Indian makes up 2.17% of population and is the largest black and minority ethnic community group in Southampton. The overall black and minority ethnic population is around 20,000. Source: Office for National Statistics ~ Census 2001.

### **EDUCATIONAL ATTAINMENT**

Southampton has been improving with academic studies and figures from the LEA raising from 43.1% in 2001 to 49.0% in 2006 i.e. pupils attaining 5 GCSEs. Source LEA Performance tables, DfES

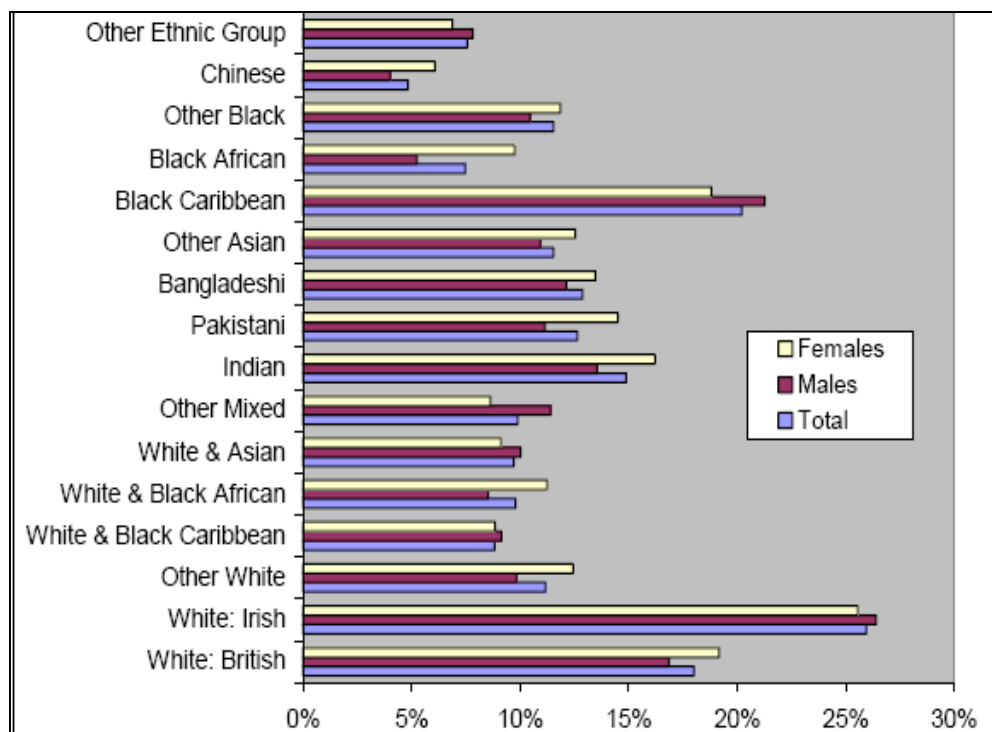
### EQUALITIES SURVEY

Recent survey carried out in 2006, found BME (black and minority ethnic) Southampton communities wanted the following:

- Respondents wanted more translators to fulfil their needs.
- Expressed the perception form filling for the elderly, frail, visual and sensory impaired was overwhelming complicated.

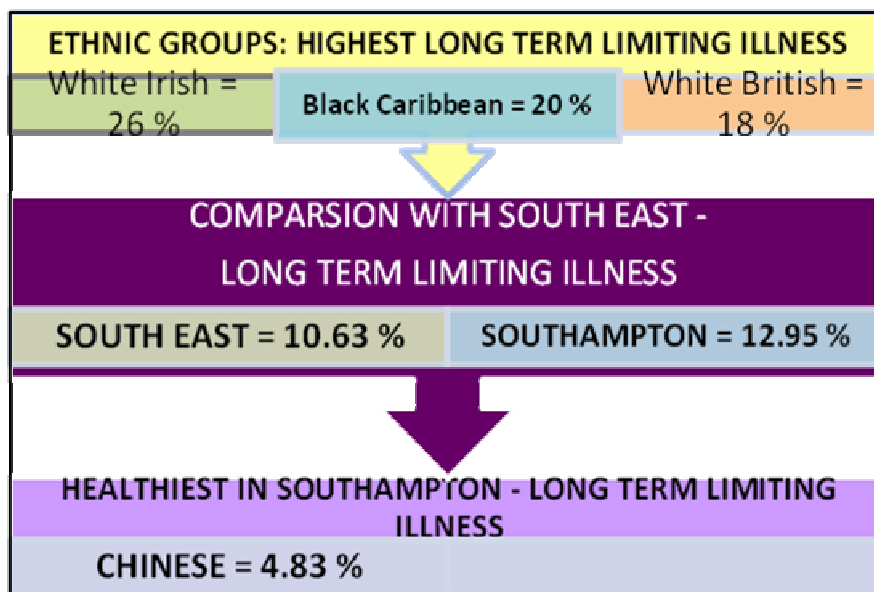
### HEALTH

Graph percentages of ethnic population on long term limiting illness



Source: Office for National Statistics ~ Census 2001

Southampton’s black and minority ethnic population with poorest figures are as follows: BARGATE, BEVOIS & WESTON



## HOUSING RESEARCH

Recently concluded in Southampton (2007) BME (black and minority ethnic) housing needs research found the following regarding disabilities in the communities’;

Illness or disability	Ethnic group	% of sample	Numbers
Visual impairment	Other ethnic	20 %	6
Hearing impairment	Chinese	17 %	4
Mobility problems	Pakistani	12 %	6
Learning disabilities	Kurdish	8 %	4
<b>Mental health</b>	Kurdish	46 %	23
<b>Severe mental health</b>	Bangladesh	6 %	3
Frailty (elderly)	Chinese	30 %	7
Health\Asthma\Respiratory	Zimbabwe	26 %	13
Diabetes	Bangladeshi	20 %	10
Drug and alcohol problems	Irish	8 %	3
AIDS/HIV	-	-	0
Sickle Cell	Jamaica	9 %	2
High blood pressure	Indian	24 %	12

*Source: Permalloo. S 2006 'Connecting Communities Southampton's BME Housing needs research'*

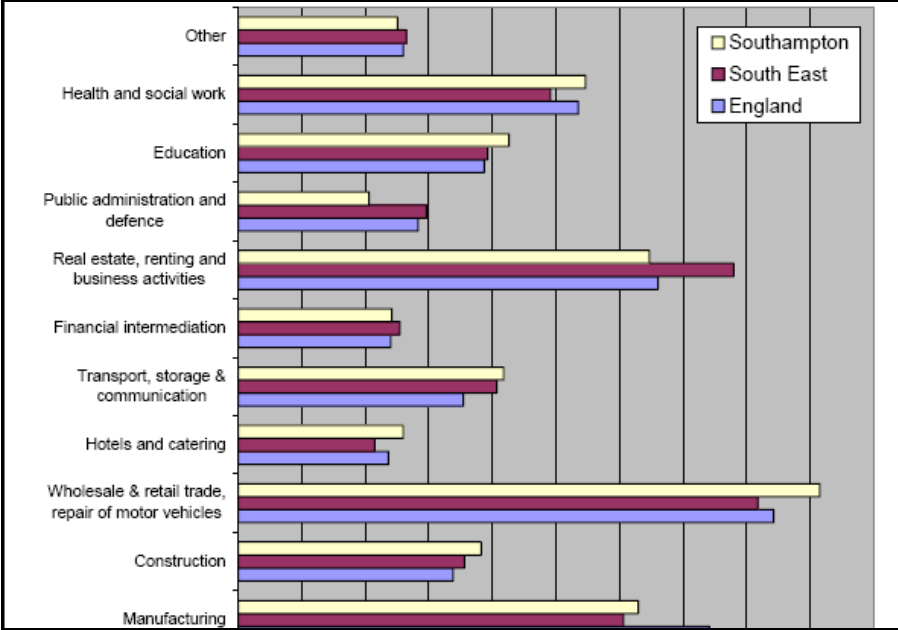
## HOUSING ownership

In the black and minority ethnic housing in the city sees the picture mirrored with the national picture with Bangladeshi, Caribbean; Chinese, Indian, Pakistani communities were favourably with home ownership mainly because of the long standing established household for decades. Average house prices are around £167,776. Source Land Registry 2006

## UNEMPLOYMENT

The unemployment rate in Southampton stands at 2.4% who are claiming job seekers allowance of those in the working population, 3,442 were claiming benefits at the time we were writing up this research report. Wards with the highest level of unemployment were Bevios, Redbridge, Bitterne and Woolston. Black and minority ethnic communities concentrated mainly in the SO14 and SO15, Bevios and Bitterne within Southampton fall within these areas.

**EMPLOYMENT**



Source: Office of National Statistics.

## **METHODOLOGY**

### **\* RECRUITMENT**

The recruitment of the 'researchers' was made by advertising for the positions through the black and minority ethnic ex-service users and carers groups around Southampton and Hampshire by placing adverts in the local networks for prospective interested individuals. They were short listed in May 06 and interviewed about their perceptions on the following areas:

- ❖ Interest in the mental health research project.
- ❖ Benefits to the black and minority ethnic ex-service users and carers in the communities.
- ❖ Possible barriers they would encounter in carrying out the isolation and loneliness questionnaire.
- ❖ Present goals, future mental health courses, present employment and aspirations in future endeavours.

**RESEARCHERS:** In total we recruited 4 researchers:

- ▶ an ex-service user
- ▶ one working in the supportive housing care schemes
- ▶ a part-time mental health student from the Somali community
- ▶ finally one from the voluntary sector.

### **\* TRAINING**

Training arrangements were compulsory and provided by the University of Central Lancashire personnel. There were seven workshops delivered, focussing on giving participating groups vital information on delivering race equality in mental health practices, mental health policies, research methods and analysing data between June and November 06. This process was linked with an accreditation in a University Certificate Level 1 qualification after attending workshops.

Additional training was carried out for capacity building through our supervision sessions, held weekly and when our support worker gave us his thoughts. They were facilitated by the lead 'researcher' on aspects pertaining to mental health practices, research methods and the project work overall.

### **\* SUPPORT**

The 'researchers' were supported by the support workers system at the University of Lancashire on a fortnightly basis. The Steering Group of the project, Focussed Implementation Site's 'Satisfaction with services' group also gave us support and guidance.

### **\* STEERING GROUP**

The Steering group was made of a number of organisations from the statutory, mental health care trusts and voluntary agencies from Southampton, Portsmouth and Hampshire and the Isle of Wight. A community engagement model was used for organisations linking up and this brought about a whole systems approach and involvement in decision making for finalising questionnaires and giving final approval for the survey to go ahead.

### **\* CSIP (Care Service Improvement Partnerships) National Institute for Mental Health in England (NIMHE) involvement**

The South East Development Centre in Guildford through our Race Equality Lead supported this research project. There was also involvement from the Centre in facilitating a Delivering Race Equality conference ('new ways of working') in November 06, which gave us an opportunity to showcase and highlight the importance of the community engagement research project.

## \* RESEARCH DESIGN

We used an independently designed semi-structured questionnaire formulated by members of the research team. The questionnaire was made up investigating the following areas, which we placed under the following:

### AREAS INVESTIGATED

- ⊗ Adding activities on wards.
- ⊗ Combating isolation and isolation on the wards
- ⊗ Spiritual needs for wards to help in-patients.
- ⊗ A ward scheme to enhance social interaction
- ⊗ A black and minority ethnic support group for ex-service users
- ⊗ A targeted information service for the wards and communities
- ⊗ Accessing voluntary service after leaving the in-patients' wards
- ⊗ Enhancing cultural and diversity training for staff

TWT Research Team, Southampton CE Project 06

### QUESTIONNAIRES

The ex-service users and carers questionnaire had 8 areas with 39 questions and the service providers' questionnaire had 7 sections (research team felt the support group area should be answered by the ex-service users and carers) with 23 questions (**see both in Appendix 10+11**). These questionnaires were circulated to the University of Lancashire's ethical approval board, Steering Group members for comments and guidance on the format, re-structuring and grammatical errors where applicable. The two questionnaires were devised to cater for ex-service users/carers and the other for service providers' respondents.

## \* PARTICIPANTS

We asked a sample of 52 participants from ex-service users/carers groups and service providers (20 ex-service users, 10 carers and 22 service providers). The sample looked at people between the ages of 16 to 50+ for participation in the survey. We had 20 males and 32 females, which took part in the research into isolation and loneliness. Participants replied by e-mails, self-addressed return letters, word of mouth and telephoning.

### PROCEDURE ~ PLANNING

The researchers brainstormed the specific areas around isolation and loneliness on in-patient wards and in the communities. We looked at the ward environment on a diagram designed to look at all personnel working with in-patients and areas concerned with after-care on leaving the wards. In total 8 areas were identified to be investigated, 4 within the wards and another 4 within the communities.

### ETHICAL APPROVAL

The research's tool Performa was formulated using the University of Central Lancashire's guidance document supplied in our handbook. The University's Ethics Committee granted us approval in October before interviewing prospective respondents. We registered the survey with the Hampshire Partnership NHS Trust's Research and Development for 'a service evaluation of staff associated with in-patient wards' it was obtained in November 2006.

## **INVITATION**

This was carried out by an invitational letter sent out to sets of groups, (i) ex-service users (ii) carers and (iii) service providers for acceptance to partake in the research.

## **INTERVIEWING PROCESS**

All interviews were conducted between 9-5 p.m. at an office at Solent Mind. Interviews were arranged through lead 'researcher' and appointments finalised to suit ex-service users or carers. All respondents were asked to fill out a core data form supplied by the University of Central Lancashire. **(Appendix 2)**

The core data form elicited information concerning age last birthday, gender, ethnicity, were they born in the United Kingdom, length of time lived here, resident status, first language spoken/written, first language fluent spoken/written, religion, sexuality and disability status.

The list questionnaire interview respondents were given an interview lasting 40 minutes. Service providers were sent the survey evaluation e-questionnaire by e-mail and it was returned by post. Some of the service providers elected to be interviewed face to face and its' duration was 30 minutes.

## **ANALYSING RESEARCH DATA**

All questionnaires were analysed by thematic content analysis **(Krueger R.A. 1994)** as suggested by our University of Central Lancashire tutors. We circulated all transcribed comments from respondents to our Steering Group to get peoples' suggestions on possible themes.

In one of the sessions we invited our Focussed Implementation Site's co-ordinator to facilitate the process of coding, finding commonalities and themes deriving from comments made on a reduction of isolation and loneliness. A document was designed to look at summary points, themes of the groups of respondents. Key words or phrases were placed into themes, which were illustrated from the whole process. In the discussion section further explanation will be discussed in detail where respondents' perspectives in the findings of this study.

## CORE DATA RESULTS

### 1. Age last birthday

16 – 18	0	-
19 – 21	0	-
22 – 24	0	-
25 – 29	3	5.76 %
30 – 39	9	17.30 %
40 – 49	25	48.07 %
50 +	15	28.85 %

### 2. Gender

<b>Males</b>	<b>20</b>	<b>38.46 %</b>
<b>Females</b>	<b>32</b>	<b>61.54 %</b>
<b>Trans-gendered</b>	<b>0</b>	<b>-</b>

### 1.3 Ethnicity

#### White

<b>White</b>	<b>British</b>	<b>11</b>	<b>21.1 %</b>
	Irish	2	3.84 %
	Other	0	-

#### ❖ Mixed

<b>Mixed</b>	<b>White and Black Caribbean</b>	<b>1</b>	<b>1.92 %</b>
	White and Black African	0	-
	White and Asian	0	-
	Other	2	3.84 %

#### ❖ Asian or Asian British

<b>Asian or Asian British</b>	<b>Indian</b>	<b>9</b>	<b>17.30 %</b>
	Pakistani	3	5.76 %
	Bangladeshi	0	-
	Other	0	-

#### ❖ Black and Black British

<b>Black or Black British</b>	<b>Caribbean</b>	<b>15</b>	<b>28.85 %</b>
	African	4	7.69 %
	Other	0	-

#### ❖ Chinese and other group

<b>Chinese or other ethnic group</b>	<b>Chinese</b>	<b>0</b>
	Other	0

#### 1.4 Born in the U.K.?

<b>Yes</b>	<b>27</b>	<b>51.92 %</b>
<b>No</b>	<b>25</b>	<b>48.08 %</b>

#### 1.4 Length of residence in UK

Less than 1 year	0	-
1 – year	0	-
1 – 5 years	1	1.92 %
6 – 10 years	1	1.92 %
11 years or more	23	44.23 %

#### 1.5 Citizenship

<b>British Citizen</b>	<b>49</b>	<b>94.23 %</b>
Refugee	1	1.92 %
Asylum seeker	2	3.85 %
Other	-	-

#### 1.6 Languages

<b>First language spoken</b>	<b>Nos</b>
English	42
Percentage	80.77 %

<b>First language written</b>	<b>Nos</b>
English	50
Percentage	96.15 %

<b>First language fluent in spoken</b>	<b>Nos</b>
English	34
Percentage	65.38 %

<b>First language fluent in written</b>	<b>Nos</b>
English	40
Percentage	76.92 %

#### ❖ Other languages

<b>First language spoken</b>	<b>Nos</b>	<b>%</b>
Krio	2	3.85 %
Gujarati	2	3.85 %
Hindi	1	1.92 %
Kachi (Sindi)	1	1.92 %
Punjabi	1	1.92 %
Urdu	1	1.92 %

<b>First language written</b>	<b>Nos</b>
Kachi (Sindi)	1
Percentage	1.92 %

<b>First language fluent</b>	<b>Nos</b>	<b>%</b>
French	4	7.69 %
Gujarati	2	3.85 %
Hindi	2	3.85 %

<b>Kachi (Sindi)</b>	<b>1</b>	<b>1.92 %</b>

❖ Multiple numbers of languages fluent in

<b>English, Swahili + Urdu</b>	<b>1</b>	<b>1.92 %</b>
<b>English, Urdu + Punjabi</b>	<b>1</b>	<b>1.92 %</b>
<b>French, English + Spanish</b>	<b>1</b>	<b>1.92 %</b>
<b>Hindi , Urdu + Punjabi</b>	<b>1</b>	<b>1.92 %</b>
<b>Punjabi + Hindi</b>	<b>2</b>	<b>3.85 5</b>
<b>Urdu, Pashto, Dari, Farsi + English</b>	<b>1</b>	<b>1.92 %</b>

<b>First language written</b>		
<b>English , Urdu + Punjabi</b>	<b>1</b>	<b>1.92 %</b>
<b>English + Urdu</b>	<b>1</b>	<b>1.92 %</b>
<b>Hindi , Urdu + Punjabi</b>	<b>1</b>	<b>1.92 %</b>
<b>Punjabi + Hindi</b>	<b>1</b>	<b>1.92 %</b>
<b>Urdu + English</b>	<b>1</b>	<b>1.92 %</b>

### 1.7 Religion

<b>None</b>	<b>10</b>	<b>19.23%</b>
<b>Christian</b>	<b>23</b>	<b>44.23%</b>
<b>Buddhist</b>	<b>0</b>	<b>-</b>
<b>Hindu</b>	<b>2</b>	<b>3.85%</b>
<b>Jewish</b>	<b>0</b>	<b>-</b>
<b>Muslim</b>	<b>7</b>	<b>13.46%</b>
<b>Sikh</b>	<b>5</b>	<b>9.62%</b>
<b>Other</b>	<b>3</b>	<b>5.77%</b>

### 1.8 Sexuality

<b>Lesbian or gay woman</b>	<b>0</b>	<b>-</b>
<b>Homosexual or gay man</b>	<b>0</b>	<b>-</b>
<b>Heterosexual or straight</b>	<b>46</b>	<b>88.46%</b>
<b>Bisexual</b>	<b>0</b>	<b>-</b>
<b>Do not wish to answer</b>	<b>5</b>	<b>11.54%</b>
<b>Other</b>	<b>0</b>	<b>-</b>

