

COMMUNITY ENGAGEMENT PROJECT

NIMHE Mental Health Programme

REPORT OF THE COMMUNITY LED RESEARCH PROJECT FOCUSING ON
The mental health needs of the Bangladeshi community in Portsmouth

BANGLADESHI WELFARE ASSOCIATION AND CULTURE WORKS
PORTSMOUTH BANGLADESHI COMMUNITY

Shipa Ahmed Khan

Syed Aminul Haque, Mohammed Saiful Islam,
Shefali Uddin, Nazir Ahmed, Amirun Nessa

March 2007



**Culture
Works**

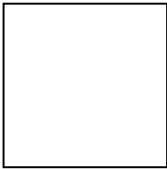


Portsmouth City **NHS**
Primary Care Trust



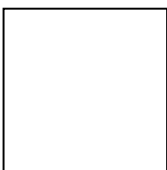
Care Services Improvement Partnership **CSIP**

The following people were involved in this community engagement project:



Shipa Ahmed Khan, Lead Researcher

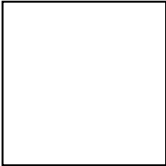
I am married with three children. After my studies I worked as a Bengali Community Worker with Portsmouth City Council Social Services department for 13 years. This role gave me a wealth of experience in various fields and enabled me to run and manage numerous community projects. I then managed a mental health service called 'Culture Works'. Recently I have been appointed as a Community Development Worker for Mental Health. I hope that in some way the findings from this report would help to inform and shape future mental health service provision for all BME communities.



Syed Aminul Haque, Lead Researcher

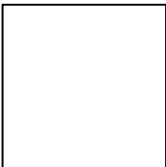
Born and educated in Bangladesh, I originally came to England to further my studies, eventually I set up in business. I have been self employed for most of my working life but now work part time for Portsmouth City Council as an interpreter. Being involved with this mental health project for the Bangladeshi community through the UCLan training programme, I have gained further knowledge in Mental health issues.

I have always had an interest in volunteering to support members of my community and have done so for over 40 years. As well as sitting on many boards and organisations I am currently the President of the Bangladeshi Welfare Association (BWA) in Portsmouth. It has been a privilege to be a part of this important project.



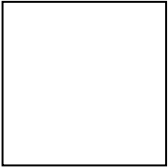
Mohammed Saiful Islam, Researcher

I am a qualified Doctor in Bangladesh and came to England to further my education. I have always had an interest in community work and am keen to support my community. This project has given me the opportunity to be involved in a live research. Personally I have gained a lot of valuable experience in community development and I feel that this project will help the Bangladeshi Community in Portsmouth.



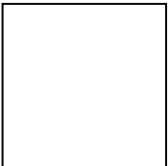
Shefali Uddin, Researcher

I currently work part time as an administrator for a local community centre. My intention of wanting to be involved in a project like this is to help contribute to the welfare of my community by raising awareness of mental health issues. I have gained many key skills and developed a greater understanding and knowledge of mental health issues. I hope that by doing this project we have given the Bangladeshi community a voice and that it will help to improve services. I feel honoured to be a part of this prestigious and unique project.



Nazir Ahmed, Researcher

I am currently working as a trainee mortgage advisor. I am a highly motivated individual with the drive and desire to succeed. I have acquired a wide range of skills, both articulate and analytical. I am a team player and thrive on challenges. I found it rewarding to be given an opportunity to take part in this project, as it aims to enhance the knowledge of my local Bangladeshi community by providing educational and supporting services in the mental health field.



Amirun Nessa, Researcher

I have enjoyed working on this project and working in the community. It has given me good communication and people skills which I can carry forward. I have learnt a lot about mental health.

Acknowledgements

UCLAN, CSIP/NIMHE, Poppy Jaman, The Steering Group members, BME sub group of the Local Implementation Team, Diane Law, Di Grist, Jan Finch, Course tutors and fellow CE projects (Names of projects)

With special thanks to our support worker Anthony Kollie, Beverley Meeson, Jim Hawkins, Justina Jeffs, Shabina Tarafder, the BWA committee,

[The Bangladeshi Community in Portsmouth and all who took part in this project.](#)

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Executive Summary

In December 2005 the Bangladeshi Welfare Association (BWA) and Culture Works a local BME mental health service submitted a joint bid to the University of Central Lancashire (UCLAN). Our bid was successful we proposed to undertake a Mental Health research project with the Bangladeshi Community in Portsmouth.

The aim of our project is to:

“Investigate the mental health needs of the Bangladeshi Community in Portsmouth”

To determine the level of awareness of mental health issues and services. As well as looking at barriers to accessing services and the impact of cultural and religious factors.

Our project also looked at Mental Health service providers and how they feel they are meeting the needs of the Bangladeshi Community. We constructed a service provider’s evaluation form to look at the views of individuals.

This project aims to address the following three from the DRE 12 point action plan.

- Less fear of mental health services among BME communities and BME service users;
- Increase satisfaction with services.

- 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.

The project will do this by:

- Engaging with the Bangladeshi Community, through the use of a questionnaire.
- Encouraging the community to be more active and involved in the project.
- Encouraging discussion to reduce fear and stigma associated with mental health.
- Actively involving Bangladeshi service users and carers, to gain a better understanding of individual first hand experience.
- Giving out information about mental health and services to reduce fear.
- Making links between the community and service providers.
- Engaging with service providers and obtaining individual views on services through an evaluation.

We recruited 6 Bengali researchers from the local community who were offered regular support and training. The researchers also undertook an accredited course on mental health and research methodology through the University of Central Lancashire. The research team devised a structured questionnaire, which was translated into Bengali looking at the following areas:

- Core data
- Definition and awareness of mental health
- Access to mental health services
- Treatments
- General Questions.

We interviewed 132 people aged between 18 – 70yrs from the Bangladeshi Community in Portsmouth. We approached various community support groups, local centres, halal shops, the Mosque and individuals in the community.

The evaluation form for mental health service providers looked at:

- Training needs
- Use of services by BME communities
- Promotion of services in the BME communities
- Individual views.

Our findings from this community engagement project show there are many gaps in service to the BME communities primarily there is a lack of information and knowledge about how to access local services. The barriers to these focus on issues of language and cultural factors which need to be addressed not only by services but the Bangladeshi community itself needs to be able to discuss mental health openly in order to reduce stigma. This needs to be facilitated and enabled by more culturally sensitive services. The following recommendations focus on mental health needs which is the aim of this project however there are also various other significant needs identified by the community.

Recommendations

1. For this fairly established community it would seem that mental health promotion can be couched in Western terms, so long as cultural differences are acknowledged.
2. Make appropriate mental health information easily available to the community by distributing in the relevant places.
3. Where possible information on mental health services should be in dual language both Bengali & English to engage a wider audience.
4. Education, information and opening doors to approachable community mental health services would help to reduce fear.
5. There is a huge information deficit about and on services, which the services need to address.
6. Training for all staff on cultural awareness and BME issues. Engage with local BME communities and empower them to inform services of their cultural and religious needs through training for staff.
7. Designated staff from services to outreach to BME communities. Community development workers, to act as a bridge to accessing services.
8. Encourage active involvement and partnership / link between service provider and the community. To enable a two way exchange of learning and sharing between service and the community. Those working on ground level should endeavour to visit BME community groups.

9. Hold workshops / open days give talks and presentations on mental health if required in first language at a suitable venue or location.
10. Active promotion about mental health issues and information about support services availability and access is an urgent need in the community. Look at alternative confidential support structures such as cross cultural counseling.
11. Address and acknowledge issues of shame, fear and stigma around mental health are of significance. These needs to be examined in greater detail and in collaboration with the community, faith organisations and community leaders.
12. Enable and encourage participation and open discussion to address cultural issues such as shame, stigma etc. Consultation through workshops or talks, possibly facilitated by community development workers.
13. Support available to families, children and carers need to be highlighted as soon as possible and at the forefront.
14. More promotion of what and who is a carer, and differentiating between the roles of carer.
15. Engaging with this community and developing strong links could yield positive results in terms of satisfaction with services and recovery levels.
16. Information about services and efforts to improve access to secondary care where appropriate should be targeted at primary care.
17. GPs need to be mindful of the cultural needs of this client group, work needed with GPs.

18. Employ more BME staff and offer opportunities for volunteering in the mental health services.

19. Need for BME specialist mental health services, support groups and drop-in services looking at various issues of concern to the community. For example the need for a community centre, isolated women, the needs of families, and drug abuse issues.

Introduction

The Centre for Ethnicity and Health's Model of community engagement

Background to the community engagement model

We often hear the following words or phrases:

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

Sometimes these terms are used inter-changeably; sometimes one term is used by different people to mean different things. The Centre for Ethnicity and Health has a very specific notion of community engagement. The Centre's model of community engagement evolved over several 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 (DH) awarded a contract to what was then the Ethnicity and Health Unit at the University of Central Lancashire (UCLan) to administer and support a new grants initiative. The initiative aimed to get local Black and minority ethnic community groups across England to conduct their own needs assessments, in relation to drugs education, prevention, and treatment services.

The DH had two key things in mind when it commissioned the work; first, the DH 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 DH had wanted was a needs assessment and a 'glossy report', they could have commissioned researchers and produced yet another set of reports that may have had little long term impact. However this scheme was to be different. The DH 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; however they would have proven access to the communities they were working with, the potential to be supported and trained, and the infrastructure to conduct such a piece of work. They would be able to use the nine-month process to learn about drug related issues, and how to undertake a needs assessment. They would be able to benefit and learn from the training and support that the Ethnicity and 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 (DATs). 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 of work. These include:

- Substance misuse
- Criminal justice system
- Policing
- Sexual health
- Mental health
- Regeneration
- Higher education
- Asylum seekers and refugees

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 and trans-gender people
- Women
- White deprived communities
- Rural communities

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

The key ingredients of the model

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 up a group for this specific purpose of conducting the community engagement research.

The key thing is that this host community organisation should have good links to the defined target community¹, such that it is able to recruit a number of people from the target community to 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 co-ordinate the work, and provide an infra-structure (e.g. somewhere to meet; access to phones and computers; financial systems) for the day-to-day activities of the project. One of the first tasks that this host community organisation undertakes is to recruit a number of people from the target community to work on the project.

The second key ingredient is the research task that the community undertakes. 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 have involved communities in undertaking a piece of research or a consultation exercise within their own communities. In some cases there has been an initial resistance to doing 'yet another piece of research', but this misses the point. As in the initial programme run on behalf of the DH, the process and its outcomes have equal importance. 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. It is not expected that community groups offer their time and input for free. Typically a payment in the region of £15-20,000 will be made available to the host organisation. It is expected that the bulk of this money will be used to pay people from the target community as community researchers². A named member of staff from the community engagement team is allocated as a project support worker. This person will visit the project for at least half a day once a fortnight. It is their role to support and guide the host organisation and the researchers throughout the project. The University also provides a package of training, typically in the form of a series of accredited workshops.

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

² This is not always possible, for example, where potential participants are in receipt of state benefits and where to receive payment would leave the participant worse off.

The accredited workshops give participants in the project a chance to gain a University qualification whilst they undertake the work. The support workers will also assist the group to form an appropriate steering group to support the project³.

The steering group is an essential element of the project: it helps the community researchers to identify the community they are engaging with, and can also facilitate the long term sustainability of the projects recommendations and outcomes. The community researchers undertake a needs assessment or a consultation exercise. However the steering group will ensure that the work that the group undertakes sits with local priorities and strategies; also that there is a mechanism for picking up the findings and recommendations identified by the research. The steering group can also support individuals' career development as they progress through the project

The community engagement team

The community engagement team comprises of senior support workers, support workers, teaching and learning staff, administration team and a communications officer. They work across a range of community engagement areas of specialisation, within a tight regional framework.

| National Programme Directors | | | |
|------------------------------|-----------------|-----------------------|------------------------------|
| Northern Team | Midlands Team | Southern Team | Senior Programme Advisors |
| Senior Support Worker | | Senior Support Worker | |
| Support Workers | Support Workers | Support Workers | Drug Interventions Programme |
| | | | Citizen Shaped Policing |
| Teaching And Learning Team | | | |
| Administration Team | | | |
| Communications Officer | | | |

³ Very often we will have helped groups to do this very early on in the process at the point at which they are applying to take part in the project.

Programme outcomes

Each group involved in the Community Engagement Programmes is required to submit a report detailing the needs, issues or concerns of the community. The qualitative themes that emerge from the reports are often very powerful. 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.