### 1.9 Disability

<b>Participants with a disability</b>	<b>15</b>	<b>28.84 %</b>
<b>Participants with no disability</b>	<b>37</b>	<b>71.16 %</b>

## RESULTS

The total numbers of completed questionnaires from the following categories were **52**

### EX-SERVICE USERS AND CARERS

- ❖ Ex-service users = **20**
- ❖ Carers = **10**

## SERVICE PROVIDERS

- ❖ Strategic Personnel = 5
- ❖ Statutory-Clinical Hampshire Partnership NHS Trust = 11
- ❖ Voluntary / Community questionnaires = 6

(See appendix 10 and 11 for copies of the questionnaires)

## RESEARCHED areas

1.1 In question AREA 1 about the promotion of added activities on psychiatric wards and communities to relieve isolation and loneliness we asked respondents “**What types of activities do you think would relieve isolation and loneliness on wards?**”

- 9 said they thought **Cultural days**
- 18 said they thought **Visitors and volunteers from the same community**
- 8 said they thought **Day trips**
- 12 said they thought **Family meetings**
- 4 said they thought **Food preparation**
- 4 said they thought **Games**
- 1 said they thought **Poetry**
- 0 said they thought **Other**

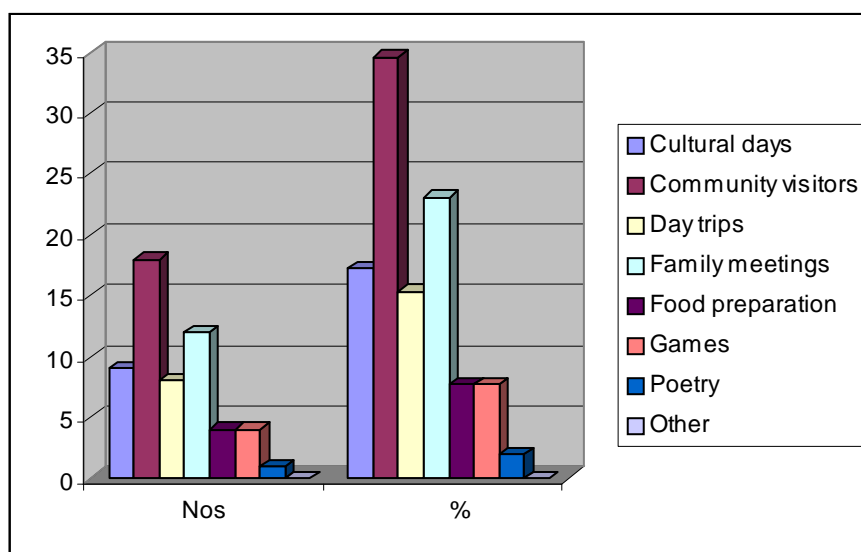


Fig 1 TWT Research Team, Southampton, Hampshire

1.2 In question 2 we made this statement to respondents:  
“**Staff should try to prevent isolation on the wards?**”

- 2 said they **Strongly disagreed**
- 2 said they **Disagreed**
- 2 said they were **Undecided**
- 11 said they **Agreed**
- 35 said they **Strongly agreed**

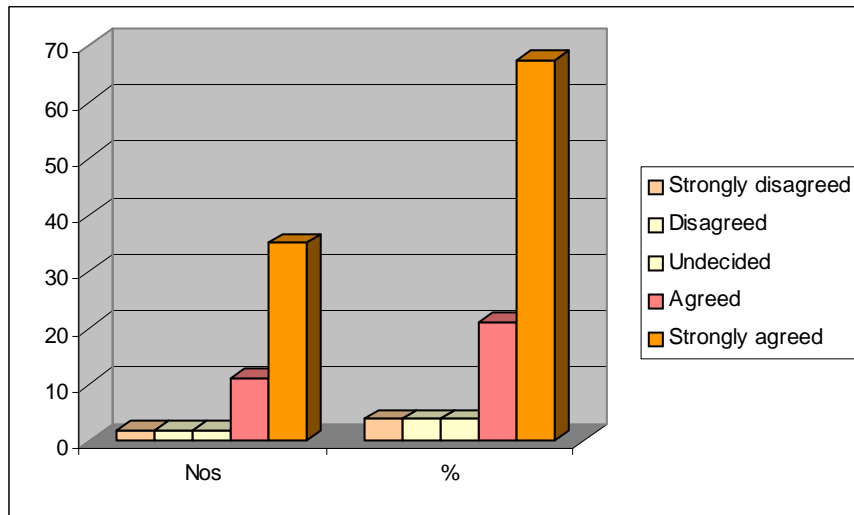


Fig 2 TWT Research Team, Southampton, Hampshire

1.3 In question 3 we asked respondents “How can an in-patient wards be an environment where isolation and loneliness can be reduced?”

- 17 said they thought by **Assessing why and how loneliness occurs**
- 11 said they thought by **Identify potential solutions**
- 6 said they thought by **Part of the Risk Assessment Plan on wards**
- 5 said **Psychiatric problems make it difficult to assess the said situation**
- 10 said they thought by **Reducing barriers to identify patient stressors**
- 3 said they thought by **Other**

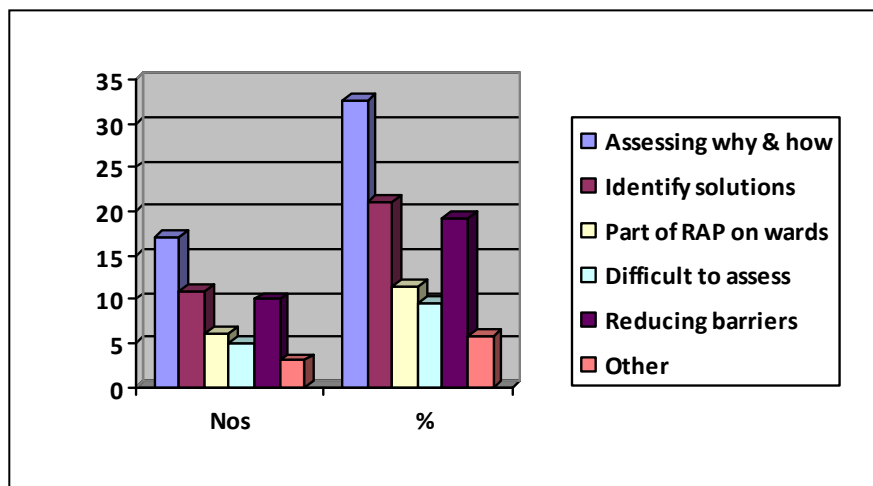


Fig 3 TWT Research Team, Southampton, Hampshire

1.4 In question 4 we asked respondents “How would staff be alerted if an in-patient on the wards was isolated and lonely?”

- 10 said they thought by **A formal protocol is in place to report signs**
- 16 said they thought by **Counselling and psychotherapy services personnel**
- 3 said they thought by **Part of the Risk Assessment Plan on wards**
- 5 said **Psychiatric problems make it difficult to assess the aid situation**
- 15 said they thought by **Reducing barriers to identify patient stressors**
- 3 said they thought by **Other**

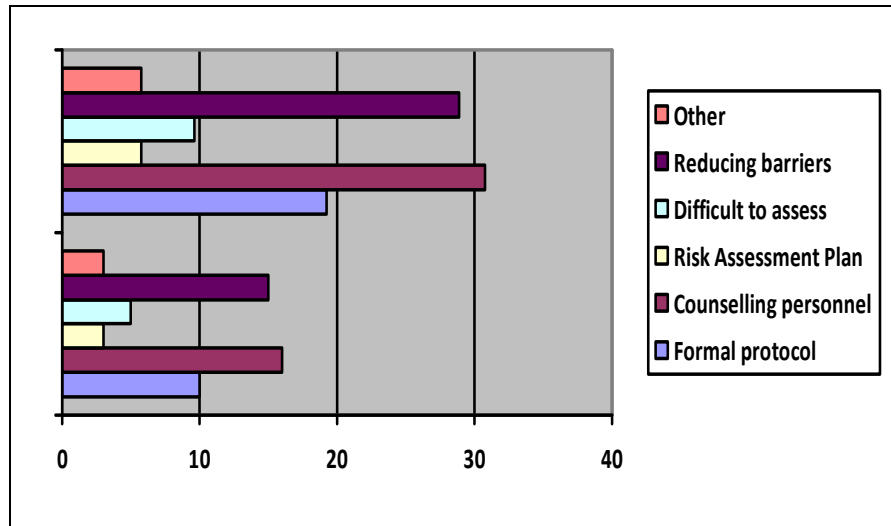


Fig 4 TWT Research Team, Southampton, Hampshire

1.5 In question 5 we made this statement to respondents **“More contact with staff aids in alleviating isolation and loneliness”?**

- 2 said they **Strongly disagreed**
- 2 said they **Disagreed**
- 8 said they were **Undecided**
- 15 said they **Agreed**
- 25 said they **Strongly agreed**

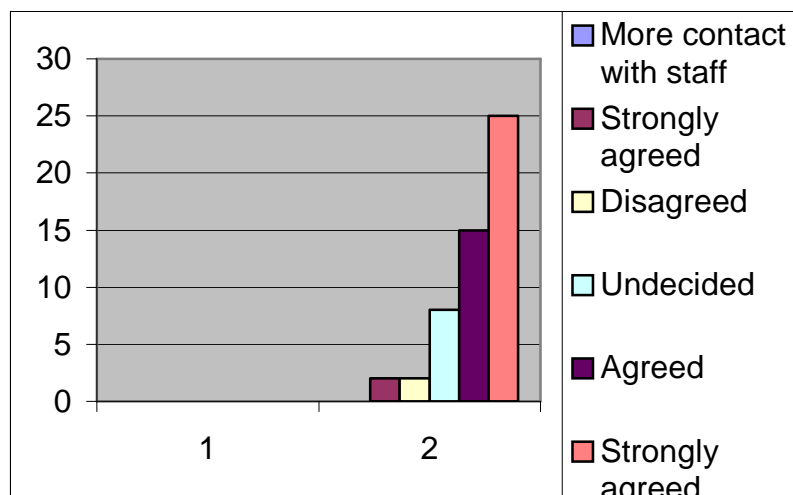


Fig 5 TWT Research Team, Southampton, Hampshire

2.1 In **AREA 2** we asked respondents about raising awareness of the need to combat isolation and loneliness in the communities and the in-patient wards **“How can we/we raise awareness across all sections of the communities”?**

- 11 said they thought by **Community involvement in mental health issues**
- 11 said they thought by **Education in schools**
- 13 said they thought by **Including community/service users in decision making**
- 4 said they thought by **Through employment opportunities**
- 13 said they thought by **Working partnerships**

0 said they thought by **Other**

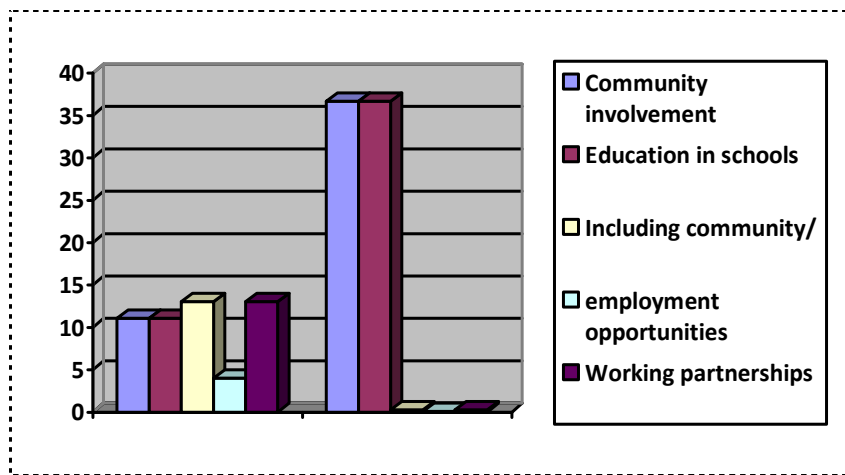


Fig 6 TWT Research Team, Southampton, Hampshire

**2.2** In question 2 we asked respondents “**How can we go about promoting self-help and community groups?**”

- 9 said they thought by **Newspapers**
- 11 said they thought by **Radio sessions**
- 11 said they thought by **Religious establishments**
- 16 said they thought by **Through community gatherings**
- 5 said they thought by **Other**

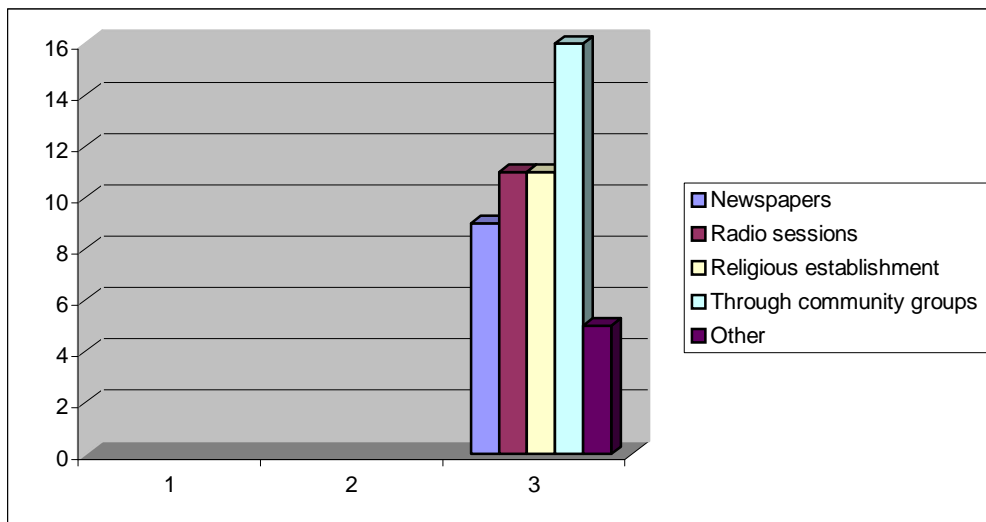


Fig 6 TWT Research Team, Southampton, Hampshire

**2.3** In question 3 we asked respondents “**What can be done to get more people to raise awareness about stigma?**”

- 17 said they would by **More people local people working in mental health settings**
- 13 said they would by **Sessions with prominent BME groups**
- 4 said they would by **Speaking to spiritual leaders**
- 10 said they would by **Through health promotion activities**
- 4 said they would by **Using City Council Authorities**

3 said they would by **Other**

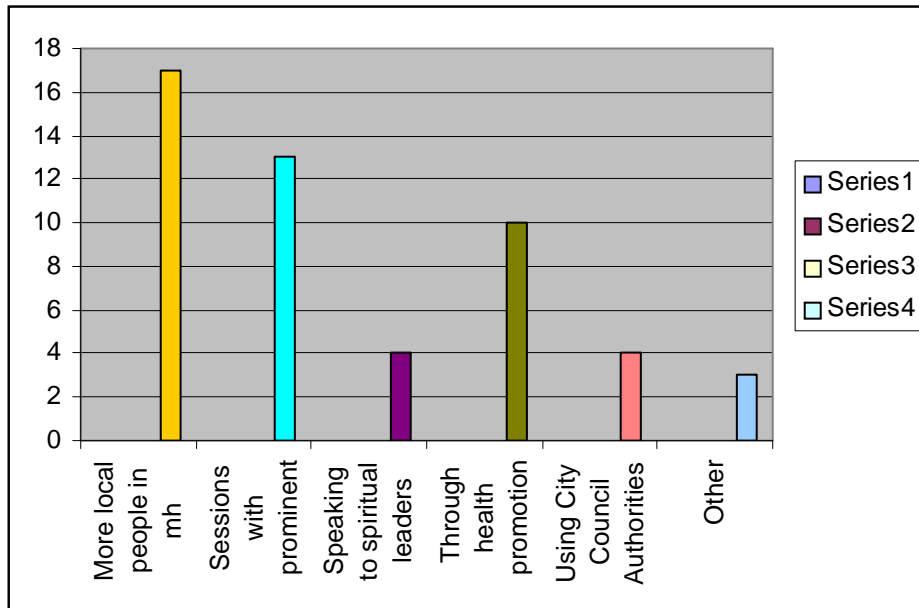


Fig 7 TWT Research Team, Southampton, Hampshire

2.4 In question 4 we made this statement to respondents **“Employment can help in raising awareness about stigma”**

- 1 said they **Strongly disagreed**
- 2 said they **Disagreed**
- 7 said they were **Undecided**
- 20 said they **Agreed**
- 22 said they **Strongly agreed**

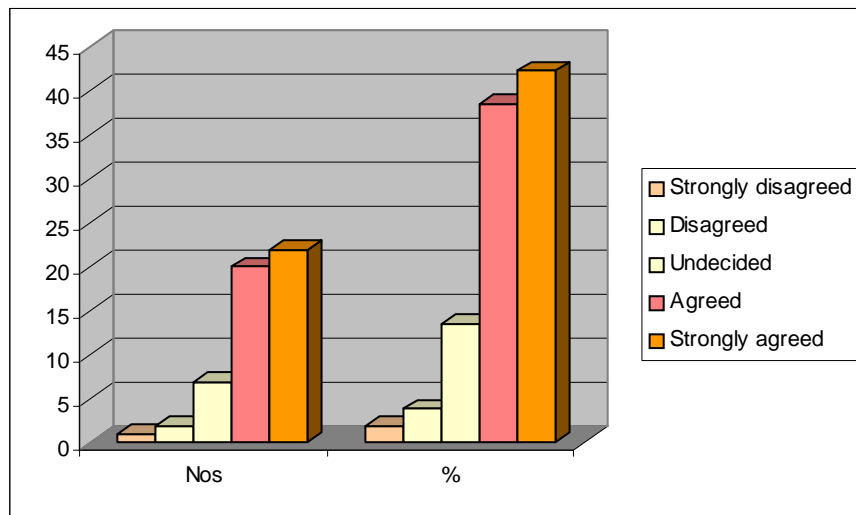


Fig 8 TWT Research Team, Southampton, Hampshire

3.1 In **AREA 3** about spirituality – inspiration to relieve isolation and loneliness on the wards and communities we asked respondents **“What are some of the spiritual needs you would want to prevent isolation and loneliness on wards and communities?”**

- 5 said they thought by **Faith resources e.g. religious texts, prayer mats**
- 0 said they thought by **None at all**

- 9 said they thought by **Pastoral visits**
- 17 said by **Raising awareness amongst staff about religious significant dates**
- 13 said they thought by **Services for all faiths in hospital**
- 8 said they thought by **Other**

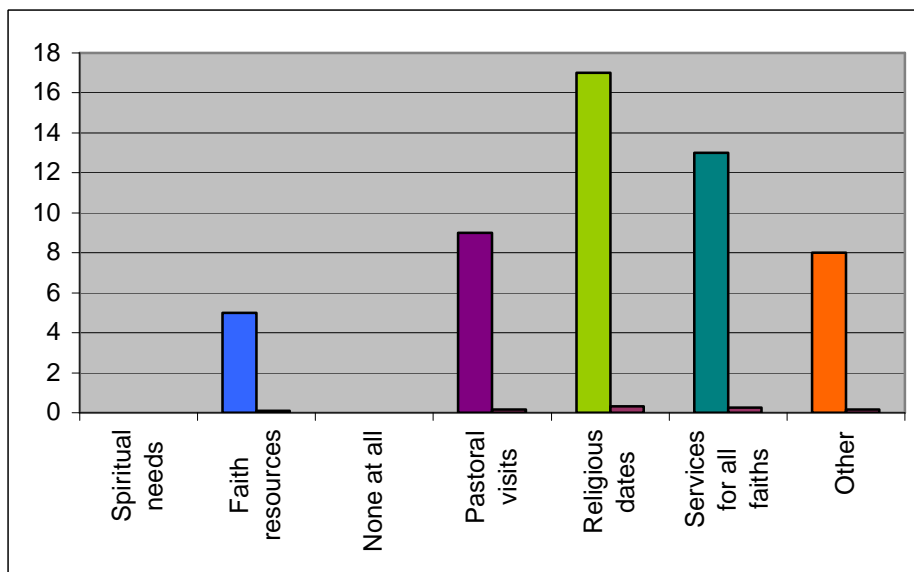


Fig 7 TWT Research Team, Southampton, Hampshire

3.2 In question 2 we asked respondents **“When do you think these needs can be met?”**

- 12 said they thought **Daily**
- 1 said they thought **Monthly**
- 2 said they thought **On special occasions**
- 12 said they thought **Weekly**
- 0 said they thought **Yearly**
- 3 said they thought **Other**