In 2005/-6 the Substance Misuse Community Engagement Programme was externally evaluated. This concluded that:

- The Community Engagement Programme had made very significant contributions to increasing awareness of substance misuse and understanding of the substance misuse needs of the participating communities. It also raised awareness of the corresponding specialist services available and of the wider policy and strategy context.
- The Community Engagement Programme had enabled many new networks and professional relationships to be formed and that DATs appreciated the links they had made as a result of the programme (and the improvements in existing contacts) and stated their intentions to maintain those links.
- Most commissioners reported that they had gained useful information, awareness and evidence about the nature and substance misuse service needs of the participating organisations.
- All DATs reported positive change in their relationship with the community organisations. They stated that the Community Engagement Programme reports would inform their plans for the development of appropriate services in the future.
- A significant number of the links established between DATs and community organisations as part of the Community Engagement Programme were made for the first time.
- The majority of community organisations reported their influence over commissioners had improved.
- Training and access to education was successful and widely appreciated. 379 people went through an accredited University education programme.
- A third of community organisations in the first tranche reported that new services had been developed as a result of the Community Engagement Programme.
- The vast majority of participants and stakeholders expressed high levels of satisfaction with 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 views expressed in this report are those of the group that undertook the work, and are not necessarily those of the Centre for Ethnicity and Health at the University of Central Lancashire.

Since 2000 over 200 community groups have taken part in one or other of the Centre for Ethnicity and Health's Community Engagement Work Programmes. National Institute for Mental Health in England (NIMHE) Community Engagement Programme:

Aims and Objectives

The Bangladeshi Welfare Association (BWA) in Portsmouth and Culture Works submitted a joint mental health project bid in December 2005. The aim was to:

“Investigate the Mental Health needs of the Bangladeshi Community in Portsmouth.”

In order to determine the level of awareness of mental health issues and services as well as looking at barriers to accessing services and the impact of cultural and religious factors.

As part of this project we also wanted to look at Primary and Secondary Mental Health service providers and how they feel they are meeting the needs of the Bangladeshi Community. We have constructed a service providers evaluation form to look at the views of individuals and how they feel services can be improved. In doing so we want to see if there are any correlations between the service providers and the community.

This project aims to address the following three from the DRE 12 point action plan.

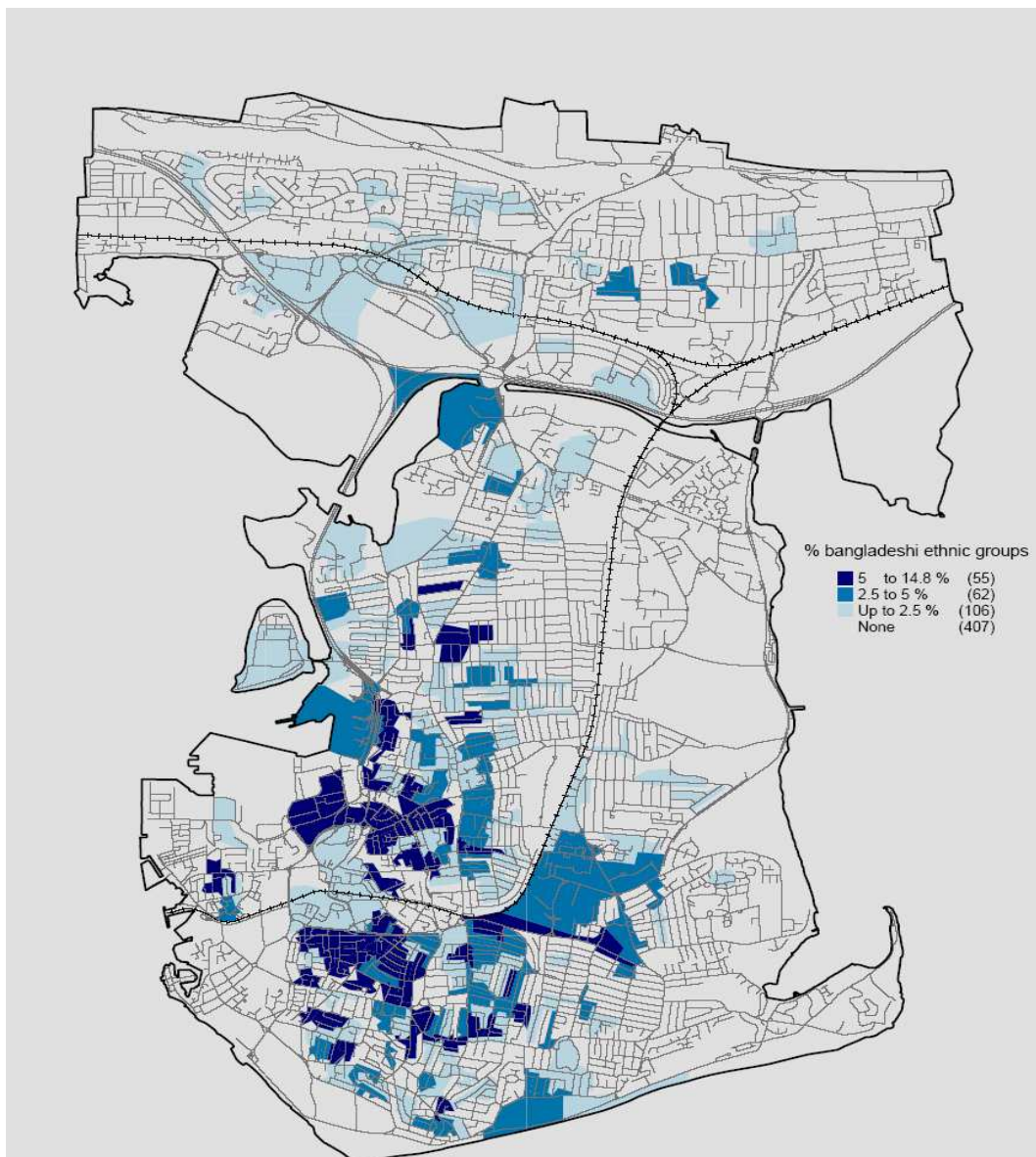
- ⊕ Less fear of mental health services among BME communities and BME service users;
- ⊕ Increase satisfaction with services.
- ⊕ A more active role for BME communities and BME service users in the training of professionals, in the development of mental health policy, and in the planning and provision of services.

This will be done by:

- ✦ Engaging with the Bangladeshi Community, through the use of a questionnaire.
- ✦ Encouraging the community to be more active and involved in the project.
- ✦ Encouraging discussion to reduce fear and stigma associated with mental health.
- ✦ Actively involving Bangladeshi service users and carers, to gain a better understanding of individual first hand experience.
- ✦ Giving out information about mental health and services to reduce fear.
- ✦ Making links between the community and service providers.
- ✦ Engaging with service providers and obtaining individual views on services through an evaluation.

Background & Demographics

Portsmouth is a nautical island city with a rich history, attracting thousands of tourists and visitors each year. It has hosted the Volvo yacht race and recently the Trafalgar 2000 celebrations. Portsmouth is a densely populated city with a population of 109,210 according to the 2001 census. The city is divided into 14 wards, this map shows the distribution of the Bangladeshi Community in Portsmouth.



With a large University population and a rising general population Portsmouth remains the most densely populated city outside of London. With a population density of 46.4 hectares compared to England and Wales (3.4 persons per hectare). The population density is highest in the Somerstown area. This area is predominantly made up of blocks of flats, and also where most of the Bangladeshi community live.

Portsmouth has a diverse multi cultural community making up 5.3% of the resident population. The largest BME group being the Bangladeshi's making up 1.4% of the community, compared to 0.5% for England and Wales. (Health Atlas)

Statistical Information

The Bangladeshi community in Portsmouth is well established, the community has been around for many years, with some of the earliest families in their 4th and 5th generations. The majority of the community are made up of children and young people.

| | ALL PEOPLE | White groups | Mixed groups | Asian or Asian British: | | | | Chinese or Other Ethnic Group: | | |
|-------------------|------------|--------------|--------------|-------------------------|-----------|-------------|-------------|--------------------------------|---------|--------------------|
| | | | | Indian | Pakistani | Bangladeshi | Other Asian | Black or Black British | Chinese | Other Ethnic Group |
| ALL PEOPLE | | | | | | | | | | |
| Males | 49.3 | 49.1 | 52.2 | 54.2 | 54.0 | 51.0 | 56.4 | 56.5 | 51.8 | 44.0 |
| Females | 50.7 | 50.9 | 47.8 | 45.8 | 46.0 | 49.0 | 43.6 | 43.5 | 48.4 | 56.0 |
| AGE | | | | | | | | | | |
| 0 to 15 | 19.4 | 19.0 | 40.8 | 17.0 | 17.7 | 37.6 | 21.9 | 10.7 | 13.6 | 13.8 |
| 16 to 24 | 14.6 | 13.9 | 20.2 | 31.7 | 36.7 | 19.9 | 21.1 | 27.5 | 37.0 | 20.9 |
| 25 to 49 | 38.0 | 38.0 | 30.5 | 38.3 | 34.9 | 32.5 | 43.2 | 48.6 | 34.2 | 53.9 |
| 50 to 59 | 10.5 | 10.8 | 4.0 | 6.1 | 2.9 | 4.4 | 6.6 | 6.1 | 7.0 | 5.0 |
| 60 to 64 | 4.1 | 4.2 | 1.2 | 3.0 | 2.3 | 3.2 | 3.4 | 3.0 | 2.7 | 2.0 |
| 65 to 74 | 7.4 | 7.6 | 1.9 | 3.1 | 4.2 | 2.0 | 2.4 | 2.1 | 3.7 | 3.0 |
| 75 and over | 8.0 | 8.4 | 1.3 | 0.8 | 1.4 | 0.5 | 1.4 | 2.1 | 1.9 | 1.4 |

As a whole there are considerably high levels of deprivation and unemployment. The Bangladeshi Community have the lowest levels of educational attainment as well as the highest level of unemployment compared to other ethnic groups.

| | Asian or Asian British: | | | | | | | Chinese or Other Ethnic Group: | | |
|------------------------------------|-------------------------|--------------|--------------|--------|------------|--------------|-------------|--------------------------------|---------|--------------------|
| | ALL PEOPLE | White groups | Mixed groups | Indian | Paki stani | Bangl adeshi | Other Asian | Black or Black British | Chinese | Other Ethnic Group |
| ALL PEOPLE | 186,701 | 178882 | 1859 | 1,320 | 215 | 2,522 | 498 | 942 | 1,807 | 858 |
| No qualifications or level unknown | 34.8 | 35.1 | 24.1 | 14.9 | 6.3 | 64.5 | 20.9 | 15.8 | 29.3 | 28.8 |
| Lower level qualifications | 47.6 | 48.0 | 51.7 | 48.4 | 51.7 | 38.0 | 35.8 | 48.8 | 36.1 | 28.4 |
| Higher level qualifications | 17.6 | 16.9 | 24.2 | 38.7 | 42.0 | 9.5 | 43.5 | 35.6 | 34.6 | 42.8 |
| Not aged 16 to 74 | 37.7 | 37.7 | 72.9 | 21.8 | 23.6 | 61.5 | 30.4 | 14.7 | 18.2 | 17.9 |

| | Asian or Asian British: | | | | | | | Chinese or Other Ethnic Group: | | |
|--|-------------------------|--------------|--------------|--------|------------|--------------|-------------|--------------------------------|---------|--------------------|
| | ALL PEOPLE | White groups | Mixed groups | Indian | Paki stani | Bangl adeshi | Other Asian | Black or Black British | Chinese | Other Ethnic Group |
| ALL PEOPLE | 186,701 | 178882 | 1859 | 1,320 | 215 | 2,522 | 498 | 942 | 1,807 | 858 |
| LIMITING LONG-TERM ILLNESS | | | | | | | | | | |
| Has a limiting long-term illness | 17.4 | 17.8 | 9.0 | 10.6 | 11.2 | 13.3 | 9.8 | 8.8 | 7.0 | 8.5 |
| Does not have a limiting long-term illness | 82.6 | 82.2 | 91.0 | 89.4 | 88.8 | 86.7 | 90.4 | 91.4 | 93.0 | 91.5 |
| GENERAL HEALTH | | | | | | | | | | |
| Good Health | 67.9 | 67.5 | 80.0 | 77.2 | 72.6 | 68.4 | 74.9 | 77.2 | 74.9 | 76.5 |
| Fairly Good Health | 23.5 | 23.7 | 15.6 | 17.0 | 22.8 | 24.3 | 17.9 | 18.2 | 22.1 | 18.0 |
| Not Good Health | 8.6 | 8.8 | 4.4 | 5.8 | 4.7 | 7.3 | 7.2 | 4.7 | 3.0 | 5.5 |

There is no local information around uptake of mental health services by different ethnic origin. However with these high figures showing deprivation and unemployment coupled with ill health, the Bangladeshi community are at a more significant risk of suffering from mental health problems.

The Bangladeshi Community

The People 's Republic of Bangladesh has an area of 144,000 sq. kilometres with a population of around 140 million. The majority of people in the UK are from the region known as Sylhet. The official language is Bengali although the more common colloquial Sylheti is used in Portsmouth. Sylheti is a dialect and has no written format this has serious implications when translating information.

The community initially came to England back in the 1950's and 1960's many were brought over to cover a shortage of factory workers particularly in the north. In Portsmouth however many of the Bangladeshis were working on the ships often as cooks or in the dockyard.

Eventually families joined them and they settled into their new life. Many began to set up businesses predominantly Indian restaurants, after having worked as cooks this was a very natural progression. Today there are around 100 Indian restaurants in Portsmouth, although called Indian almost all of these restaurants are run and owned by Bangladeshis. The majority are still family run although many of the younger generations are expanding into other careers.