When needs can be met	Nos	%
Daily	12	40.00
Monthly	1	3.33
On special occasions	2	6.67
Weekly	12	40.00
Yearly	0	-
Other	3	
<b>TOTAL</b>	<b>30</b>	<b>100.00</b>

Fig 8 TWT Research Team, Southampton,

**Hampshire**

3.3 In question 3 we asked respondents **“Where would be the best place for it to be performed?”**

- 3 said they thought the best place would be **At home**
- 2 said they thought the best place would be **In the communities**
- 10 said they thought the best place would be **In your room on the ward with family**
- 12 said they thought the best place would be **On the wards**
- 1 said they thought the best place would be **Religious establishments**
- 2 said they thought the best place would be **Other**

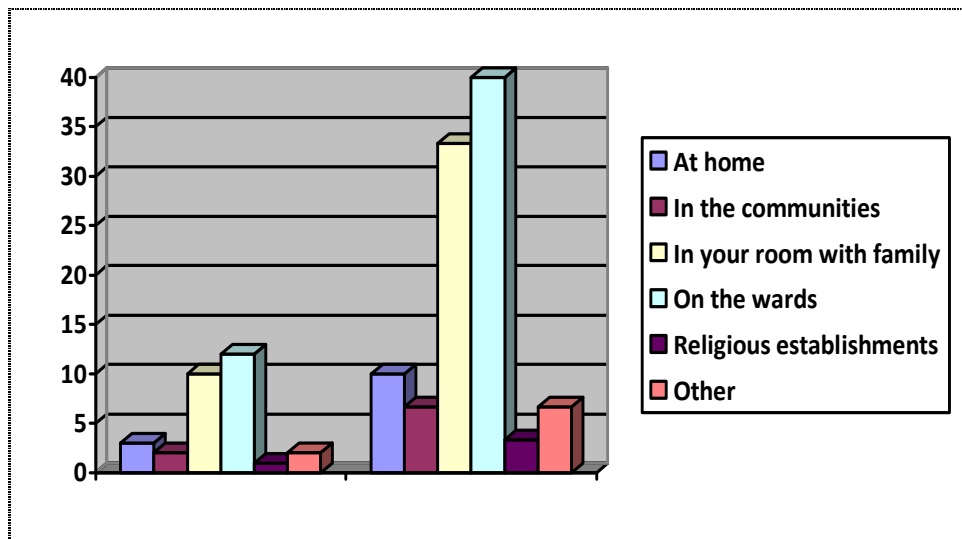


Fig 8 TWT Research Team, Southampton, Hampshire

**3.4 In question 4 we asked respondents (Ex-service-users/carers) “What are the potential benefits of spiritual needs”?**

- 1 said the potential benefits were **None at all**
- 2 said the potential benefits were **Practice beliefs**
- 3 said the potential benefits were **Spiritual enlightenment**
- 1 said the potential benefits were **To congregate**
- 15 said the potential benefits were **Well-being**
- 1 said the potential benefits were **Other**:

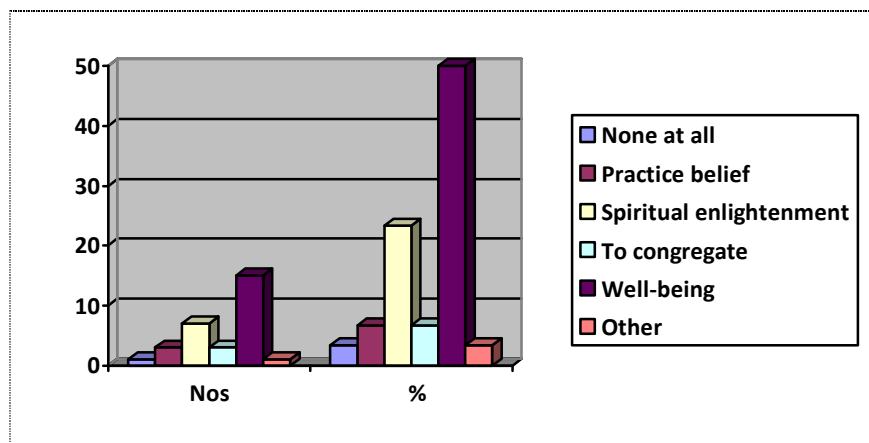


Fig 9 TWT Research Team, Southampton, Hampshire

**3.5 In question 5 we made this statement to respondents “Staff should develop ways to form strong links with the diverse local communities”**

- 2 said they **Strongly disagreed**
- 0 said they **Disagreed**
- 7 said they were **Undecided**
- 22 said they **Agreed**
- 21 said they **Strongly agreed**

Statement responses	Nos	%
Strongly disagreed	2	3.85
Disagreed	0	-
Undecided	7	13.46
Agreed	22	42.31
Strongly agreed	21	40.38
<b>TOTAL</b>	<b>52</b>	<b>100.00</b>

Fig 10 TWT Research Team, Southampton, Hampshire

4.1 In **AREA 4** was about Establishing a Scheme for ex-service users on the wards and communities, we asked respondents “**Could this scheme work as either one of the following**”? They were asked to tick all which applied

- 19 Befriending ~ i.e. visits to service users on wards by peers from BME communities
- 20 Buddying ~ i.e. having a person outside hospital who service user is able to phone
- 13 Peer mentoring ~ i.e. long term support by member of the BME community

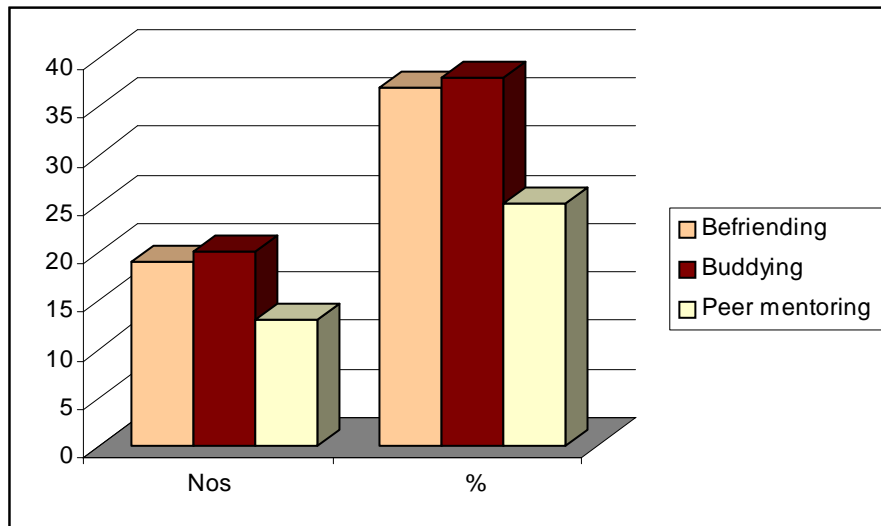


Fig 11 TWT Research Team, Southampton, Hampshire

4.2 In question 2 we asked respondents “**How could this scheme be introduced on the wards?**”

- 0 said they would introduce the scheme by **Private Firm**
- 4 said they would introduce the scheme by **Statutory Agencies**
- 22 said they would introduce the scheme by **The Voluntary Sector**
- 19 said **Through the Care Planning Approach process**
- 3 said they would introduce the scheme by **Do not know**
- 4 said they would introduce the scheme by **Other**

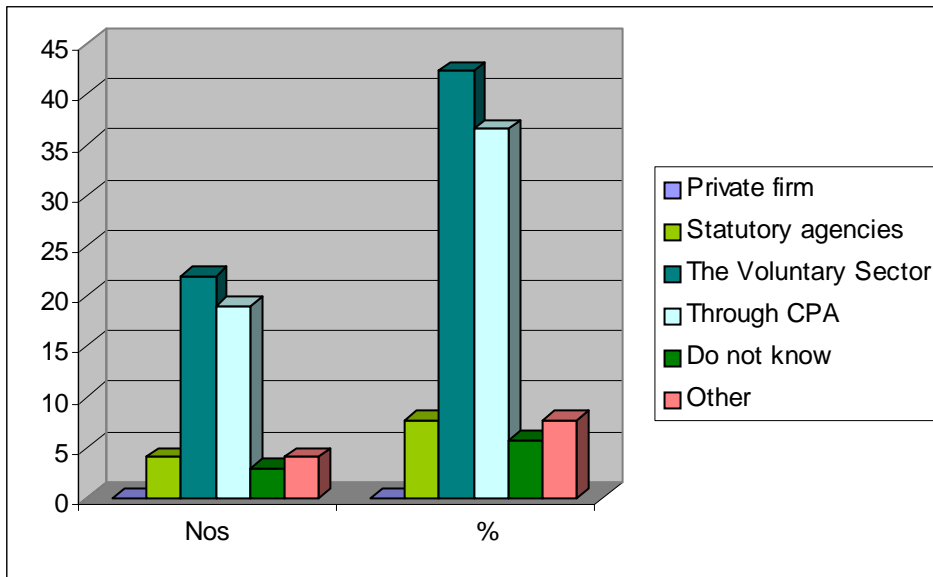


Fig 12 TWT Research Team, Southampton, Hampshire

4.3 In question 3 we made this statement to respondents “**A (befriending, budding or peer mentoring) scheme is able to function in a psychiatric setting?**”

- 1 said they **Strongly disagreed**
- 1 said they **Disagreed**
- 4 said they were **Undecided**
- 27 said they **Agreed**
- 19 said they **Strongly agreed**

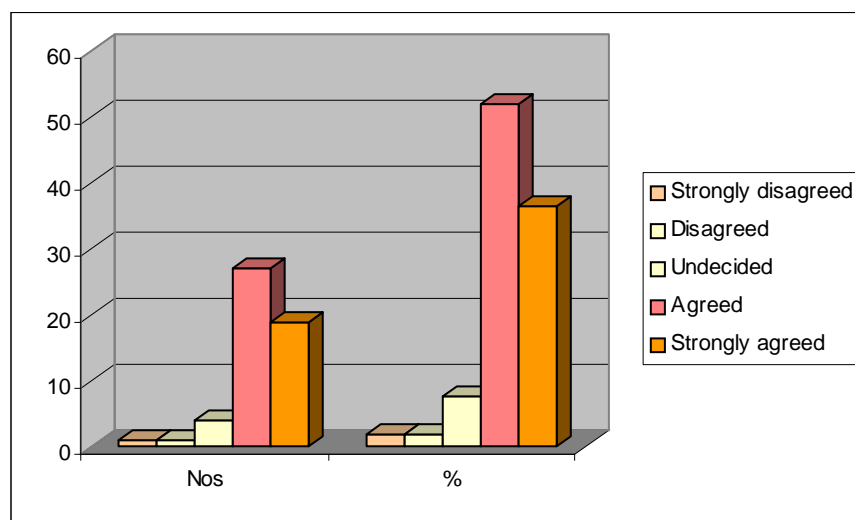


Fig 13 TWT Research Team, Southampton, Hampshire

4.4 In question 4 we asked respondents “**What appeals most about the scheme?**”

- 6 said they thought this appeals most about the scheme **Identifying a need**
- 5 said they thought this appeals most about the scheme **Providing friendship**
- 7 said they thought this appeal most about the scheme **To raise self-esteem**
- 11 said they thought this appeal most about the scheme **To relieve isolation**
- 1 said they thought this appeal most about the scheme **Will not work**

0 said they thought this appeal most about the scheme **Other**

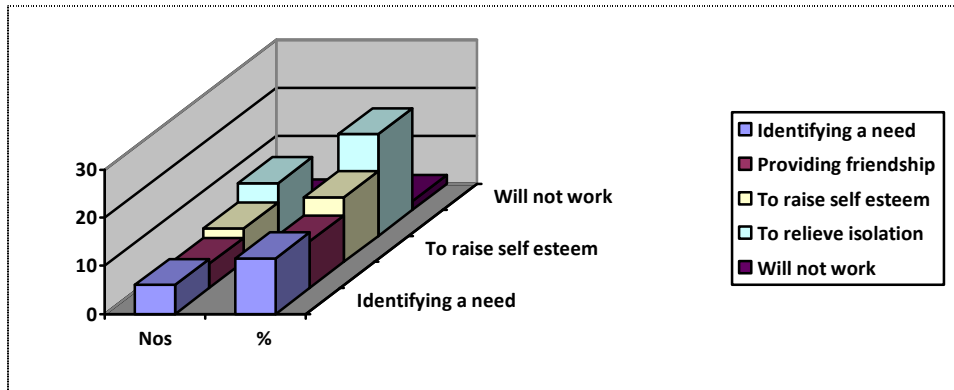


Fig 14 TWT Research Team, Southampton, Hampshire

4.5 In question 5 we asked respondents **“When would you like to see this started?”**

24 said they wanted the scheme started **As soon as possible**

1 said they wanted the scheme started **Don't know**

0 said they wanted the scheme started **Never**

5 said they wanted the scheme started **Next year**

0 said they wanted the scheme started **This year**

0 said they wanted the scheme started **Other**

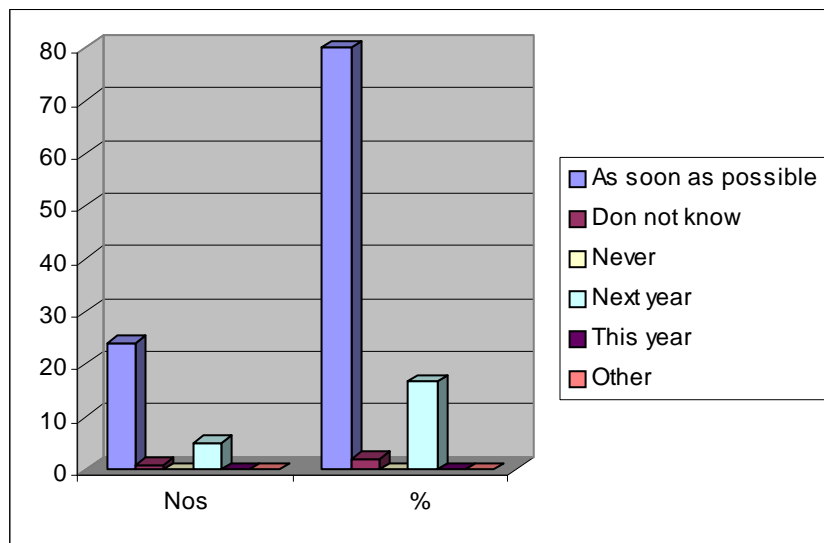


Fig 15 TWT Research Team, Southampton, Hampshire

5.1 In **AREA 5** was centred on Forming a service-user black and minority ethnic Support Group and we made this statement to respondents **“A black and minority ethnic service group will be useful on the wards/communities”?**

0 said they **Strongly disagreed**

0 said they **Disagreed**

1 said they were **Undecided**

12 said they **Agreed**

17 said they **Strongly agreed**

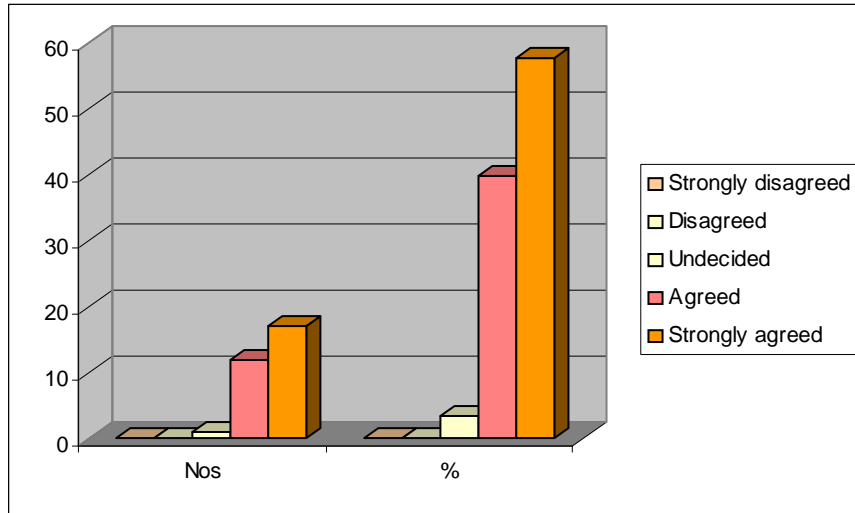


Fig 16 TWT Research Team, Southampton, Hampshire

**5.2** In question 2 we asked respondents “What would be the benefits of having a group like this”?

- 3 said they thought the benefits would be **Empowering them**
- 5 said they thought the benefits would be **Highlighting needs**
- 4 said they thought the benefits would be **Making a difference**
- 6 said they thought the benefits would be **Sharing information**
- 9 said they thought the benefits would be **Support one another**
- 3 said they thought the benefits would be **Shape and design service**
- 0 said they thought the benefits would be **Other**

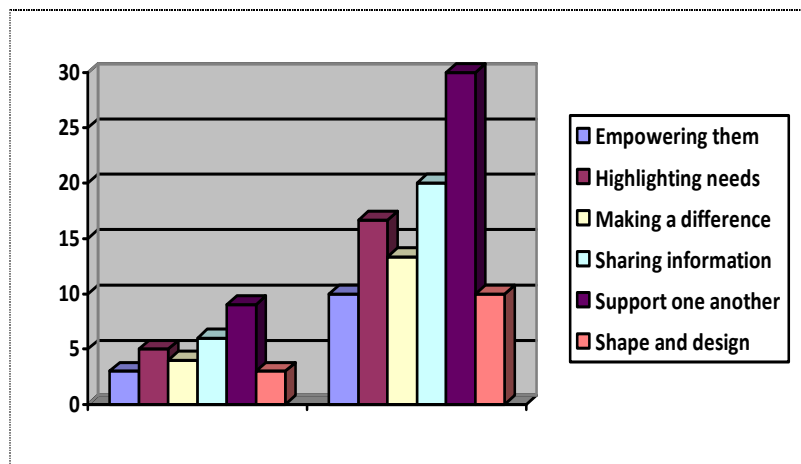


Fig 17 TWT Research Team, Southampton, Hampshire

**5.3** In question 3 we asked respondents “How would we form a group like this?”

- 4 said they thought the group would be formed by **Advertising**
- 4 said they thought the group would be formed by **Consultation**
- 6 said they thought the group would be formed by **Raising awareness of issues**
- 12 and by **Linking the Care Approach Programme with Support Group**
- 3 said they thought the group would be formed by **Outreach worker**
- 1 said they thought the group would be formed by **Do not know**
- 0 said they thought the group would be formed by **Other**

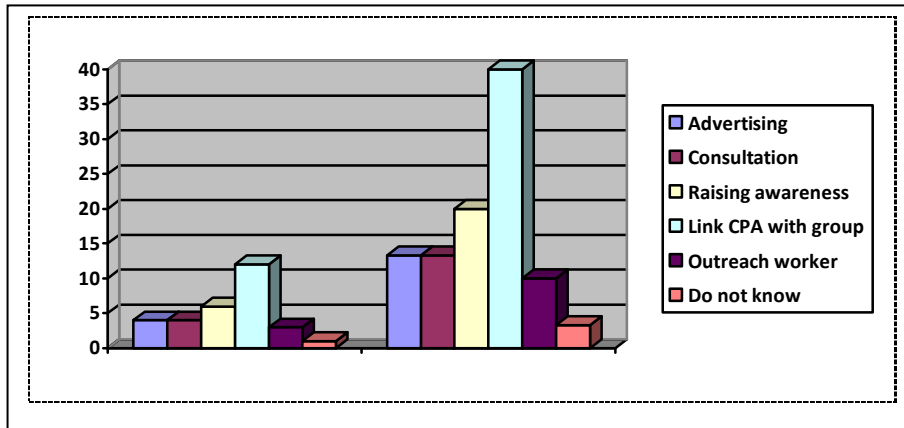


Fig 18 TWT Research Team, Southampton, Hampshire

5.4 In question 4 we asked respondents “Where would be the most suitable or appropriate place to run this group?”

- 8 said the most suitable or appropriate place would be **Community Centre**
- 10 said the most suitable or appropriate place would be **Day Centre**
- 2 said the most suitable or appropriate place would be **Religious establishments**
- 3 said the most suitable or appropriate place would be **Voluntary Service**
- 6 said the most suitable or appropriate place would be **Wards**
- 1 said the most suitable or appropriate place would be **Other**

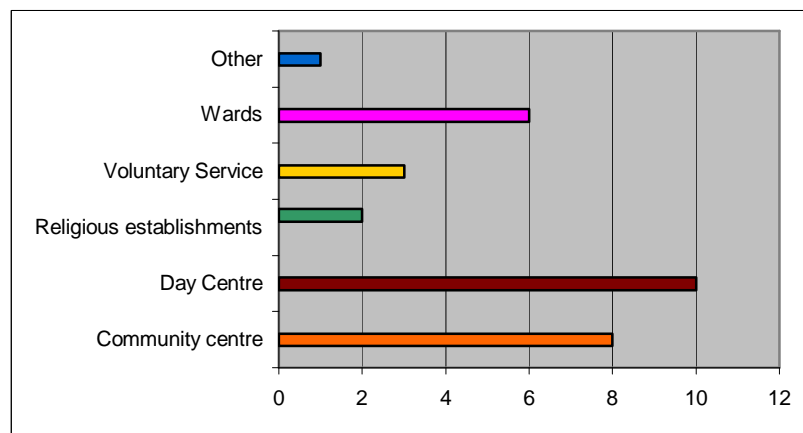


Fig 19 TWT Research Team, Southampton, Hampshire

5.5 In question 5 we asked respondents “How often would they meet?”

- 11 said they would meet **Every week**
- 3 said they would meet **Every two months**
- 10 said they would meet **Monthly**
- 4 said they would meet **Quarterly**
- 2 said they would meet **Other**

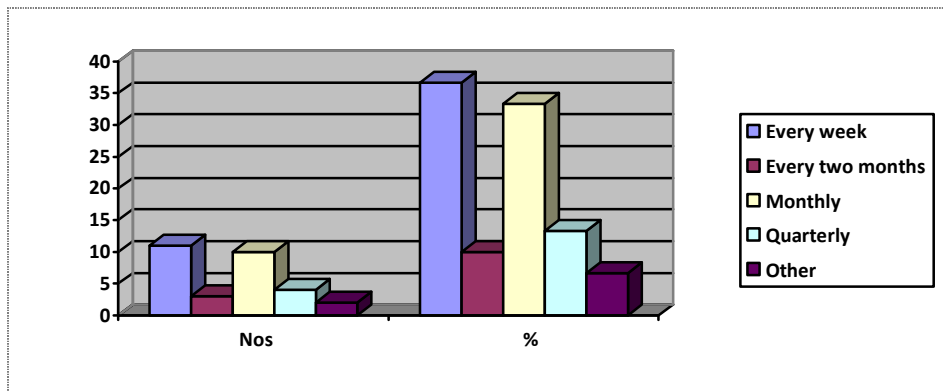


Fig 20 TWT Research Team, Southampton, Hampshire

6.1 In **AREA 6** was centred on introducing an information service specifically for the wards and communities on available services, in question 1 we made this statement to respondents **“There is a general need for an appropriate and targeted information service for black and minority ethnic service users and carers”?**

- 2 said they **Strongly disagreed**
- 1 said they **Disagreed**
- 1 said they were **Undecided**
- 23 said they **Agreed**
- 25 said they **Strongly agreed**

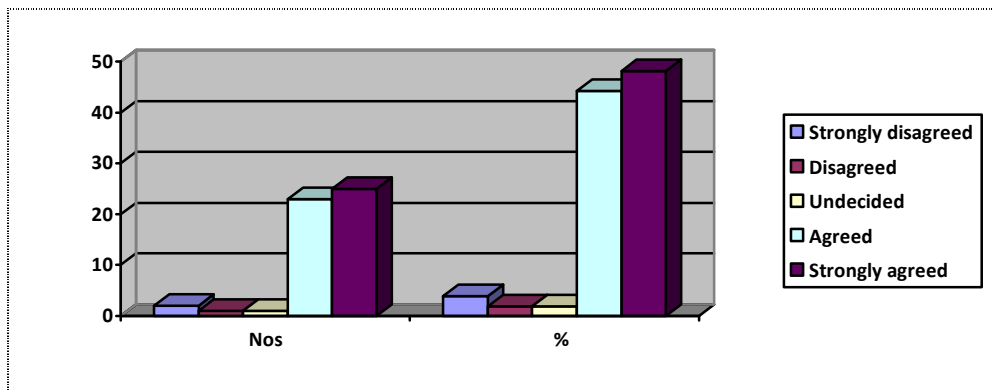


Fig 21 TWT Research Team, Southampton, Hampshire

6.2 In question two we asked respondents **“What types of information can be available in this service”**

**They were given the option to pick as many as which they thought appropriate**

- 22 said these types of information **Accessing personal medical and case notes**
- 32 said these types of information **Advocacy**
- 33 said these types of information **Carers help lines**
- 29 said these types of information **Health promotion leaflets**
- 25 said these types of information **On Patient, Advice & Liaison**
- 32 said these types of information **On services/treatment and conditions**
- 25 said these types of information **Medication**
- 24 said these types of information **Rehab groups**
- 23 said these types of information **Translation services**

TYPES OF INFORMATION	NOS	
Access personal notes	22	Choices
Advocacy	32	Choices
Carers help lines	33	Choices
Health promotion	29	Choices
On Patient Advice & Liaison	25	Choices
On service/treatment	32	Choices
Medication	25	Choices
Rehab groups	24	Choices
Translation services	23	Choices
Other	0	

Fig 22 TWT Research Team, Southampton, Hampshire

6.3 In question 3 we asked respondents “Where would the best place where this can be seen”?

- 8 said they thought the best place would be **Communities**
- 3 said they thought the best place would be **Mail shot**
- 5 said they thought the best place would be **Newsletter**
- 9 said they thought the best place would be **On the wards**
- 4 said they thought the best place would be **Religious places**
- 1 said they thought the best place would be **Other**

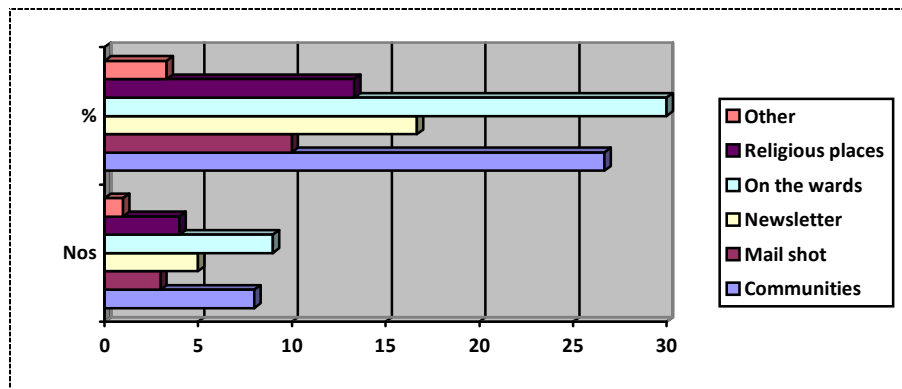


Fig 23 TWT Research Team, Southampton, Hampshire

6.4 In question 4 we made this statement “This scheme should be a service-user and carer lead initiative”

- 1 said they **Strongly disagreed**
- 1 said they **Disagreed**
- 1 said they were **Undecided**
- 21 said they **Agreed**
- 6 said they **Strongly agreed**

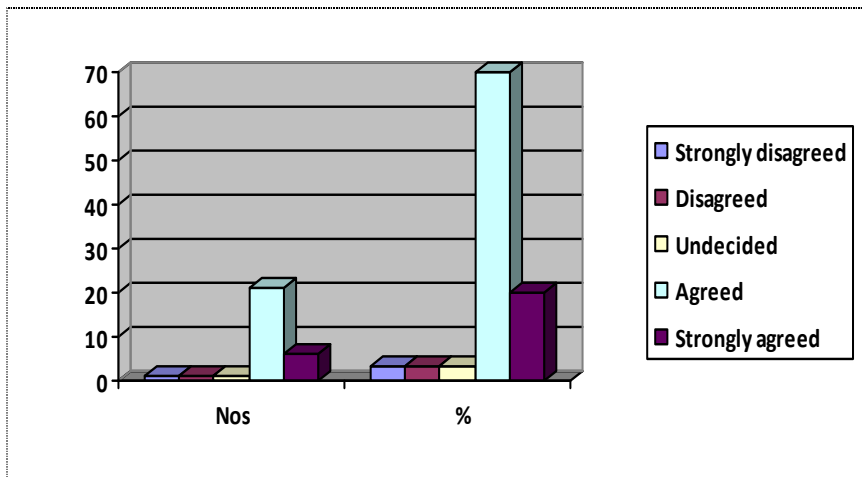


Fig 24 TWT Research Team, Southampton, Hampshire

6.5 In question 5 we asked respondents “How can this be reflective of the communities”?

- 5 said they thought could be reflective of the communities **By the NHS**
- 3 said they thought could be reflective of the communities **City Council led**
- 6 said they thought could be reflective of the communities **Ex-service users/carers**
- 6 said they thought could be reflective of the communities **In different languages**
- 9 said they thought could be reflective of the communities **Run by a BME group**
- 1 said they thought could be reflective of the communities **Other**

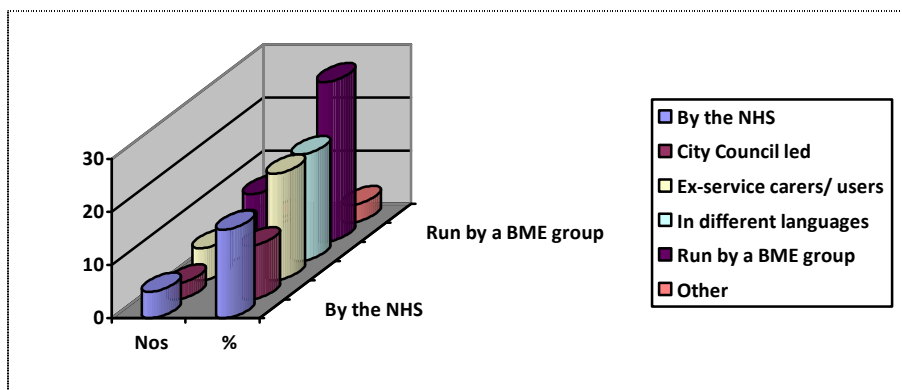


Fig 25 TWT Research Team, Southampton, Hampshire

7.1 In **AREA 7** was centred on promoting access to voluntary services i.e. rehabilitation, vocational, employment and therapeutic needs, our first question we asked respondents “Have you been offered any voluntary/community services”

7 Said **Yes**

23 Said **No**

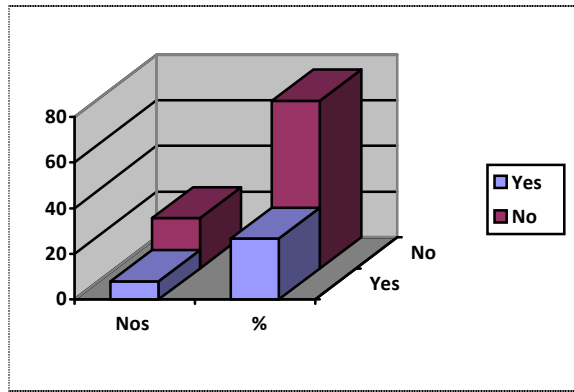


Fig 26 TWT Research Team, Southampton, Hampshire

**7.2 In question 2 we asked respondents “Were you offered any information on how to access these services”?**

- 1 said they were offered information on **Day care services**
- 4 said they were offered information on **Entitled benefits**
- 3 said they were offered information on **Employment opportunities**
- 0 said they were offered information on **Horticultural placement**
- 4 said they were offered information on **Therapeutic activities**
- 2 said they were offered information on **Vocational services**
- 2 said they were offered information on **Other**

Offered any information	Nos
Day care services	1
Entitled benefits	4
Employment opportunities	3
Horticultural placement	0
Therapeutic activities	4
Vocational services	3
Other	2
<b>TOTAL</b>	<b>8</b>

Fig 26 TWT Research Team, Southampton, Hampshire

**7.3 In question 3 we asked respondents “How can we promote access to voluntary/community services”?**

- 20 said they would promote access by **Key Worker**
- 11 said they would promote access by **Mental Health Teams**
- 4 said they would promote access by **Primary Care Trust**
- 8 said they would promote access by **Voluntary groups**
- 3 said they would promote access by **Ward managers**
- 3 said they would promote access by **Other**

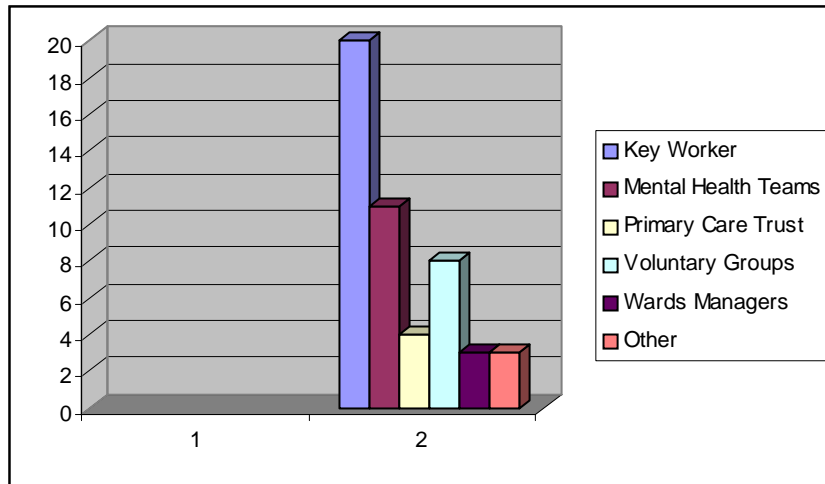


Fig 27 TWT Research Team, Southampton, Hampshire

**7.4 In question 4 we asked respondents “How can the effectiveness of day and drop-in centres services contribute?”**

- 13 said they would contribute by **advertising available services on offer**
- 12 said they would contribute by **Better working with CMHTs, statutory & voluntary**
- 11 said they contribute by **Consultation with service users about reform**
- 9 said they would contribute by **Looking at the planning and design of services**
- 4 said they would contribute by **Review of day and drop-in centres**
- 3 said they would contribute by **Other**

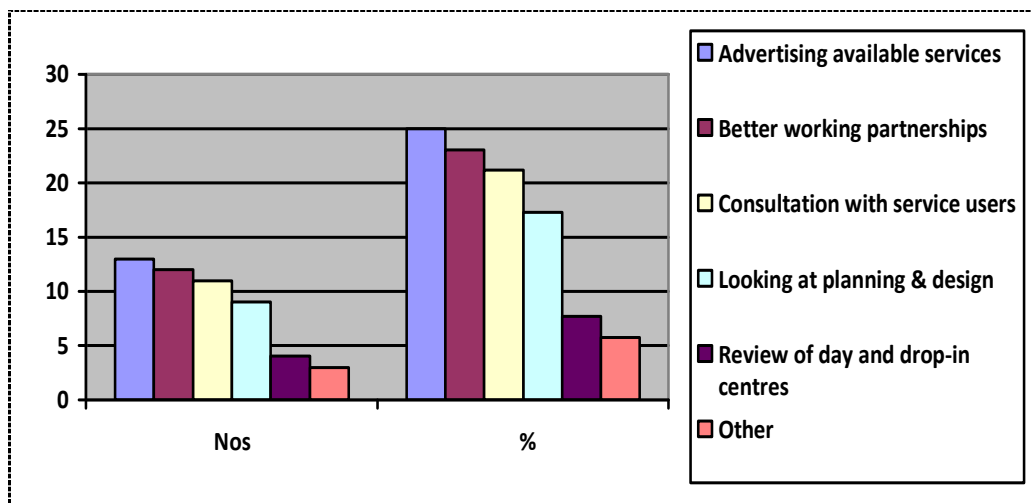


Fig 28 TWT Research Team, Southampton, Hampshire

**7.5 In question 5 we made this statement to respondents “Accessing these services benefit ex-service users and carers”**

- 0 said they **Strongly disagreed**
- 0 said they **Disagree**
- 3 said they were **Undecided**
- 11 said they **Agreed**
- 16 said they **Strongly agreed**

Statement responses	Nos	%
Strongly disagreed	0	0
Disagree	0	0
Undecided	3	15
Agreed	11	55
Strongly agreed	16	80

Strongly disagreed	0	-
Disagreed	0	-
Undecided	3	<b>10.00</b>
Agreed	11	<b>36.67</b>
Strongly agreed	16	<b>53.33</b>
<b>TOTAL</b>	<b>30</b>	<b>100.00</b>

Fig 29 TWT Research Team, Southampton, Hampshire

**7.6** In question 6 we asked respondents **“How would you contact voluntary services after leaving the wards”?**

- 13** said they would by **Approved Social Worker**
- 9** said they would by **Care Programme Approach**
- 10** said they would by **Community Psychiatric Nurse**
- 9** said they would by **Community Mental Health Team**
- 8** said they would by **General Practitioner**
- 3** said they would by **Other**

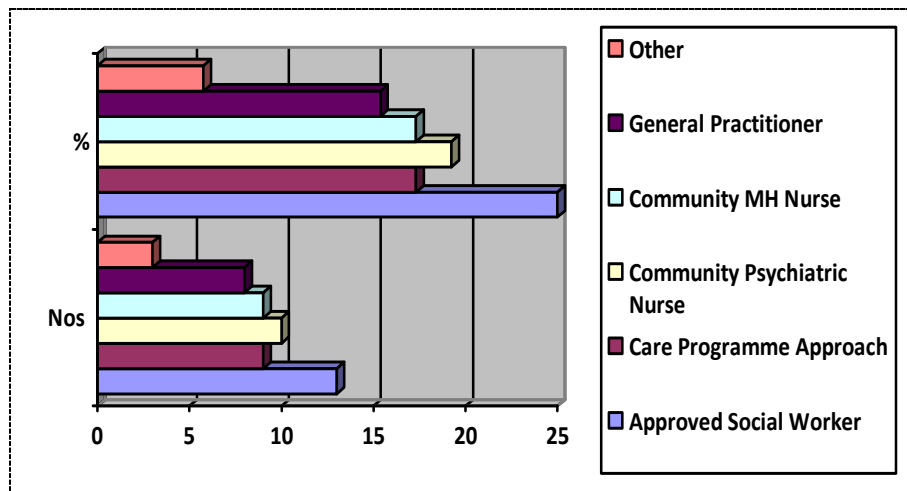


Fig 30 TWT Research Team, Southampton, Hampshire

**8.1** In **AREA 8**, was centred on Cultural Awareness Training for clinical staff and other statutory and voluntary services. The first question we made this statement to respondents **“Your cultural needs were not met while on the wards”**

- 3** said they **Strongly disagreed**
- 4** said they **Disagreed**
- 8** said they were **Undecided**
- 9** said they **Agreed**
- 6** said they **Strongly agreed**