The Bangladeshi Welfare Association (BWA)

The Pakistan Welfare Association was formed in 1963. After the war of independence of Bangladesh in 1971, it was called Bangladesh Shomitee until 1978 when it was renamed as the Bangladesh Welfare Association (BWA). The Association has charitable status and is governed by a constitution. There are 29 committee members, 8 office bearers 4 advisory councillors and 17 executive committee members.

The BWA has been involved in many different activities and events as well as running support groups. The BWA has always maintained strong links with other organisations and agencies in order to provide better services for our community. In the past through funded joint working initiatives with social services, health and education we have been able to provide many opportunities for our community.

Over the years we have been able to provide various support groups and advice on a range of issues and services. Some of the groups we have run in the past include: Mothers and toddlers group, English for speakers of other languages courses (ESOL) Older women's group, Older men's group, Youth groups, Sewing courses. As well as healthy living workshops focusing on the health needs of the community. Looking at diabetes, heart disease, breast cancer and a range of other health related issues. As

an organisation we have also been involved in training Portsmouth City Council staff around cultural and religious awareness.

To date the BWA still runs various sports activities and competitions as well as the Priory Bangla School which runs Bengali language classes for children at the weekends. On a day to day basis we deal with queries from our community ranging from social care to immigration often signposting people to the relevant service. We have the interest of our community at heart and want to be involved in this mental health project to inform our community and to help shape services for the future.

Culture Works

In 1992 Social services set up a support group for BME women in the local community, to look at various health related issues including depression which was rising amongst Asian women. A multicultural social group called 'Harmony' for all BME women was set up with a crèche, the group proved to be very successful with a lot of women from all backgrounds attending.

A second group called Shanti was set up in 1994 for both men and women from BME communities who were experiencing mental health difficulties. Again it was well attended by people who clearly needed this external support.

The groups engage with people by giving out information, going on trips, organising regular activities, arts and crafts, sports / fitness, and healthy cooking.

Local research demonstrated that people from BME communities were unable to access mainstream mental health services for a variety of reasons, including lack of knowledge about services, language and cultural issues. As a response the 'Home Support Project' was set up, which later changed its name to 'Culture Works'.

The aim of Culture Works is to improve the quality of life for people from BME communities experiencing Mental Health difficulties through the provision of support. By providing information, advice and one to one support to help them to live meaningful lives within the community.

Culture Works is a team of 8 people from various ethnic backgrounds with a range of different languages and a wealth of experience in the mental health field. Where possible we try to provide support in the service users first language. We encourage and try to motivate individuals to take part in everyday activities and to work towards a goal or pursue an activity or course.

The local BME themed review by the City Council and Portsmouth PCT / NHS, Joint Contracts officer Stephen Corrigan (2004).

“Historically it seems the AMH BME equality agenda has been, almost exclusively, the responsibility of Culture Works, a small team of workers whose main role has been to provide support to people from minority communities. This needs to change so that meeting the needs of the BME population is the responsibility of all services and is embedded within service delivery.”

Culture Works recognises the need for change and a more appropriate mental health service for all BME communities. This will take time and although Culture Works has had to close its service as of January 2007 due to funding and a restructuring of local mental health services. We were still keen to be involved with this project as it gave us a unique opportunity to explore the needs of the largest ethnic group in Portsmouth.

We hope that the findings from this report will inform the Community Development Workers and be instrumental in shaping local services, to be more sensitive to BME needs. We also hope that this report will encourage other ethnic groups to be more vocal and to come forward with their views about local services.

Aims and Objectives

The aim of our project is to

“Investigate the mental health needs of the Bangladeshi Community in Portsmouth”

In order to determine the level of awareness of mental health issues and services. As well as looking at barriers to accessing services and the impact of cultural and religious factors.

Our target group is the Bangladeshi community in Portsmouth aged 17 – 70+ years.

Methods

As the lead researchers Mr Syed Aminul Haque president of the BWA and myself Shipa Ahmed Khan Team Leader of Culture Works we recruited a further four Bengali researchers from the local community, making a team of 6 researchers.

We advertised in the local newspaper, and produced a leaflet which was displayed in our local halal shops, the Mosque, Schools and other community support groups, as well as by word of mouth. We specifically wanted to recruit an equal number of men and women in order to be more culturally and religiously sensitive to individual needs, giving people the choice to be interviewed by some one of the same gender. This is more acceptable when asking personal questions.

It was important that the researchers not only had some understanding of mental health but were also from the community themselves. This enabled the researchers to be more easily accepted and trusted, but also they would be aware of local sensitivities and issues affecting the community.

As a research team we had scheduled meetings looking at various aspects of research work and how research can impact on individuals. We explored issues of health and safety, confidentiality and bias as well as looking at the cultural needs, training and interpreting the questionnaire.

The research team also undertook the University of Central Lancashire accredited course on Mental Health and Research methodology. Regular meetings fortnightly with our support worker Anthony Kollie helped us to develop as a team.

Our steering group was made up of various individuals from the Focussed Implementation Site (FIS), Portsmouth City Council (PCC), Primary Care Trust (PCT), and the NHS. The steering group was instrumental in supporting us throughout the project.

As a research team we were all fully involved in the whole process from designing and piloting, to applying for ethical approval and delivering our project at all stages. We decided to do a questionnaire with predominantly closed questions in order to get more quantitative data. There are several open questions allowing people the opportunity to expand on the answers given enabling us to gain more qualitative data.

Some of the community were aware of our project due to the advertising we had done previously in order to recruit the researchers. We then later produced another leaflet explaining the project and asking people in the community to come forward as respondents. At the same time we also gave out an information sheet detailing the background of the project and individuals rights should they choose to be interviewed. The criteria for participation was that respondents had to be from the Bangladeshi community in Portsmouth and aged between 18 to 70+ years.

We targeted various community support groups, local centres, halal shops, and approached the Mosque. We randomly selected individuals in the community and then worked on a snowballing effect. The research took place in various locations including a women's support group at a local community centre, at the respondent's home via an appointment and also at the Bangladeshi Welfare Association office. The interviews took place in a secure environment and only proceeded with the full consent of the individual being interviewed. The respondents were required to complete a consent form, and were made fully aware of their rights as a respondent. This included things such as being able to terminate the interview at any time or not answering questions if they felt uncomfortable to do so.

As a project we felt that it was important to produce our questionnaire, consent form and the background information in Bengali to enable a wider audience to understand what we were trying to do. This also helped to clarify questions and any issues related to the research for individuals whose first language is not English.

We devised a semi structured questionnaire, looking at the following areas:

- Core data
- Definition and awareness of mental health
- Access to mental health services
- Treatments
- General Questions

We interviewed 132 people aged between 18 to 50+ years from the Bangladeshi Community in Portsmouth.

The service providers evaluation form was also kept very simple. However we did not know that we would need additional consent and have to go through a local ethical procedure in order to pursue this part of our project.

Although in the end we did not need to seek ethical approval it did delay our project considerably. There were a lot of difficulties in trying to access the relevant body in order to gain consent to conduct the evaluation, in this matter our steering group was invaluable. We circulated the evaluation form to primary and secondary local mental health services by post and email as well as through individuals working in mental health community services.

The evaluation form for mental health service providers looked at:

- Training needs
- Use of services by BME communities
- Promotion of services in the BME communities
- Individual views

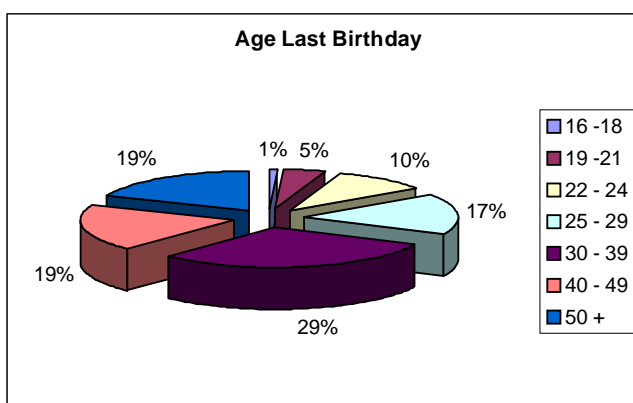
In total there were 27 responses from various mental health service providers.

Results

Core Data

1.1 Age last birthday

| Age Last Birthday | | |
|----------------------|------------|-------------|
| Age | Total | % |
| 16 -18 | 1 | 1% |
| 19 -21 | 6 | 5% |
| 22 – 24 | 13 | 10% |
| 25 – 29 | 22 | 17% |
| 30 – 39 | 40 | 29% |
| 40 – 49 | 25 | 19% |
| 50 + | 25 | 19% |
| No. of people | 132 | 100% |



1.2 Gender

| Gender | | |
|------------|-------|-----|
| Gender | Total | % |
| Male | 66 | 50% |
| Female | 64 | 48% |
| Not Stated | 2 | 2% |

| No of men & women by age band | | | | |
|-------------------------------|------|--------|------------|-------|
| Age | Male | Female | Not stated | Total |
| 16 -18 | 1 | 0 | 0 | 1 |
| 19 -21 | 3 | 3 | 0 | 6 |
| 22 – 24 | 5 | 8 | 0 | 13 |
| 25 – 29 | 12 | 10 | 0 | 22 |
| 30 – 39 | 16 | 23 | 1 | 40 |
| 40 – 49 | 15 | 9 | 1 | 25 |

| | | | | |
|--------------|-----------|-----------|----------|------------|
| 50 + | 14 | 11 | 0 | 25 |
| Total | 66 | 64 | 2 | 132 |

1.3 Ethnicity

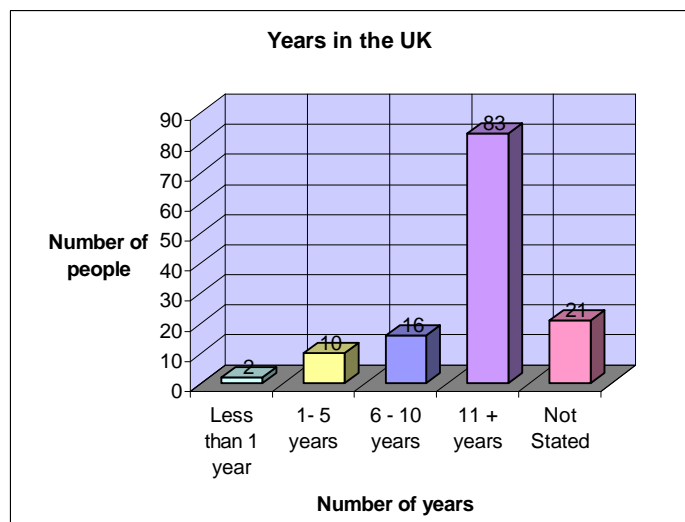
| Ethnicity | | |
|-----------------------------|-------|-----|
| Ethnicity | Total | %3 |
| Asian British / Bangladeshi | 131 | 99% |
| Not Stated | 1 | 1% |

1.4 Were you born in the UK?

| Were you born in the UK | | |
|-------------------------|-------|-----|
| Born in UK | Total | % |
| Yes | 24 | 18% |
| No | 107 | 81% |
| Not Stated | 1 | 1% |

1.4a If no how long have you lived here?

| Years in the UK | | |
|------------------|-------|-----|
| Years | Total | % |
| Less than 1 year | 2 | 2% |
| 1- 5 years | 10 | 8% |
| 6 - 10 years | 16 | 12% |
| 11 + years | 83 | 62% |
| Not Stated | 21 | 16% |

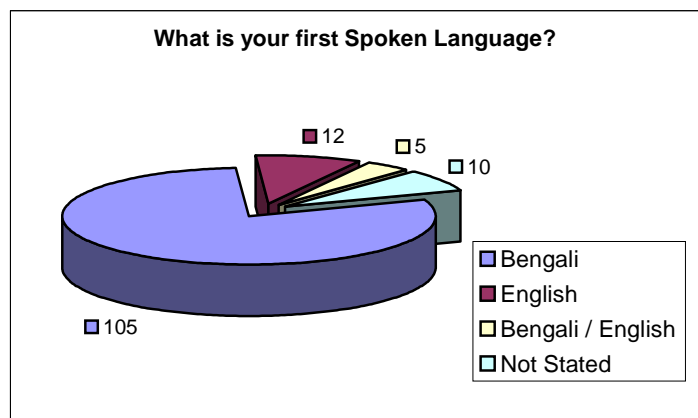


1.5 Are you a:

| Are you a: | | |
|-----------------------|-------|-----|
| Immigration Status | Total | % |
| British Citizen | 109 | 82% |
| Refugee | 0 | 0% |
| Asylum Seeker | 0 | 0% |
| Settlement | 4 | 3% |
| Student | 3 | 2% |
| Working Holiday Maker | 1 | 1% |
| Bangladeshi | 1 | 1% |
| Not Stated | 14 | 11% |