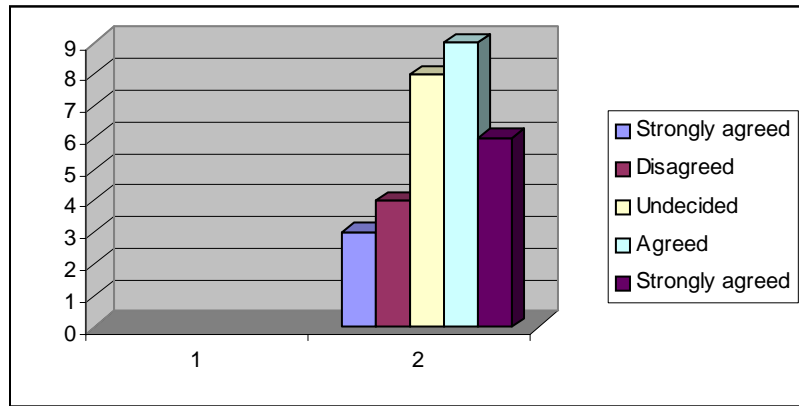


Fig 31 TWT Research Team, Southampton, Hampshire

**8.2 In question 2 we asked respondents “What areas do you think clinical staff needs cultural awareness training”?**

- 11 said they thought staff needed training on **Dietary needs**
- 4 said they thought staff needed training on **Issues around conduct on wards**
- 6 said they thought staff needed training on **Language interpretation**
- 6 said they thought staff needed training on **Religious beliefs traditions**
- 2 said they thought staff needed training on **Traditions**
- 1 said they thought staff needed training on **Other**

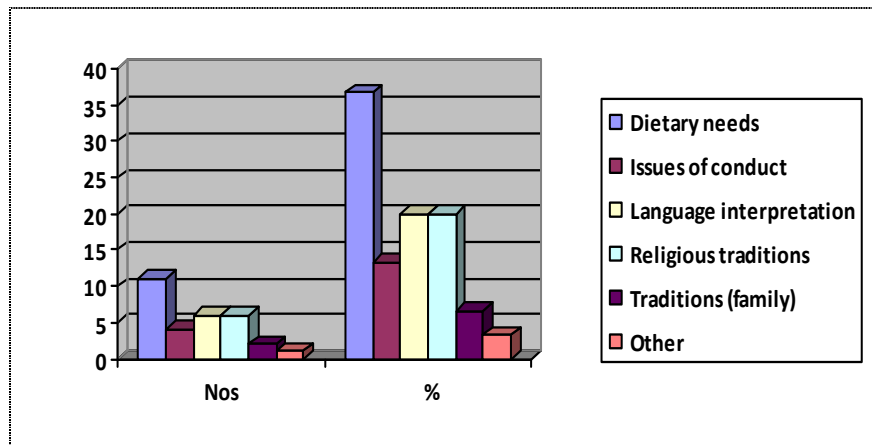


Fig 32 TWT Research Team, Southampton, Hampshire

**8.3 In question 3 we asked respondents “What would be the potential benefits of having culturally trained staff?”**

- 18 said the potential benefits were **Better communication with service users**
- 10 said the potential benefits were **Better response from service users to intervention**
- 15 said the potential benefits were **Easier to relate to culturally different service users**
- 4 said the potential benefits were **Knowledge of values and family dynamics**
- 3 **May make the experience of being a mental health service user more bearable**
- 2 said the potential benefits were **Other**

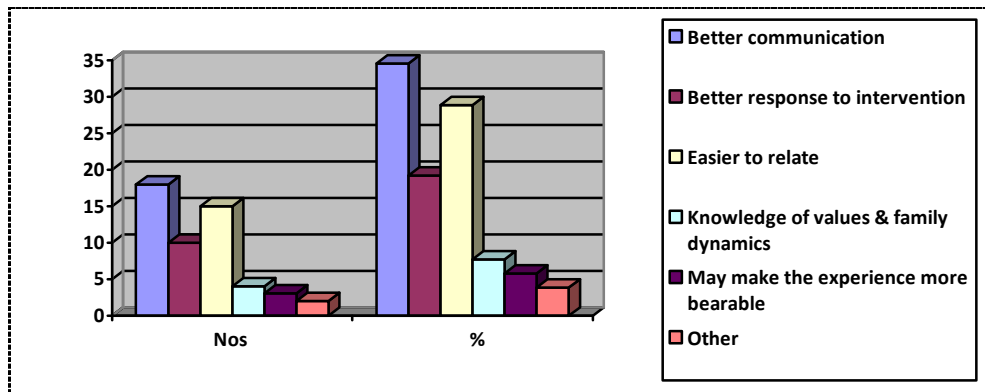


Fig 33 TWT Research Team, Southampton, Hampshire

8.4 In the question 4 we made this statement to respondents “**Cultural Awareness training contribute to identifying isolation and loneliness in black and minority ethnic in-patients**”

- 0 said they **Strongly disagreed**
- 1 said they **Disagreed**
- 1 said they were **Undecided**
- 16 said they **Agreed**
- 12 said they **Strongly agreed**

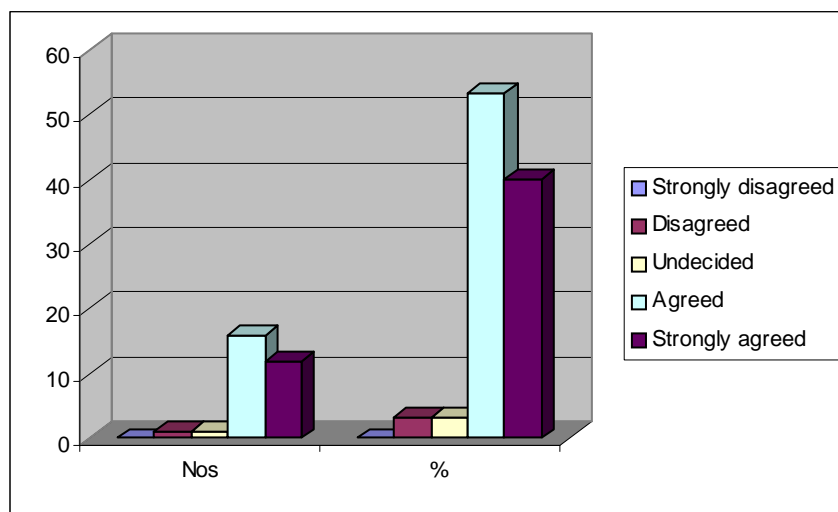


Fig 34 TWT Research Team, Southampton, Hampshire

8.5 In question 5 we made the statement to respondents “**Cultural awareness training in religious customs can be beneficial for staff within the ward environment**”

- 3 said they **Strongly disagreed**
- 0 said they **Disagreed**
- 1 said they were **Undecided**
- 25 said they **Agreed**
- 23 said they **Strongly agreed**

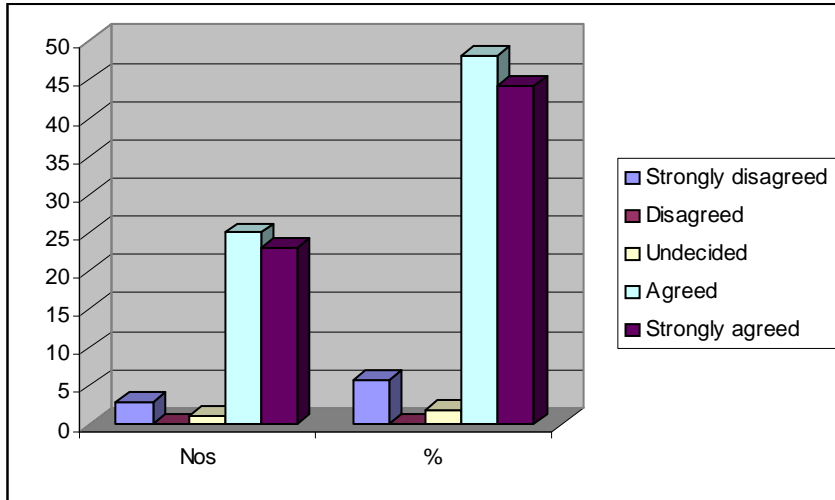


Fig 35 TWT Research Team, Southampton, Hampshire

8.6 In question 6 we made this statement to respondents “ **Religious and cultural training can be beneficial to staff in performing duties**”

- 0** said they **Strongly disagreed**
- 0** said they **Disagreed**
- 2** said they were **Undecided**
- 16** said they **Agreed**
- 12** said they **Strongly agreed**

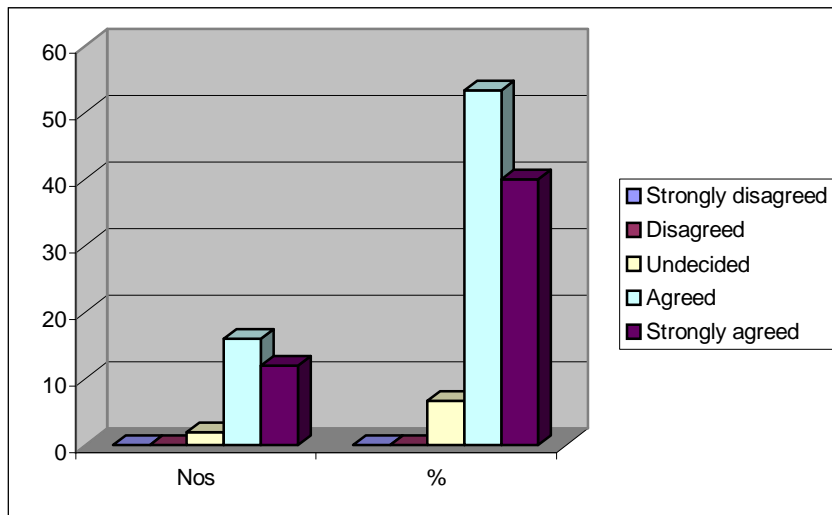


Fig 36 TWT Research Team, Southampton, Hampshire

### 9.1 SATISFACTION WITH SERVICES

Respondents (Ex-service users and carers) were asked:

**“How satisfied were you with the services you received while on the wards?”**

#### On a scale of 1 to 10 In-patients wards

Extremely satisfied (10)

extremely unsatisfied (1)

10 9 8 7 6 5 4 3 2 1 *They indicated by encircling their choice*

The following were respondents' choice

<b>S</b>	<b>10</b>	<b>9</b>	<b>8</b>	<b>7</b>	<b>6</b>	<b>5</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>	<b>0</b>	<b>T</b>
<b>Nos</b>	0	0	3	1	6	8	1	3	3	3	2	<b>30</b>

9.2 Respondents (Ex-service users and carers) were asked:

**“How satisfied were you with the services you received while in Primary Care Services e.g. GP Surgeries?”**

#### On a scale of 1 to 10 G.P Surgeries

Extremely satisfied (10)

extremely unsatisfied (1)

10 9 8 7 6 5 4 3 2 1 *They indicated by encircling your choice*

The following were respondents' choice

<b>S</b>	<b>10</b>	<b>9</b>	<b>8</b>	<b>7</b>	<b>6</b>	<b>5</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>	<b>0</b>	<b>T</b>
<b>No</b>	4	1	5	4	2	4	3	3	0	4	-	<b>30</b>

#### On a scale of 1 to 10 Walk-in Centres

Extremely satisfied (10)

extremely unsatisfied (1)

10 9 8 7 6 5 4 3 2 1 *They indicated by encircling your choice*

The following were respondents' choice

<b>S</b>	<b>10</b>	<b>9</b>	<b>8</b>	<b>7</b>	<b>6</b>	<b>5</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>	<b>0</b>	<b>T</b>
<b>No</b>	3	1	2	1	1	4	1	2	0	2	-	<b>17</b>

**N.B. 13** Respondents never knew what a Walk-in Centre was or there was never a cause to use facility.

## Discussion

This research was investigating the extent and impact of isolation and loneliness amongst black and minority ethnic ex-service users and carers in Southampton. Loneliness overall is very common today and is health threatening, (**Lauder et al 2004**). Researchers have found loneliness is related to depression and mental health problems and is linked to poor economic conditions, (**Mc Innis & White 2001 and Mullins et al 1996**). On the other hand, the lack of friendships may lead to depression, loneliness and psychosomatic mental illness, (**Knickmeyer et al 2002**).

Black and minority ethnic communities may experience loneliness because they are immigrants who may have poor social networks, view immediate neighbours and society as not supportive mechanisms, (**Stressmen et al 1996**). In-equalities in the communities and a lack of social inclusion is linked to poor mental health and is associated to long episodes of mental health disorders, (**Kawachi et al 1994**).

Our main discovery in carrying out the interviews, we found respondents amongst the 16-22 age grouping was hard to find and after further investigation we realised some of respondents we were seeking either were on the restricted part of research i.e.

- **on the in-patient wards** (research's remit centred on the black and minority ethnic ex-service and carers in the communities) and we found from invitations the following:
- **3 were serving criminal long custodial sentences** between the 18-22 ages grouping bracket for 12 months to 40 months.

We found there were differences and commonalities in respondents' views on what should be done to alleviate isolation and loneliness. On the other hand, 75% of the respondents, the ex-service users /carers and service providers were unanimous that a scheme providing a mechanism for forming links with social interaction, guidance and support was inevitable for ex-service users to relieve isolation. They would confide in someone for relieving boredom, depression and to be socially inclusive. One respondent said regarding the scheme:

"I believe from completing the survey we can all work in partnership instead of individual cultures to set one common goal in order to implement some of these useful services i.e. available access to information (to support service users and carers). The befriending scheme which is vital for relieving isolation and loneliness I believe some progress has been made by the Health Service but from this survey there are still some gaps in service provision." **Carer Female**

### \* **Spirituality and mental health care**

The spiritual needs of service users and the benefits to them when they are in crisis or recovery and what were the values of nurturing those needs of the individuals was investigated to look where spirituality fits in mental health care. Religion is best described as a system of faith, doctrines and worshipping a personal god. On the other hand some may argue spirituality may be associated with belonging to a specific church, mosque, temple or an ecclesiastic place of worship.

One respondent felt spiritual needs would not only have a religious overtone because it could be interpreted as part of a role to promote well being.

"Meeting spiritual need is an important part of recovery and wellness. I stress spiritual need doesn't have to mean religious." **Voluntary Sector Male**

50% of ex-service users and carers identified the potential benefits of their spiritual needs to signify their well being and this was clearly demonstrated in one respondent's views.

"Can bring positive mental health benefits. Spirituality may be central to a person's indemnity, sense of self and means of coping. *Alt* to these needs also shows that staff values the person and their needs." **Strategic Personnel**

32% of respondents felt there was a need to facilitate services for all faiths and 82% of all respondents thought staff should be aware of all religious significant dates. 40% of ex-service users and carers contemplated that their prayer times would be allocated weekly and staff should endeavour to form strong links the local diverse faith communities. One participant felt spiritual needs helps in earning a greater awareness of their improvement in their mental health condition.

"Everyone has spiritual needs even if they do not identify themselves with any particular faith group therefore any activity which raises self-esteem and feelings of belonging are valuable in improving mental health of individuals and "the community" as a whole." **NHS Worker Female**

All participants, ex-service users, carers and service providers recognised there were benefits in improving communication and dialogue to relieve isolation and loneliness on in-patients wards, one respondent clearly demonstrated this.

"I think where service users are spiritual, it helps them understand their problems and how they see the world. You can't ignore peoples' spiritual needs, having a dialogue on how mental health works with spirituality. We need to build bridges and find solutions." **Strategic Personnel**

The black and minority ethnic communities have a role to play in nurturing spiritual needs to relieve isolation and loneliness by established ecclesiastical establishments. The main goal would be to play a part in the depressed and mentally ill individuals' recovery.

"The church needs to be more involved in understanding and reducing isolation and loneliness. Community needs to understand what it means to be lonely." **Carer Female**

#### \* **Staff on psychiatric in-patient units**

We were looking at the extent and impact of isolation and loneliness particularly on in-patient units and the hypothesis of this research were clearly to investigate all elements which interfaces with in-patients entering the wards, their carers and staff which providers the service.

While we were planning this research we felt this area should be given the utmost attention as in-patients spent a great portion of their recovery on the wards. All respondents recognised staffs at times had immense strain on them to deliver a service which is fair and looks at the best interest of its' occupants while they are in the units. This quite clearly is enshrined in the 'philosophy of care' and the patients' charter, which all staffs abide by in delivering care on psychiatric in-patient units.

Ex-service users and carers felt at times they were misunderstood and this led to a lack of trust on the cultural competencies of staffs. There needs be to 'cultural' engagement, which gives in-patients and carers the inclination that their care comes before anything and they are listened to.

One respondent graphically spoke of their views about been stereotyped on arrival on wards and going through the adjustment period of settling in to receive the appropriate care.

“Identifying their cultural and religious need is first thing they should assess when patients enter the ward. There is always a misconception of black and minority ethnic service users when they enter the wards. A lack of understanding culture and cultural needs can make a person isolated and lonely. Staff and service providers should be trained to find the triggers and signs which help slow down the process of been isolated and lonely.” **Ex-service user Male**

#### \* **Cultural awareness training for staffs**

There were differences and commonalities in respondents' views on what cultural competencies training should be for staffs to work within a multicultural community. We asked service users and carers which areas they thought clinical staff would benefit them most, 36% of all respondents said dietary needs.

On the one hand, clinical staffs were not responsible for dietary needs specifically but service users and carers were saying many staff did not understand their cultural customs around eating. One respondent felt his cultural and religious dietary needs were not sufficiently met while on the in-patients' wards by his response.

“Better interaction between staff and patients. Providing for better food and greater variety in foods and the portions of food is very small and do not cater for Halal meats.” **Ex-service user Male**

Overall, locally here in Southampton there has been greater emphasis on training staff to undergo mandatory cultural competence training like the Race Equality and Cultural Capabilities materials and some improvements have been achieved in raising awareness of black and minority ethnic issues. Changing practices requires a concerted effort to address some of the underlying issues, which faces service users and carers.

Ex-service users and carers respondents (32.69%) thought cultural awareness training would help to identify isolation and loneliness but on the other hand service providers (21.15%) also agreed favourable with training to spot those signs.

#### \* **Resources on in-patient units**

The resources on wards at times are insufficient and ex-service users and carers felt this was contributing to a lack of attention to them. Communication and involvement goes a long to achieve respect for one another, more person to person contact would change attitudes and change work cultures, one respondent illustrated their perspective.

“Staff should not be blamed, is Managers and people higher up! Resources are scare on the wards but I think appliances can be better. Food should be better and in bigger portions. A vending machine catering for sandwiches and chocolates should be introduced.” **Ex-service user Male**

#### \* **Activities for in-patient wards**

After looking carefully at the results of the investigation we concurred social activities on wards would prevent isolation and loneliness suffered by in-patients, 32.69% of ex-service users\ carers and 38.46% of service providers respondents felt the need for community

visitors from the same community visiting while in the units. We believe our two main points from the Delivering Race Equality 12 characteristics would be met by these measures.

- **A reduction in the rate of admission of people from black and minority ethnic communities to psychiatric inpatient units.**
- **A reduction in the disproportionate rates of compulsory detention of BME service users in the inpatients units.**

There were suggestions from a respondent to install confectionery machines on units and visits from loved ones to reduce isolation in these wards.

“Conjugal special visits from love ones and sexual needs helps to relieve isolation and frustration on the wards. Better awareness of people with mental health issues from the community as a whole. Something is been done and it would help a lot of people.” **Ex-service user Male**

Activities on wards would not take many resources from the views of respondents and an information service outlining core services was suggested. Mainly to communicate what is available ranging from advocacy services, carers help lines, medication, and rehabilitation and translation services.

Mental stimulation remains the number one priority for in-patients, to introduce activities, which involves people and raises their self-esteem, one respondent vividly made a case for it.

“Involving more activities, people are not confidence, doing some kind of voluntary work will definitely help to relieve isolation and loneliness.” **Ex-service user Female**

#### \* **CPA (Care programme Approach)**

The Care Programme Approach was introduced in 1991 to look at the direct needs of those suffering with severe mental illness. During the course of this investigation into isolation and loneliness on in-patients wards and communities the CPA (Care Programme Approach) came up intermittently. It was designed to look at all needs whether they are cultural, generic, religious, spiritual or otherwise. In our investigation, we found 42% of respondents (ex-service users and carers) wanted a support group linked with the care programme approach.

#### \* **Community awareness of isolation and loneliness**

Key phases came to us:

- ❖ Promote appropriate information on mental health and well being
- ❖ Black and minority ethnic groups cohesion and acknowledgement of mental health issues
- ❖ Churches, mosques, temples and other places of worship to seek to understand mental health/isolation/loneliness.
- ❖ Comfort, support and families to promote well being in the communities.

#### \* **More research/reaction patient & ward staff**

In the course of this investigation we were not able to reach all groups involved on in-patients wards and this opens the way for further work specifically people who are presently on wards. One respondent offered thoughts for future work.

“It would be better if more research was done on how in-patients are treated. I do not think it is lonely on the wards there because the patients help each other. Just staffs do not help you and does not give a hands-on approach to looking after you. Research should be done on treatment of staff to in-patients on the wards and the reaction.” **Ex-service user Female**

## Recommendations

### Hampshire Partnership NHS Trust ~ Focussed Implementation Site

- We recommend the Steering Group of the site use the groups’ resources of its membership and the CDWs (Community Development Workers) to develop a strategic work plan around the report’s findings and recommendations. Primarily, to reduce the disproportionate numbers of black and minority ethnic people which end up in the psychiatric wards.
- To oversee the implementation measures and to facilitate greater awareness of the importance of the impact of isolation and loneliness on the BME (black and minority ethnic) ex-service users and carers in the communities.
- To audit the work plan after six months and thereafter on the anniversary of the report’s launched to measure achievements and outcomes.

### Hampshire Partnership NHS Trust ~ In-patient wards

**TRAINING** Research data suggests the following should be taken on board for future training modules:

- Cultural awareness training to identify isolation and loneliness in black and minority ethnic in-patients.
- To include **dietary, religious and cultural customs** as part of training practices.
- To ensure appropriate staff becomes acquainted with **religious significant dates**.
- ⊕ To urgently seek to establish a **befriending/buddying scheme** to reduce isolation and loneliness suffered by in and out patients on the wards and the communities.
- To establish a protocol for staffs to familiarise themselves with a **pathway introduction** to the proposed (befriending/ buddying) scheme on wards.
- ⊕ To use available resources within the black and minority ethnic communities to introduce a black and minority ethnic **support group** for reliving isolation and loneliness.

### Southampton Local Implementation Team

- \* To start future commissioning service provision preparations for funding to establish the befriending/buddying scheme and to ensure it’s sustainability in the foreseeable future.

### Southampton City Primary Care Trust

- ❖ To highlight greater working partnerships between primary and secondary to influence more appropriate and responsive services.
- ❖ To develop targeted appropriate information for service users, carers, the secondary services and the voluntary sector for greater accessibility of primary and secondary care services.

## Solent Mind ~ voluntary services sector provider

- \* To primarily look at improving the way the organisation advertises its' available services to the diverse black and minority ethnic communities in Southampton.
- \* To embark on a drive which looks at promoting access of available services on offer to black and minority ethnic outpatients clients and carers in the communities.

**Other voluntary agencies:** To organise a service, which could made available within the in-patient wards for visiting people who are hospitalised from their own ethnic group.

## Reflection

After carefully looking at the analysis and emerging themes of this investigation into isolation and loneliness, we found out there is a substantial gap in the communities and mental health setting regarding the acknowledgement of in-patients and outpatients being isolated and lonely.

There is a compelling case for introducing activities that reduces boredom and stimulates interaction for social inclusion in society. We strongly recommend the findings of this report is looked at for introducing the befriending / budding scheme and the scheme which lets communities' members from the same group visiting those on the wards.

These measures will certainly reduce the disproportionate numbers of black and minority ethnic people who ends up in mental health institutions and seek to reduce those who are compulsory placed on wards.

### \* What has been learnt collectively as a team?

Collectively as a team we bonded very quickly and were able to come up with a substantial questionnaire. We found the following:

- ❖ The benefits of teamwork
- ❖ Value of partnerships
- ❖ Shared experiences
- ❖ Networked with people having a common goal
- ❖ Community engagement practices
- ❖ Management of a community research with mental health ex-service users, carers and service providers with some skill.
- ❖ Gained valuable knowledge about mental health and isolation/loneliness

### \* As individuals what has been learnt on the research project

“For me, this Community Engagement project I gained knowledge about mental health service provision for the Somali community and other ones different to understand mental health issue. I have a better understanding of BME communities' mental health issue and plan to help others. I have learnt about BME Communities mental health issues, the gaps, service providers and service users. I would like to try mental health research in Somali community to improve my knowledge and experience about mental health and working in partnership with the University Central Lancashire and NHS.” **Nor**

As for me as an individual I have learnt how to work as a valuable team member, how important a community engagement project as far as mental health is into BME (black and minority ethnic) is concerned. I have developed new skills into community-based research, to collect information, devise questionnaires and interviewing skills to reach deadlines. From a selfish point I have decided that I would really like to work with the black and minority ethnic community in mental health.” **Greg**

“It was a pleasure working with an enthusiastic bunch of people. Overall, personally fulfilling the aims and objectives has been the core of the drive to succeed in the final report. I was struck by the genuineness of ex-service users and carers in coming forward for a very tricky research area in mental health. The main part of this work we have finished, now primarily it gives everyone a chance to help those who suffer with isolation and loneliness. They have given us their time, thoughts and aspirations for better living situations.” **Phil**

✳ **How has the Wiltshire Trust benefited or developed as a result of this project?**

The Wiltshire Trust have benefited by:

- ❖ Improving our resourcefulness
- ❖ Gaining better capacity building methods
- ❖ Training new black and minority ethnic with mental health skills
- ❖ Interfacing with new organisations in Hampshire & the Isle of Wight
- ❖ Acquiring more research creditability in the region, 1998, 2003 + 2007
- ❖ Learning from community engagement practices

✳ **Unexpected outcomes**

- ❖ Difficulty in accessing respondents from the 16-24 age grouping
- ❖ General Practitioners reluctance to be part of the survey
- ❖ Challenging instances in getting mental health trust appropriate staff to embrace the importance of the work

✳ **Advice for future groups embarking on similar projects.**

- ❖ Work closely with your Race Equality Lead and Focussed Implementation Site’s Co-ordinator for success
- ❖ Planning is vital for good outcomes
- ❖ Teamwork is essential for getting ideas to reality
- ❖ Use the University of Central Lancashire’s good system for guidance
- ❖ Form partnerships with recognised voluntary sector communities
- ❖ Last but not least, use the resources of your project’s Steering Group

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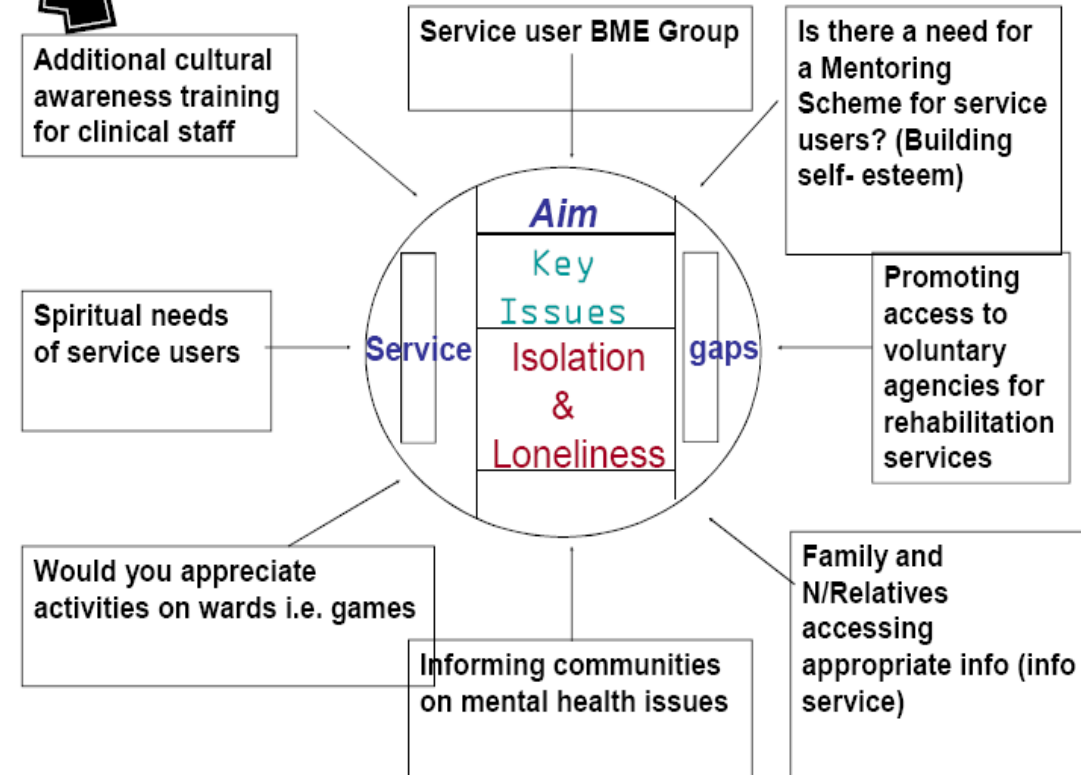
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Appendix 1



# Brainstorming – Questionnaire 10-07-06





Project Plan Activities	Who	MAY Mnth -1	JUN Mnth -2	JUL Mnth 1	AUG Mnth 2	SEP/OCT Mnth 3 & 4	NOV/DEC Mnth 5 & 6	JAN Mnth 7	FEB Mnth 8	MAR Mnth 9
<b>ESTABLISH CONTACT/ LEAD PERSONNEL</b> Race Equality Lead – Poppy Jaman Focussed Implementation Site – Beverley Meeson	PS	✓	✓							
<b>RECRUITMENT OF 'RESEARCHERS'</b> To attend Workshop days in June & the Autumn	PS		✓	✓						
Notify key groups in community about work.	PS		✓	✓						
<b>'RESEARCHERS' ATTEND WORKSHOPS</b> Familiarization with community research Key aims of 5 year plan DRE document	ALL			✓	✓					
	ALL									
<b>DEVELOP WORK PLAN with SUPPORT</b> Worker – Norman Powell. <b>Steering Group facilitation plans – Focussed Implementation Site</b>	PS		✓	✓						
<b>MONITORING TOOL OF THE RESEARCH</b> Nine months of the research, from inception to the completion of the Community based research.	PS			✓	✓					
<b>BRAINSTORM: All relevant documents</b> Invitation letter, Information letter, Consent form, Filling out demographic Personal details, Draft Questionnaire & Complete Draft Research Tool	ALL			✓	✓					
	ALL			✓	✓					
<b>SUBMISSION OF RESEARCH DOCUMENTS</b>	ALL				✓	✓				
<b>RESEARCHERS UNDERTAKE FIELDWORK SOUTHAMPTON AND HAMPSHIRE.</b>	ALL					✓	✓			
<b>ATTEND AUTUMN REMAINING WORKSHOPS</b>	ALL					✓	✓			
<b>RESEARCHERS UNDERTAKE ANALYSIS OF DATA COLLECTED. START WRITING UP REPORT AND FINALISE FIRST DRAFT</b>	ALL						✓	✓		
	ALL						✓	✓		
<b>SUBMISSION OF DRAFT REPORT – 1 HARD COPY &amp; 1 ELECTRONIC TO UCLan</b>	ALL							✓	✓	
REVIEW , AMENDMENTS AND FINAL REPORT DISSEMINATION – LAUNCH OF WORK	ALL								✓	✓
<b>COMMUNITY RESEARCH – MH NEEDS SOTON &amp; HANTS PROJECT COMPLETED</b>	ALL									✓
										✓

AP  
PE  
NDI  
X 2

WARD SETTING – REDUCTION IN ISOLATION & LONELINESS

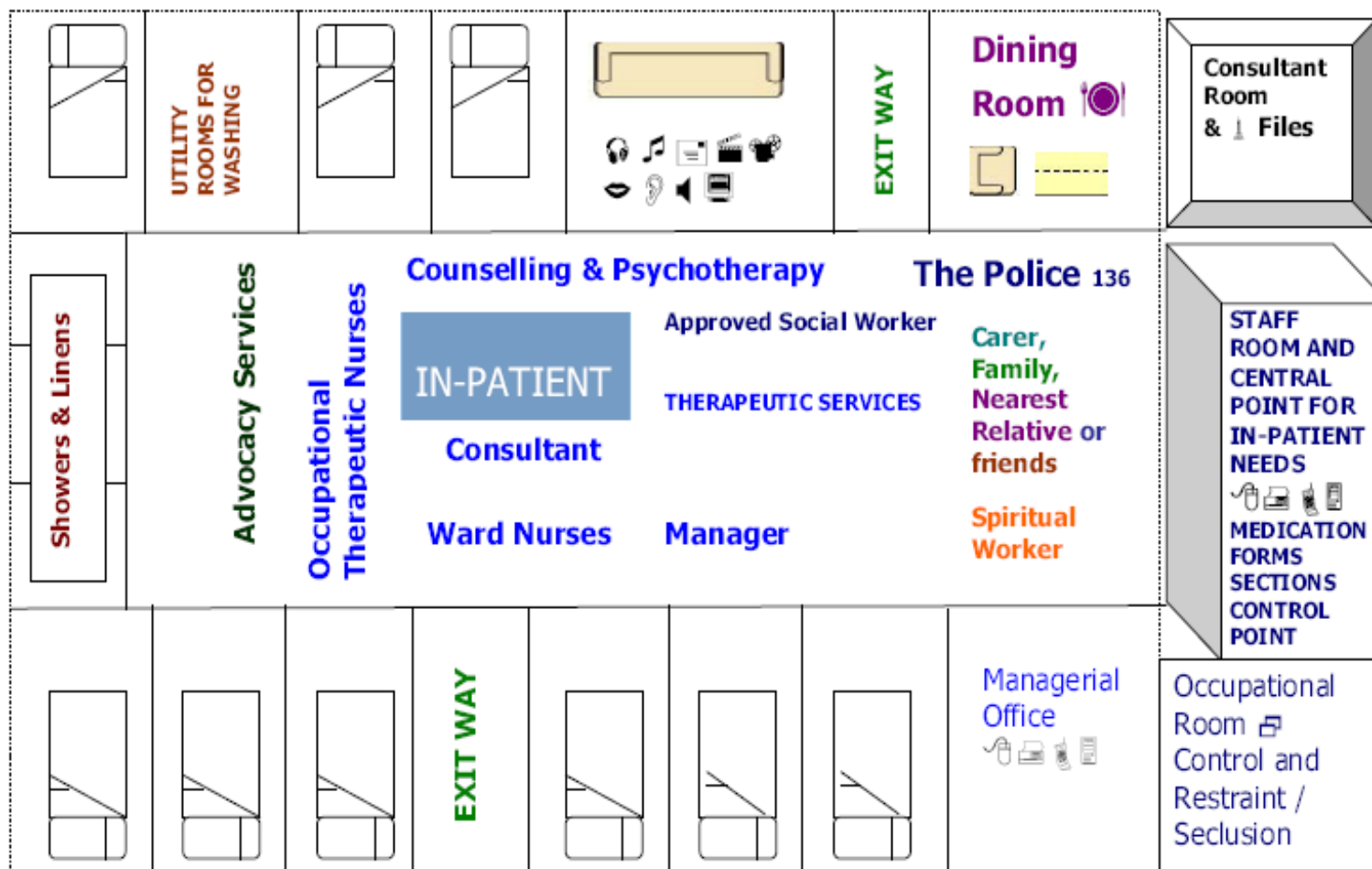


Diagram: TWT Research Team, Soton, Hants Pdazzler Production

Appendix 3

Name of Group	The Wiltshire Trust
Address	P.O. Box 566, Southampton, SO14 3XJ, Hampshire
Name of Support Worker	Anthony Kollie
Date	20 <sup>th</sup> October 2006
<b>Section 2</b>	
What kind of work does the group intend to do as part of this project?	<p>To investigate the extent and impact of isolation and loneliness amongst mentally ill black and minority ethnic service users/carers and to look at ways of reducing this in Southampton, Hampshire communities and to augment the Delivering Race Equality two priorities of the 12 points Action Plan highlighting the following:</p> <ul style="list-style-type: none"> <li>* <b>A reduction in the rate of admission of people from black and minority ethnic communities to psychiatric inpatient units.</b></li> <li>* <b>A reduction in the disproportionate rates of compulsory detention of BME service users in the inpatients units.</b></li> </ul> <p><b>Outcomes of project</b></p> <p>How will the findings and recommendations of the research influence ~ fewer admissions to inpatient wards? In our experience of when ex-service users are re-admitted to the in-patient units primarily one of the contributing factors relates to them not being able to cope on their own in the communities because they become isolated and lonely. The research we are investigating could have some recommendations for service provision to alleviate admissions.</p>
How do they intend to do this?	Questionnaire interviews in a semi-structured format and will be carried out in pairs on a face to face basis.
Who will be the respondents be?	<p>60 ex-service users, carers, statutory and voluntary services personnel for the black and minority ethnic communities.</p> <p><b>Breakdown of respondents</b></p> <p><input checked="" type="checkbox"/> Carers = 15, <input checked="" type="checkbox"/> Ex-service user = 25, <input checked="" type="checkbox"/> Statutory and Clinical = 15 and <input checked="" type="checkbox"/> Voluntary/ Community Services = 5.</p> <p><b>Local Research Ethics Committee approval</b> NHS Research and Development Application form N47429, will be submitted for approval to the local Committee: R&amp;D University of Southampton Department of Psychiatry Brintons Road, Southampton SO14 0YH</p> <p><b>(Please see attached submitted NHS R&amp;D form)</b> No premises of Statutory services will be used in the research.</p>
Who will they get to do the	We will be recruiting people from the BME communities who

work?	have 'links' and an interest in mental health.
Where they will undertake the work?	The interviews will be carried out in a specific room at Solent Mind offices in Southampton, Hampshire with people from the 18-60 age groups between 9 a.m. to 5 p.m. Monday to Friday.
How will those who are doing the work be supported and supervised?	Support and supervision will be done by the Wiltshire Trust and will be assisted by the project's Steering Group. A Risk Assessment Plan has been drawn up to ensure that Health and Safety is adhered to.
	The group will be creating a research respondents pack made up with the following contents: <b>Invitation Letter</b> – Inviting respondents for participation in the study if they wish to do so. <b>Information sheet</b> – Entailing the projects' remit, aims and objectives explaining the following protocols: <ul style="list-style-type: none"> <li>a. The project's overall research benefits.</li> <li>b. Explaining their participation is voluntary.</li> <li>c. Dissemination of information outlining safe keeping and confidentiality of respondents' interviews.</li> <li>d. During the interviews respondents can desire to stop at any time for any reason.</li> <li>e. Respondents will be reminded that they are not obliged to answer any questions they deem uncomfortable in the researcher's questionnaire.</li> </ul> <b>Consent form</b> - The group will seek participants' consent before embarking on the questionnaire by the creating a consent form. (Please find attached documents).
Please enclose the Information sheet and confirm that it addresses issues (a), (b), (c), (d) and (e) above	Information sheet enclosed( ✓) tick to confirm Issue (a) covered ( ✓) tick to confirm Issue (b) covered ( ✓) tick to confirm Issue (c) covered ( ✓) tick to confirm Issue (d) covered ( ✓) tick to confirm Issue (e) covered ( ✓) tick to confirm
How will the project ensure confidentiality?  Note: you will not usually need to know (or collect) the names or address of respondents.	<b>Confidentiality</b> Confidentiality of the respondents' identity and responses will be guaranteed by reassuring respondents that no names or addresses will be recorded to breach confidentiality protocols. The 'researchers' will not be quoting any information to identify them. All participants names will be replaced by a pseudonym and no names will be placed on questionnaires. There are limits to confidentiality however and this will be explained to respondents. In exceptional circumstances (i.e. when the researchers have cause to believe that either the respondent or someone else is at risk of serious harm) the researchers will need to pass information on relevant personnel or services in order to try to prevent or stop the harm. The Wiltshire Trust is registered under the Data Protection Act, <b>Registration number: Z5893355</b> – Phil Simmons Data Protection Officer
If you know them already, or if you are going to ask	<b>Invitation</b> Respondents will be asked to participate by mail through the