1.6 What is your first language?

| What is your first Language? | | |
|------------------------------|--------|-----|
| Language | Spoken | % |
| Bengali | 105 | 79% |
| English | 12 | 9% |
| Bengali / English | 5 | 4% |
| Not Stated | 10 | 8% |



| What is your first Language? | | |
|------------------------------|---------|-----|
| Language | Written | % |
| Bengali | 76 | 57% |
| English | 31 | 23% |
| Bengali / English | 2 | 2% |
| French | 1 | 1% |
| Not Stated | 22 | 17% |

1.7 Which languages are you fluent in? Spoken

| Which Languages are you fluent in? | | |
|--|--------|-----|
| Languages | Spoken | % |
| Bengali | 52 | 39% |
| Bengali / Sylheti | 4 | 3% |
| English | 15 | 11% |
| English / Sylheti | 4 | 3% |
| English / Bengali | 40 | 30% |
| English / Bengali / Sylheti | 1 | 1% |
| English / Bengali / Sylheti / Hindi / Urdu | 1 | 1% |
| English / Bengali / German | 1 | 1% |
| English / French | 1 | 1% |
| Not Stated | 13 | 10% |

1.7 Which languages are you fluent in? Written

| Which Languages are you fluent in? | | |
|------------------------------------|---------|-----|
| Languages | Written | % |
| Bengali | 50 | 38% |
| English | 30 | 23% |
| English / Bengali | 23 | 17% |
| English / Bengali / German | 1 | 1% |
| English / French | 1 | 1% |
| Not Stated | 27 | 20% |

1.8 What is your religion?

| What is your religion? | | |
|------------------------|-------|-----|
| Religion | Total | % |
| None | 0 | 0% |
| Christianity | 0 | 0% |
| Buddhist | 0 | 0% |
| Hindu | 1 | 1% |
| Jewish | 0 | 0% |
| Muslim | 129 | 97% |
| Sikh | 1 | 1% |
| Other | 0 | 0% |
| Not Stated | 1 | 1% |

1.9 Sexuality

| Sexuality | | |
|-------------------------|-------|-----|
| Sexuality | Total | % |
| Lesbian / Gay Woman | 0 | 0% |
| Homosexual / Gay Man | 0 | 0% |
| Heterosexual / Straight | 118 | 90% |
| Bisexual | 0 | 0% |
| Do not wish to answer | 7 | 5% |
| Other | 0 | 0% |
| Not Stated | 7 | 5% |

1.10 Do you have a disability?

1.10a If yes please state:

| Do you have a disability | | |
|--------------------------|-------|-----|
| Disability | Total | % |
| Yes | 6 | 5% |
| No | 123 | 93% |
| Not Stated | 3 | 2% |

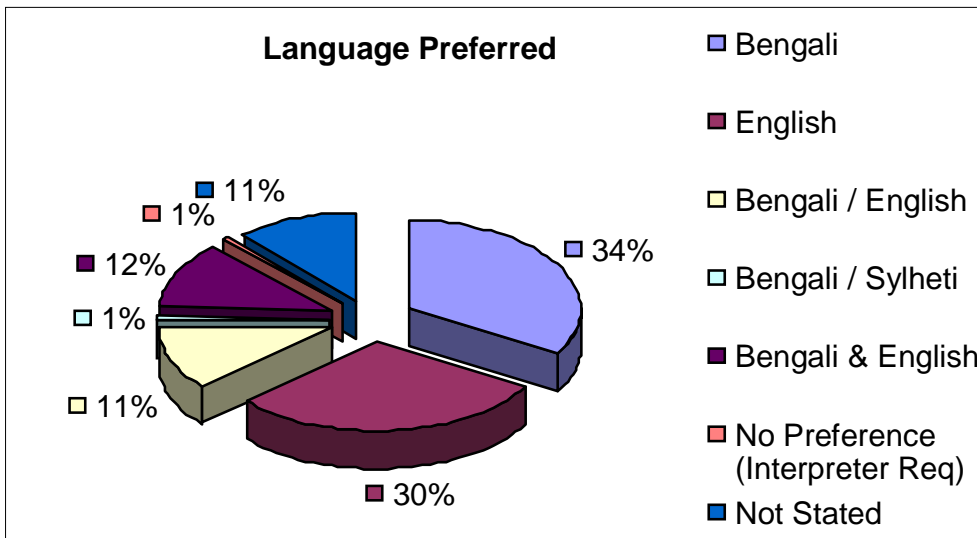
| Disability - If Yes please state | |
|----------------------------------|--------|
| Disability | Number |
| Hearing | 1 |
| Heart Condition | 2 |
| Physical | 2 |
| Not Stated | 1 |

1a. Please list all the languages you can speak, read and write:

| List all languages you can speak, read, write | | | | |
|---|--------|-------|------|-------|
| Language | Number | Speak | Read | Write |
| Arabic | 10 | 3 | 9 | 1 |
| Bengali | 124 | 124 | 97 | 89 |
| English | 109 | 107 | 87 | 84 |
| French | 3 | 3 | 2 | 2 |
| German | 3 | 3 | 1 | 1 |
| Hindi | 37 | 37 | 1 | 0 |
| Japanese | 1 | 1 | 0 | 0 |
| Sylheti | 21 | 21 | 0 | 0 |
| Urdu | 15 | 15 | 1 | 1 |

1b. If you wanted information on health related issues which language would you prefer it to be in?

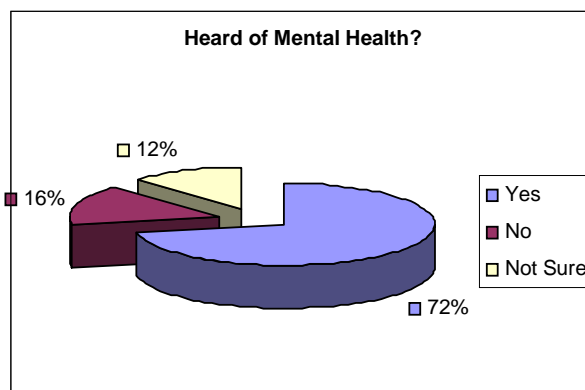
| Which language would you prefer the information to be in? | | |
|---|-------|-----|
| Language | Total | % |
| Bengali | 44 | 34% |
| English | 40 | 30% |
| Bengali / English | 15 | 11% |
| Bengali / Sylheti | 1 | 1% |
| Bengali & English | 16 | 12% |
| No Preference (Interpreter Required) | 1 | 1% |
| Not Stated | 15 | 11% |



Definition and awareness of mental health

2. Have you ever heard of mental health?

| Have you ever heard of Mental Health? | | |
|---------------------------------------|-------|-----|
| | Total | % |
| Yes | 95 | 72% |
| No | 21 | 16% |
| Not Sure | 16 | 12% |



2a. In your own words can you explain what mental health is?