<p>people their names as a matter of courtesy, these should not be recorded on questionnaires or the notes that relate to the interview.</p> <p>Note: you cannot guarantee confidentiality to anyone taking part in a focus group. You can request that people keep things within the group, but you cannot guarantee that they will. This must be made clear to people who agree to participate in focus groups.</p>	<p>Wiltshire Trust’s ex-service users and carers who have been clients of the organisation from 1996 to present with an invitation letter. It will be returned to Lead ‘researcher’ by an enclosed self-addressed envelope, by e-mail, phone or text to us.</p> <p><b>Out-patients</b> In addition, permission has been granted from Mr Brendan O’Reilly, Service Manager of Central Community Mental Health Team to place the invitation letter and the information letter on Bay Tree House out-patients notice boards on the two locations with the site.</p> <p><b>Day Care Services</b> Mr Steve Haines, Operational Manager of Bedford House Day Care Services, and Bedford Place will be approached to place invitation letter and the information letter on the foyer’s notice board. Special workers (Asian male Ramesh Heer, Adrian Spence, (African-Caribbean male specific) and Ena Lamahee (Asian female specific) will be approached to invite ex-service users and carers to the research.</p> <p>The key informants will be those with a wide range of differences in ages 18-60, gender, sex and ethnicity.</p> <p><b>Targeted numbers: n=60</b>  <input checked="" type="checkbox"/> Carers between 40-49=5 and between 50+=10  <input checked="" type="checkbox"/> Ex-services users between 25-29 =5, 30-39=10 &amp; 40-49=10  <input checked="" type="checkbox"/> Statutory/Community Services between 40-49=15</p> <p><b>Eligibility</b> Eligibility for participation will be centred on interviewing individuals suffering with mental health issues from the black and minority ethnic communities. All participants will have had some experience directly or indirectly with the mental health services in Southampton and Hampshire will be asked to take part.</p>
<p>How will data generated by the project be handled and stored?</p>	<p><b>Generation of data</b> Questionnaires will be created and stored at the office’s vault. Access to questionnaires and notes will be only available to research Team and our Support Worker, Anthony Kollie from the University of Central Lancashire and the Focus Implementation Site’s Satisfaction with services Sub Group. After data analysis all questionnaires, notes and any other information will be shredded once the final report has been submitted. This procedure will take place in the presence of research Team and our Support Worker at Solent Mind’s office.</p>
<p>What risks are there? How</p>	<p><b>Risk analysis</b></p>

will risks be identified and managed?

Note you need to think about risks to researcher and volunteers and risk to participants. For some people, simply taking part in the research may be a risk (e.g. if the parent of a young Muslim woman finds out that she has been talking to someone about drugs). For others, particular situations may be risky (e.g. if you are using ex-drug users to work on the project, are you putting them at risk of relapse by asking them to go back into situations where drugs are being sold or used? If something gets stolen from an office, will they get blamed for it [regardless of whether or not they did it] because everyone knows they are a drug user? Are interviewees particularly vulnerable or frail? Are interviewers likely to be vulnerable to allegations of misconduct?

**THIS IS ONE OF THE MOST IMPORTANT SECTIONS OF THE FORM. YOU MUST THINK CAREFULLY ABOUT WHAT THE POSSIBLE RISKS ARE AND ABOUT WHAT STEPS CAN BE TAKEN TO REDUCE AND MANAGE THEM. THE ETHICS COMMITTEE UNDERSTANDS THAT IT IS USUALLY IMPOSSIBLE TO**

Issues pertaining to risk will be part of the supervision sessions and part of the agenda at our weekly and fortnightly meetings. Our interview protocol and risk assessment policy is attached.

Identifying and managing risk is the responsibility of the Lead researcher who will supported in doing this by the Support Worker and the Focus Implementation Site Sub Group.

#### **Risk issues envisaged**

- ❖ Respondents become emotional speaking about experiences of conditions while in psychiatric care.  
*Solution: Interview stopped immediately, alerts Lead 'researcher' we will have a list of services that to sign-post people on to, and may want help someone to access a further service. However we cannot do this without respondents consent. The only time we would take action without their consent is if they give you information that leads to us believing that they or someone else is at risk of serious harm, in which case you can breach confidentiality and we will try to engage appropriate services to prevent or stop the harm. Even where we have cause to suspect that someone is at risk of serious harm we would still try to gain their consent for getting additional help. It is only if they refuse this that you may breach confidentiality.*

*In addition, all respondents will be given a new directory of Southampton's BME mental health services directory on leaving the interviews as a precautionary measure to back up any circumstances. Please find enclosed BME directory.*

- ❖ Researcher going off by him or herself to carry out an interview with a respondent.  
*Solution: Research interview protocol - No researcher must conduct any interview by him or herself, they must be conducted in pairs and Lead 'researcher' must be notified of whereabouts.*
- ❖ Respondent discloses information which suggests that either they or someone else is at risk of serious harm.  
*Solution: Interview proceedings stopped immediately. We will try to get agreement and consent of individual to mobilise appropriate help and support. If this is not possible discuss with Lead Researcher to get support for mobilising appropriate help and support. Notify Support Worker and the FIS Sub Group of incident and action taken as soon as possible.*
- ❖ 'Researcher' breaches confidentiality and discloses confidential information concerning respondents and research Team.

<p><b>ERADICATE EVERY RISK, BUT THE ETHICS COMMITTEE MUST BE SATISFIED THAT ANY RISKS ARE REASONABLE, AND THAT STEPS HAVE BEEN TAKEN TO MINIMISE THEM.</b></p>	<p><i><b>Solution:</b> Lead ‘researcher’ to discuss with the researcher. Dismal/removal from the project to be considered. Support Worker from UCLan, Beverley Meeson, the Focus Implementation Site’s Co-ordinator and the Services Satisfaction Sub Group to be informed of the incident and action taken as soon as possible. [Note The Wiltshire Trust will follow our disciplinary procedure, not our grievance procedure.]</i></p>
<p>Please confirm the make up of the Steering Group</p>	<p>Focussed Implementation Site’s Services Satisfaction Sub Group made of the following organisations:  <b>Southampton Public Health PCT, Hampshire Partnership NHS Trust PALS, East Hants Fareham and Gosport PALS, Portsmouth PALS, Portsmouth Race Equality Network Organisation, Portsmouth Race Equality Lead, Isle of Wight Race Equality Lead, Adult Community Services - Isle of Wight, Culture Works - Portsmouth, Empathy – Southampton and the Wiltshire Trust – Southampton in Hampshire and the Isle of Wight.</b></p>
<p>How often is the Steering Group meet? It needs to Meet often enough to both guide the research and keep it on track, and to pick up on any ethical issues that may arise</p>	<p>The FIS (Focussed Implementation Site) Steering Group meets every month. The group will be informed of progress through the Race Equality South-East Lead, Poppy Jaman, Beverley Meeson and Anthony Kollie through our fortnightly meetings looking at its progress and to review the planning, research fieldwork and any ethical concerns that may arise.</p>
<p>Is the Steering Group clear that it has a responsibility for helping to manage the ethical issues that may arise as a result of running this project?</p>	<p>The Focussed Implementation Site Steering Sub Group has Delivering Race Equality as its main priority and they will govern and be mindful of any concerns.</p>
<p><b>Section 3</b></p>	<p><b>To be completed by UCLan internal committee</b></p>
<p>Date received:</p>	
<p>Reviewed by</p>	<p>11/10/06 – Jez Buffin, Jane Fountain, Ali Roy, Bob Mc Donald</p>
<p>Decision</p>	

03 November 2006

Mr Phil Simmons  
Co-ordinator  
The Wiltshire Trust  
P.O. Box 566  
Southampton  
SO14 3XJ

Research & Development  
1<sup>st</sup> Floor Department of Psychiatry  
Royal South Hants Hospital  
Brintons Terrace  
SOUTHAMPTON  
SO14 0YG

Tel: 023 8082 5054  
Fax: 023 8023 4243

Dear Phil

**Re: A service evaluation of staff associated with in-patient wards**

Thank you very much for informing the Hampshire Partnership NHS Trust Research and Development office of your proposed project. As your project does not use NHS resources to any significant degree, you do not need NHS Trust approval to proceed per se: however, your project is registered on the Trust Research and Development database with the identification number of **WHC 734** for information only. It would be helpful if you could use this number on all correspondence with the R & D Office. Please note that this only applies to the current protocol.

Please notify me of :

- Any changes in circumstances
- When the study is completed
- Immediately in the event of any adverse incidents
- For any reason the project does not begin in our area
- You are also requested to give the Trust feedback on your results.

The conditions of this approval require you as Principal Investigator to ensure that the study is conducted within the Research Governance framework and I encourage you to become fully conversant with the Research Governance Framework (RGF) on Health and Social Care document, which is available from the following link: [www.dh.gov.uk/PolicyAndGuidance/ResearchAndDevelopment/](http://www.dh.gov.uk/PolicyAndGuidance/ResearchAndDevelopment/) There is also a list of basic principles listed overleaf. Any breaches of the RGF constitute non-compliance with the RGF and as a result Trust approval may be withdrawn and the project suspended until such issues are resolved.

Please do not hesitate to contact us should you require any additional information or support. May I also take this opportunity to wish you every success with your research.

Yours sincerely

Research and Development Manager  
Hampshire Partnership Trust & Southampton City PCT



An NHS Teaching Trust with the University of Southampton  
With Southampton City PCT and Southampton University Hospitals Trust

Trust Headquarters, Maples, Horseshoe Drive, Tatchbury Mount, Calmore, Southampton, SO40 2RZ, Tel 023 8067 4300

## Appendix 6

### Invitation Letter



The Wiltshire Trust  
BME Mental Health  
Southampton Hants

P.O. Box 566  
SO14 3XJ  
Tel: 023 8055 9818  
Mob/text: 07981 989 126

Dear Sir or Madam

The Wiltshire Trust with its 'researchers' in Southampton City, Hampshire is carrying out a research project on the following:

❖ **'To investigate the extent and impact of isolation and loneliness amongst mentally ill black and minority ethnic service users/carers and to look at ways of reducing this'.**

We are inviting ex-service users, carers, statutory and voluntary services to participate in the research project. You are not obligated to take part in the study and it is entirely up to you to agree.

Please note that 'researchers' to ascertain ex-service users, carers, and statutory and voluntary services informed views would use questionnaires. The work will be carried out in October and November 2006.

Please find the following in the pack informing you about the process.

- Invitation to take part in the research
- Information sheet about the research and the
- The consent form

Please read the information sheet carefully and if you would like to take part in the survey you can reply by the self-addressed envelope enclosed, by phone, text or e-mail.

If you would like to find out more or have any other questions please contact the Lead 'researcher', **Phil Simmons** at the address for more information on the process:

✉ **The Wiltshire Trust, Community Research, P.O. Box 566, Southampton,**

**SO14 3XJ Hampshire ☎ 023 8055 9818 📱 Mobile 07981 989 126**

✉ E-mail: [pdazzler@excite.com](mailto:pdazzler@excite.com)

Yours sincerely

Phil Simmons

**Phil Simmons, Co-ordinator- Lead 'researcher' and the Research Team**

## Appendix 7 Information Sheet



The Wiltshire Trust  
BME Mental Health  
Southampton Hants

P.O. Box 566  
SO14 3XJ  
Tel: 023 8055 9818  
Mob/text: 07981 989 126

**Please carefully read the following information sheet so you have a better idea of the research, which we are embarking on. Feel free to contact us if you have any questions you would like answered.**

### **What the research is about?**

We would like to identify gaps in service provision and to provide this information to clinical, statutory and voluntary sector professionals with a view to improving services.

**Research focus:** 'To investigate the extent and impact of isolation and loneliness amongst mentally ill black and minority ethnic service users/carers in the communities and to look at ways where community engagement would be beneficial for delivering race equality in mental health services in Southampton and Hampshire'.

The study will include interviewing ex-service users, carers, and some personnel working in statutory and voluntary agencies to measure everyone perspective on the subject matter.

**Outcomes:** To look specifically at the Delivering Race Equality two priorities for the National 12 points Action Plan.

- ❖ **A reduction in the rate of admission of people from black and minority ethnic communities to psychiatric inpatient units.**
- ❖ **A reduction in the disproportionate rates of compulsory detention of BME service users in the inpatients units.**

### **Who have funded the project?**

We applied in December 2005 to the National Institute for Mental Health in England NIMHE to be one of the nation's Community Engagement Projects. We were successful in March 2006 and it gave us the opportunity to carry out this important piece of work in collaboration with Centre for Ethnicity and Health (the University of Central Lancashire).

### **Who will be conducting the interviews?**

A team of black and minority ethnic 'researchers' from the communities will conduct the interviews.

### **Why were you invited to take part in the project?**

You were invited because you have had contact with Southampton and Hampshire's mental health services as either an ex-service user, carer or from the statutory or voluntary services.

### **Do you have to take part?**

You are not required to take part in the research and it is strictly voluntarily, you can say 'no thanks' and we will not contact you about this again.

**If you want to take part, how will it be arranged?**

Please carefully read the information sheet and if you are satisfied and want to take part use self-addressed reply envelope and we shall be in touch to arrange a schedule to see 'researchers'.

**Will my taking part remain private and confidential?**

All information will be strictly confidential and private 'researchers' are bound by a confidentiality clause in their Contract. All questionnaires will be placed in the office's vault and kept safely.

**Are you going to be paid?**

No but as an incentive for participation we will be entering all ex-service users and carers into a draw for three £50.00 John Lewis vouchers which will be drawn after all interviews have been completed.

Obviously we will need to take your name and address for this, but we ensure that the names and addresses of people who are entered in to the draw are kept completely separately from any completed questionnaires. When we announce the winner of the draw it will be possible for others to see that you took part in the research, but they will not know what you said to us. You do not have to take part in the draw if you do not wish to.

**What happens to information given?**

The information that you give will be used along with the information given by other respondents to produce a report that we will share with people who are responsible for commissioning and providing mental health services.

Your details and everything that you tell us will be kept confidential (apart from in very exceptional circumstances which we will tell you about below) and it will not be possible for anyone reading the report to tell that you have taken part in it.

All questionnaires will be shredded once the final report has been submitted by Support Worker from the University of Lancashire and research team.

As stated above, in exceptional circumstances we may not be able to keep what you say confidential. This will be the case if you give us information, which leads us to believe that either you or someone else is at risk of serious harm, including child abuse.

**If I want further information whom shall I contact?**

If after reading all the information, you have any further questions you can contact the Lead 'researcher' Phil Simmons in the following ways:

✉ **The Wiltshire Trust, Community Research, P.O. Box 566, Southampton,**

**SO14 3XJ, Hampshire.**

r 023 8055 9818 📱 Mobile 07981 989 126 📧 E-mail: pdazzler@excite.com

**Appendix 8  
Consent Form**



The Wiltshire Trust  
BME Mental Health  
Southampton Hants

P.O. Box 566  
SO14 3XJ  
Tel: 023 8055 9818  
Mob/text: 07981 989 126

The following is for the introduction and participation in the research.

**Please indicate by ticking boxes to confirm you agree to take part in the study.**

**PLEASE CONFIRM**

- a. I have read and understood the information sheet.
- b. I understand that taking part is voluntary and at anytime I can stop the interview and is free to leave the room when I want.
- c. I agree to participate in the research study.
- d. I am willing to start the questionnaire with the 'researchers' for the mentioned study.
- e. I will be happy to be interviewed and I will indicate by ticking all boxes

Not applicable

Not applicable

Not applicable

\_\_\_\_\_  
Researcher's name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

**CORE DATA Questions:**

**Appendix 9**

- 1.1 Age last birthday:**
- 16 – 18
  - 19 – 21
  - 22 – 24
  - 25 – 29
  - 30 – 39
  - 40 – 49
  - 50 +

- 1.2 Gender:**
- Male
  - Female
  - Trans gendered or transsexual

- 1.3 Ethnicity:**
- White**
- British
  - Irish
  - Other (please explain)
  - .....

- Mixed**
- White and Black Caribbean
  - White and Black African
  - White and Asian
  - Other (please explain)
  - .....

- Asian or Asian British**
- Indian
  - Pakistani
  - Bangladeshi
  - Other (please explain)
  - .....

- Black or Black British**
- Caribbean
  - African

- Other (please explain)
- .....

- Chinese or Other Group**
- Chinese

- Other (please explain)
- .....

- 1.4 Were you born in the UK:**
- Yes
  - No
  - .....

**If no, how long have you lived here:** Less than 1 year

1 – 5 years   
6 – 10 years   
1 years or more

.....

**1.5 Are you a:**

British Citizen   
Refugee   
Asylum Seeker   
Other (please explain)

.....

**1.6 What is your first language?**

Spoken:

.....

Written:

.....

**1.7 Which languages are you fluent in?**

Spoken:

.....

Written:

.....

**1.8 What is your religion:**

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

.....

**1.9 Sexuality:**

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

.....

**1.10 Do you have a disability:**

- Yes (please explain)
- No

.....

<b>AREA 1</b>
---------------

**The promotion of added activities on psychiatric in-patient wards and communities to relieve isolation and loneliness**

**1.1 What types of activities do you think would relieve isolation and loneliness on wards?**

<input type="checkbox"/> Cultural days	<input type="checkbox"/> Community visitors and volunteers from the same community	
<input type="checkbox"/> Day trips	<input type="checkbox"/> Family meetings	<input type="checkbox"/> Food preparation
<input type="checkbox"/> Games	<input type="checkbox"/> Poetry reading	
<input type="checkbox"/> Other (please explain)		

*Please tell us how you feel about this statement*

**1.2 Staff should try to prevent isolation on the wards**

<input type="checkbox"/> Strongly disagree	<input type="checkbox"/> Disagree	<input type="checkbox"/> Undecided	<input type="checkbox"/> Agree	<input type="checkbox"/> Strongly agree
--	-----------------------------------	------------------------------------	--------------------------------	---

**1.3 How can in-patient wards be an environment where isolation and loneliness can be reduced?**

<input type="checkbox"/> Assessing why and how loneliness occurs	<input type="checkbox"/> Identify potential solutions
<input type="checkbox"/> Part of the Risk Assessment Plan on wards	<input type="checkbox"/> Psychiatric problems make it difficult to assess the said situation
<input type="checkbox"/> Reducing barriers to identify patient stressors	
<input type="checkbox"/> Other (please explain)	

**1.4 How would staff be alerted if an in-patient on the wards was isolated and lonely?**

<input type="checkbox"/> A formal protocol is in place to report signs	<input type="checkbox"/> Counselling and psychotherapy services personnel
<input type="checkbox"/> In-patient conveying feelings to relevant staff	<input type="checkbox"/> Staff would be able to identify the signs
<input type="checkbox"/> Other (please explain)	

*Please tell us how you feel about this statement*

**1.5 More contact with staff aids in alleviating isolation and loneliness**

<input type="checkbox"/> Strongly disagree	<input type="checkbox"/> Disagree	<input type="checkbox"/> Undecided	<input type="checkbox"/> Agree	<input type="checkbox"/> Strongly agree
--	-----------------------------------	------------------------------------	--------------------------------	---

## AREA 2

### Raising awareness of the need to combat isolation and loneliness in the communities and in-patient wards.

#### 2.1 How can we/you raise awareness across all sections of the communities?

<input type="checkbox"/> Community involvement in mental health issues	<input type="checkbox"/> Education in schools
<input type="checkbox"/> Including community/service users in decision making	<input type="checkbox"/> Through employment opportunities
<input type="checkbox"/> Working in partnerships	
<input type="checkbox"/> Other (please explain)	

#### 2.2 How can we go about promoting self-help and community groups?

<input type="checkbox"/> Newspapers	<input type="checkbox"/> Radio sessions	<input type="checkbox"/> Religious establishments
<input type="checkbox"/> Through community gatherings		
<input type="checkbox"/> Other (please explain)		

#### 2.3 What can be done to get more people to raise awareness about stigma?

<input type="checkbox"/> More local people working in mental health settings	<input type="checkbox"/> Sessions with prominent BME groups
<input type="checkbox"/> Speaking to spiritual leaders	<input type="checkbox"/> Through health promotion activities
<input type="checkbox"/> Using City Council Authorities	
<input type="checkbox"/> Other (please explain)	

Please tell us how you feel about this statement

#### 2.4 Employment agencies can help in raising awareness about stigma.

<input type="checkbox"/> Strongly disagree	<input type="checkbox"/> Disagree	<input type="checkbox"/> Undecided	<input type="checkbox"/> Agree	<input type="checkbox"/> Strongly agree
--	-----------------------------------	------------------------------------	--------------------------------	---

## AREA 3

### Spirituality – Inspiration to relieve isolation and loneliness on the communities

#### 3.1 What kind of provision would you like to see made available to meet the spiritual needs on wards and in the communities?

<input type="checkbox"/> Faith resources e.g. religious texts, prayer mats	<input type="checkbox"/> None at all	<input type="checkbox"/> Pastoral visits
<input type="checkbox"/> Raising awareness amongst staff about religious significant dates	<input type="checkbox"/> Services for all faiths in hospital	
<input type="checkbox"/> Other (please explain)		

#### 3.2 When do you think these spiritual needs can be met?

<input type="checkbox"/> Daily	<input type="checkbox"/> Monthly	<input type="checkbox"/> On special occasions
<input type="checkbox"/> Weekly	<input type="checkbox"/> Yearly	
<input type="checkbox"/> Other (please explain)		

**3.3 Where would be the best place for spiritual needs to be performed?**

<input type="checkbox"/> At home	<input type="checkbox"/> In the communities	<input type="checkbox"/> In your room with family
<input type="checkbox"/> On the wards	<input type="checkbox"/> Religious establishments	
<input type="checkbox"/> Other (please explain)		

**3.4 What are the potential benefits of having your spiritual needs met?**

<input type="checkbox"/> None at all	<input type="checkbox"/> Practice beliefs	<input type="checkbox"/> Spiritual enlightenment
<input type="checkbox"/> To congregate	<input type="checkbox"/> Well-being	
<input type="checkbox"/> Other (please explain)		

*Please tell us how you feel about this statement*

**3.5 Staff should develop ways to form strong links with the diverse local faith communities**

<input type="checkbox"/> Strongly disagree	<input type="checkbox"/> Disagree	<input type="checkbox"/> Undecided	<input type="checkbox"/> Agree	<input type="checkbox"/> Strongly agree
--	-----------------------------------	------------------------------------	--------------------------------	---

**AREA 4**

**Establishing a Mentoring scheme for ex-service users on the wards and communities**

**4.1 Could this scheme work as either one of following? (Tick all that apply)**

<input type="checkbox"/> Befriending ~ i.e. visits to service users on wards by peers from BME communities
<input type="checkbox"/> Budding ~ i.e. having a person outside hospital who service user is able to phone when in hospital
<input type="checkbox"/> Peer mentoring i.e. long term support by member of the BME community
<input type="checkbox"/> Other (please explain)

**4.2 How would a scheme be introduced on the wards?**

<input type="checkbox"/> Private firm	<input type="checkbox"/> Statutory Agencies	<input type="checkbox"/> The Voluntary Sector
<input type="checkbox"/> Through the CPA process	<input type="checkbox"/> Do not Know	
<input type="checkbox"/> Other (please explain)		

*Please tell us how you feel about this statement*

**4.3 A (befriending, budding or peer mentoring) scheme is able to function in a psychiatric setting**

<input type="checkbox"/> Strongly disagree	<input type="checkbox"/> Disagree	<input type="checkbox"/> Undecided	<input type="checkbox"/> Agree	<input type="checkbox"/> Strongly agree
--	-----------------------------------	------------------------------------	--------------------------------	---

**4.4 What appeals most about the (befriending, budding or peer mentoring) scheme?**

<input type="checkbox"/> Identifying a need	<input type="checkbox"/> Providing friendship	<input type="checkbox"/> To raise self-esteem
<input type="checkbox"/> To relieve isolation	<input type="checkbox"/> Will not work	
<input type="checkbox"/> Other (please explain)		

--

**4.5 When would you like to see this befriending, budding or peer mentoring) scheme started?**

<input type="checkbox"/> As soon as possible	<input type="checkbox"/> Don't know	<input type="checkbox"/> Never
<input type="checkbox"/> Next year	<input type="checkbox"/> This year	
<input type="checkbox"/> Other (please explain)		

**AREA 5** Forming a service-user black and minority ethnic Support Group.

*Please tell us how you feel about this statement*

**5.1 A black and minority ethnic service user group would be useful on the wards/communities**

<input type="checkbox"/> Strongly disagree	<input type="checkbox"/> Disagree	<input type="checkbox"/> Undecided	<input type="checkbox"/> Agree	<input type="checkbox"/> Strongly agree
--	-----------------------------------	------------------------------------	--------------------------------	---

**5.2 What would be the benefits of having a support group like this?**

<input type="checkbox"/> Empowering them	<input type="checkbox"/> Highlighting needs	<input type="checkbox"/> Making a difference
<input type="checkbox"/> Sharing information	<input type="checkbox"/> Supporting one another	<input type="checkbox"/> Shape and design service
<input type="checkbox"/> Other (please explain)		

**5.3 How would we form a support group like this?**

<input type="checkbox"/> Advertising	<input type="checkbox"/> Consultation	<input type="checkbox"/> Raising awareness of issues
<input type="checkbox"/> Linking CPA process with Support Group	<input type="checkbox"/> Outreach worker	<input type="checkbox"/> Do not know
<input type="checkbox"/> Other (Please explain)		

**5.4 Where would be the most suitable or appropriate place to run this support group?**

<input type="checkbox"/> Community Centre	<input type="checkbox"/> Day Centre	<input type="checkbox"/> Religious establishments
<input type="checkbox"/> Voluntary Services	<input type="checkbox"/> Wards	
<input type="checkbox"/> Other (please explain)		

**5.5 How often should the support meet within a year?**

<input type="checkbox"/> Every week	<input type="checkbox"/> Every two months	<input type="checkbox"/> Monthly
<input type="checkbox"/> Quarterly		
<input type="checkbox"/> Other (please explain)		

**AREA 6** To introduce of an information service specifically for the wards and communities on available services.

*Please tell us how you feel about this statement*

**6.1 There is a general need for an appropriate and targeted information service for black and minority ethnic service users and carers**

<input type="checkbox"/> Strongly disagree	<input type="checkbox"/> Disagree	<input type="checkbox"/> Undecided	<input type="checkbox"/> Agree	<input type="checkbox"/> Strongly agree
--	-----------------------------------	------------------------------------	--------------------------------	---

**6.2 What types of information can be available in this service? (tick all that apply)**

<input type="checkbox"/> Accessing personal medical and case notes	<input type="checkbox"/> Advocacy services	<input type="checkbox"/> Carers help lines
<input type="checkbox"/> Health promotion leaflets	<input type="checkbox"/> Information on Patient Advice & Liaison Service	
<input type="checkbox"/> Information on services/treatments and conditions		
<input type="checkbox"/> Rehab groups	<input type="checkbox"/> Medication	<input type="checkbox"/>
<input type="checkbox"/> Translation services		
<input type="checkbox"/> Other (please explain)		

**6.3 Where would be the best place where this information service can be seen?**

<input type="checkbox"/> Communities	<input type="checkbox"/> Mail shot	<input type="checkbox"/> Newsletter
<input type="checkbox"/> On the wards	<input type="checkbox"/> Religious places	
<input type="checkbox"/> Other (please explain)		

*Please tell us how you feel about this statement*

**6.4 This information service should be a service-user and carer lead initiative**

<input type="checkbox"/> Strongly disagree	<input type="checkbox"/> Disagree	<input type="checkbox"/> Undecided	<input type="checkbox"/> Agree	<input type="checkbox"/> Strongly agree
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**6.5 How would this information service be reflective of the communities?**

<input type="checkbox"/> By the NHS	<input type="checkbox"/> City Council led	<input type="checkbox"/> Ex-service users/carers
<input type="checkbox"/> In different languages	<input type="checkbox"/> Run by a BME group	
<input type="checkbox"/> Other (please explain)		

**AREA 7**

**Promoting access to the voluntary sector services vocational, employment and therapeutic needs.**

**7.1 Have you been offered any voluntary/community services while in the in-patient units?**

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> <b>If no to 7.2 or if yes proceed to 7.5</b>
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**7.2 Were you offered any information on how to access these services?**

<input type="checkbox"/> Day care services	<input type="checkbox"/> Entitled benefits	<input type="checkbox"/> Employment opportunities
<input type="checkbox"/> Horticultural placement	<input type="checkbox"/> Therapeutic activities	<input type="checkbox"/> Vocational schemes
<input type="checkbox"/> Other (please explain)		

**7.3 How can we promote access to voluntary/community services?**

<input type="checkbox"/> Key Worker	<input type="checkbox"/> Mental Health Teams	<input type="checkbox"/> Primary Care Trust
<input type="checkbox"/> Voluntary groups	<input type="checkbox"/> Ward managers	
<input type="checkbox"/> Other (please explain)		

**7.4 How can the effectiveness of day and drop-in centres services contribute to promote access to services?**

<input type="checkbox"/> Advertising available services on offer	
<input type="checkbox"/> Better working partnerships with CMHTs, statutory & voluntary sectors	
<input type="checkbox"/> Consultation with service users about reform in services	
<input type="checkbox"/> Looking at the planning and design of services	<input type="checkbox"/> Review of day and drop-in centres
<input type="checkbox"/> Other (please explain)	

*Please tell us how you feel about this statement*

**7.5 Accessing voluntary sector services can benefit ex-services and carers**

<input type="checkbox"/> Strongly disagree	<input type="checkbox"/> Disagree	<input type="checkbox"/> Undecided	<input type="checkbox"/> Agree	<input type="checkbox"/> Strongly agree
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**7.6 How would you contact voluntary services after leaving the wards?**

<input type="checkbox"/> Dietary needs	<input type="checkbox"/> Issues around conduct on wards	<input type="checkbox"/> Language interpretation
<input type="checkbox"/> Religious beliefs Traditions	<input type="checkbox"/> Traditions	
<input type="checkbox"/> Other (please explain)		

**AREA 8**

**Cultural Awareness Training for clinical staff and other statutory and voluntary services.**

*Please tell us how you feel about this statement*

**8.1 Your cultural needs were not met while on the in-patient wards**

<input type="checkbox"/> Strongly disagree	<input type="checkbox"/> Disagree	<input type="checkbox"/> Undecided	<input type="checkbox"/> Agree	<input type="checkbox"/> Strongly agree
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**8.2 What areas do you think clinical staff needs cultural awareness training?**

<input type="checkbox"/> Dietary needs	<input type="checkbox"/> Issues around conduct on wards	<input type="checkbox"/> Language interpretation
<input type="checkbox"/> Religious beliefs Traditions	<input type="checkbox"/> Traditions	
<input type="checkbox"/> Other (please explain)		

**8.3 What would be the potential benefits of having culturally trained staff?**

<input type="checkbox"/> Better communication with service users
<input type="checkbox"/> Better response from service users to intervention
<input type="checkbox"/> Easier to relate to culturally different service users
<input type="checkbox"/> Knowledge of values and family dynamics
<input type="checkbox"/> May make the experience of being a mental health service user more bearable



## AREA 1

**The promotion of added activities on psychiatric in-patient wards and communities to relieve isolation and loneliness.**

**1.1 What types of activities do you envisaged to relieve isolation and loneliness on wards?**

<input type="checkbox"/> Cultural days	<input type="checkbox"/> Community visitors and volunteers from the same community	
<input type="checkbox"/> Day trips	<input type="checkbox"/> Family meetings	<input type="checkbox"/> Food preparation
<input type="checkbox"/> Games	<input type="checkbox"/> Poetry reading	
<input type="checkbox"/> Other (please explain		

**1.2 Staff should try to prevent isolation and loneliness on the wards**

*Please tell us how you feel about this statement*

<input type="checkbox"/> Strongly disagree	<input type="checkbox"/> Disagree	<input type="checkbox"/> Undecided	<input type="checkbox"/> Agree	<input type="checkbox"/> Strongly agree
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**1.2 How can in-patient wards be an environment where isolation and loneliness can be reduced?**

<input type="checkbox"/> Assessing why and how loneliness occurs	<input type="checkbox"/> Identify potential solutions
<input type="checkbox"/> Part of the Risk Assessment Plan on wards	<input type="checkbox"/> Psychiatric problems make it difficult to assess the said situation
<input type="checkbox"/> Reducing barriers to identify patient stressors	
<input type="checkbox"/> Other (please explain	

**1.4 How would staff be alerted if an in-patient on the wards was isolated and lonely?**

<input type="checkbox"/> A formal protocol is in place to report signs	<input type="checkbox"/> Counselling and psychotherapy services personnel
<input type="checkbox"/> In-patient conveying feelings to relevant staff	<input type="checkbox"/> Staff would be able to identify the signs
<input type="checkbox"/> Other (please explain)	

*Please tell us how you feel about this statement*

**1.5 More contact with staff aid in alleviating isolation and loneliness**

<input type="checkbox"/> Strongly disagree	<input type="checkbox"/> Disagree	<input type="checkbox"/> Undecided	<input type="checkbox"/> Agree	<input type="checkbox"/> Strongly agree
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## AREA 3

## Spirituality – Inspiration to relieve isolation and loneliness on the wards and communities

### 3.1 What are some of the spiritual needs you would like to prevent isolation and loneliness on wards and in the communities?

<input type="checkbox"/> Faith resources e.g. religious texts, prayer mats	<input type="checkbox"/> None at all	<input type="checkbox"/> Pastoral visits
<input type="checkbox"/> Raising awareness amongst staff about religious significant dates		
<input type="checkbox"/> Services for all faiths in hospital		
<input type="checkbox"/> Other (please explain)		

### 3.2 What are the potential benefits of nurturing service user’s spiritual needs?

<b>Open ended ~ Please explain</b>	

*Please tell us how you feel about this statement*

### 3.3 Staff should develop ways to form strong links with the diverse local faith communities

<input type="checkbox"/> Strongly disagree	<input type="checkbox"/> Disagree	<input type="checkbox"/> Undecided	<input type="checkbox"/> Agree	<input type="checkbox"/> Strongly agree
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## AREA 4

## Establishing a Mentoring scheme for ex-service users on the wards and communities

### 4.1 Could this scheme work as either one of following? (tick all that apply)

<input type="checkbox"/> Befriending ~ i.e. visits to service users on wards by peers from BME communities
<input type="checkbox"/> Budding ~ i.e. having a person outside hospital who service user is able to phone when in hospital
<input type="checkbox"/> Peer mentoring i.e. long term support by member of the BME community
<input type="checkbox"/> Other (please explain)

### 4.2 How could a (befriending, budding or peer mentoring) scheme be introduced on the wards?

<input type="checkbox"/> Private firm	<input type="checkbox"/> Statutory Agencies	<input type="checkbox"/> The Voluntary Sector
<input type="checkbox"/> Through the CPA process	<input type="checkbox"/> Do not Know	
<input type="checkbox"/> Other (please explain)		

Please tell us how you feel about this statement

**4.3 A (befriending, budding or peer mentoring) scheme able to function in a psychiatric setting**

<input type="checkbox"/> Strongly disagree	<input type="checkbox"/> Disagree	<input type="checkbox"/> Undecided	<input type="checkbox"/> Agree	<input type="checkbox"/> Strongly agree
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**AREA 5**

**The introduction of an information service specifically for the wards and communities on available services.**

Please tell us how you feel about this statement

**5.1 There is a general need for an appropriate and targeted information service for black and minority ethnic service users and carers**

<input type="checkbox"/> Strongly disagree	<input type="checkbox"/> Disagree	<input type="checkbox"/> Undecided	<input type="checkbox"/> Agree	<input type="checkbox"/> Strongly agree
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**5.2 What types of information can be available in this information service?**

<input type="checkbox"/> Accessing personal medical and case notes	<input type="checkbox"/> Advocacy services	<input type="checkbox"/> Carers help lines
<input type="checkbox"/> Health promotion leaflets	<input type="checkbox"/> Information on Patient Advice & Liaison Service	
<input type="checkbox"/> Information on services/treatments and conditions	<input type="checkbox"/> Medication	<input type="checkbox"/> Rehab groups
<input type="checkbox"/> Translation services		
<input type="checkbox"/> Other (please explain)		

**AREA 6**

**Promoting access to the voluntary sector services i.e. rehabilitation, vocational, employment and therapeutic needs.**

**6.1 How can we promote access to voluntary/community services?**

<input type="checkbox"/> Key Worker	<input type="checkbox"/> Mental Health Teams	<input type="checkbox"/> Primary Care Trust
<input type="checkbox"/> Voluntary groups	<input type="checkbox"/> Ward managers	
<input type="checkbox"/> Other (please explain)		

**6.2 How can the effectiveness of day and drop-in centres services contribute?**

<input type="checkbox"/> Advertising available services on offer	
<input type="checkbox"/> Better working partnerships with CMHTs, statutory & voluntary sectors	
<input type="checkbox"/> Consultation with service users about reform in services	
<input type="checkbox"/> Looking at the planning and design of services	<input type="checkbox"/> Review of day and drop-in centres
<input type="checkbox"/> Other (please explain)	

**AREA 7**

**Cultural Awareness Training for clinical staff and other statutory and voluntary services.**

**7.1 What would be the potential benefits of having culturally trained staff?**

<input type="checkbox"/> Better communication with service users
<input type="checkbox"/> Better response from service users to intervention
<input type="checkbox"/> Easier to relate to culturally different service users
<input type="checkbox"/> Knowledge of values and family dynamics
<input type="checkbox"/> May make the experience of being a mental health service user more bearable
<input type="checkbox"/> Other (please explain)

*Please tell us how you feel about this statement*

**7.2 Cultural awareness training contribute to identifying isolation and loneliness in black and minority ethnic in-patients**

<input type="checkbox"/> Strongly disagree	<input type="checkbox"/> Disagree	<input type="checkbox"/> Undecided	<input type="checkbox"/> Agree	<input type="checkbox"/> Strongly agree
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*Please tell us how you feel about this statement*

**7.3 Cultural awareness training in religious customs can be beneficial for staff within the ward environment**

<input type="checkbox"/> Strongly disagree	<input type="checkbox"/> Disagree	<input type="checkbox"/> Undecided	<input type="checkbox"/> Agree	<input type="checkbox"/> Strongly agree
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**Do you have any comments to make towards reducing isolation and loneliness on the in-patients wards and communities?**


**8.1 We would like to know how you feel about the questionnaire that you have just completed. Would you say it was?**

<input type="checkbox"/> A negative experience	<input type="checkbox"/> Mixed feelings	<input type="checkbox"/> A positive experience
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