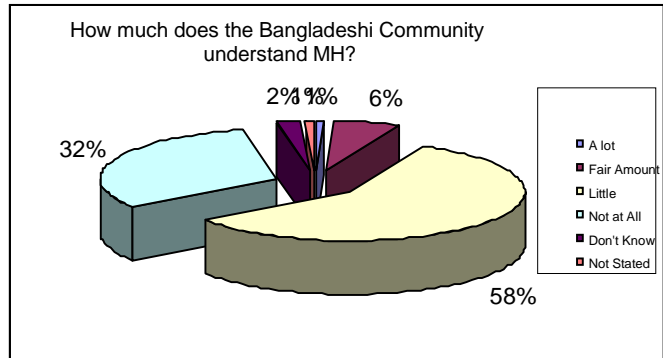
| In your own words can you explain what MH is? | |
|---|-------|
| Description | Total |
| Abnormal Behaviour | 7 |
| Aggression | 1 |
| Ahlziemers | 1 |
| Anxiety | 5 |
| Brain / Head problems | 19 |
| Communication Difficulties / Speech | 2 |
| Depression | 36 |
| Disability | 1 |
| Eating Disorder | 1 |
| Emotional / Mood | 6 |
| Illness / Medical / Health problems | 20 |
| Insomnia | 1 |
| Life / family relationship breakdown | 4 |
| Loneliness | 1 |
| Low self esteem | 1 |
| Madness | 3 |
| Manic | 2 |
| Mental ill / problem / breakdown | 26 |
| Mind | 22 |
| Physical | 3 |
| Psychological | 5 |
| Schizophrenia | 3 |
| Stress / Pressure | 9 |
| Thinking / Forgetful / Understanding | 6 |
| Trauma | 1 |
| Various | 7 |
| Well being / Happy life | 3 |
| Don't Know | 17 |
| Not Stated | 6 |

3. If you believed you or someone close to you had a mental health problem where would you go to seek help / advice?

| Where would you go to seek help? | | |
|--|-------|-----|
| | Total | % |
| Bangladesh Welfare Association | 1 | 1% |
| Counselling | 1 | 1% |
| Doctor | 25 | 16% |
| GP | 86 | 54% |
| Health Centre | 1 | 1% |
| Health Visitor / Nurse | 6 | 4% |
| Hospital / St. James' Hospital | 8 | 5% |
| Imam | 2 | 1% |
| Internet | 3 | 2% |
| Local BME MH specialist service | 1 | 1% |
| Local Mental Health Service | 2 | 1% |
| Mental Health / NHS Helpline | 2 | 1% |
| NHS | 3 | 2% |
| Portsmouth City Council | 2 | 1% |
| Relative / Friend / Neighbour / Myself | 3 | 2% |
| Social Worker | 2 | 1% |
| Specialist / Qualified person | 2 | 1% |
| Don't Know / Not stated | 10 | 4% |

4. How well do you think the Bangladeshi community in Portsmouth know of and understand mental health issues?

| How much does the Bangladeshi Community understand MH? | | |
|--|--------------|------------|
| | Total | % |
| A lot | 1 | 1% |
| Fair Amount | 8 | 6% |
| Little | 77 | 58% |
| Not at All | 42 | 32% |
| Don't Know | 3 | 2% |
| Not Stated | 1 | 1% |



5. Please tick if you have heard of these services. How useful was it?

| List of local mental health services in Portsmouth | | | | |
|--|----------|-----------|------------|------|
| | Heard of | Not heard | Not Stated | Used |
| 117 Orchard Road | 17 | 111 | 13 | 0 |
| Acorn Lodge | 23 | 105 | 13 | 2 |
| All Saints Church drop - in | 27 | 102 | 12 | 0 |
| Befriending service | 10 | 120 | 11 | 1 |
| Campion Place | 26 | 104 | 11 | 2 |
| Care Co-ordinators | 20 | 109 | 12 | 2 |
| Carers Service | 27 | 102 | 12 | 2 |
| Cavendish House | 26 | 105 | 10 | 0 |
| Chaplaincy | 18 | 113 | 10 | 0 |
| Crisis resolution team | 16 | 114 | 11 | 0 |
| Culture Works | 55 | 74 | 12 | 3 |
| Day treatment | 43 | 88 | 10 | 0 |
| Dietician | 60 | 71 | 10 | 2 |
| Early Intervention Team | 23 | 109 | 9 | 0 |
| Harmony group | 73 | 58 | 12 | 7 |
| Leisure services interaction | 35 | 97 | 9 | 1 |
| MENDOS | 22 | 109 | 10 | 0 |
| Oakdene | 10 | 121 | 10 | 0 |
| Occupational Therapists | 43 | 89 | 9 | 1 |
| Other social / day support | 25 | 106 | 10 | 0 |
| PORT outreach team | 24 | 107 | 10 | 1 |
| Port of call cybercafé | 8 | 122 | 11 | 0 |
| Portsmouth MIND | 24 | 108 | 9 | 2 |
| Psychological Therapies | 35 | 96 | 10 | 0 |
| Resettlement & Accommodation | 21 | 108 | 12 | 1 |
| Shanti group | 64 | 67 | 10 | 1 |
| Southsea United reformed church group | 22 | 108 | 11 | 0 |
| St. James's Hospital | 106 | 25 | 10 | 3 |
| The Beeches | 15 | 113 | 10 | 3 |
| The Hawthorns | 11 | 120 | 10 | 0 |
| The Maples | 12 | 119 | 10 | 0 |
| The Orchards | 16 | 114 | 11 | 0 |
| Together | 12 | 118 | 11 | 1 |
| Vocational Advisors | 15 | 116 | 10 | 1 |

5i. If you have used this service how useful did you find it?

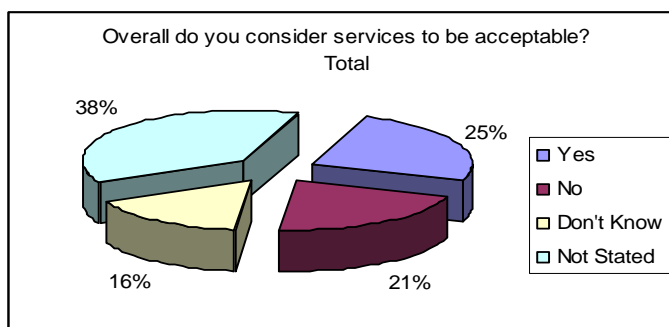
| List of mental health services used in Portsmouth | | | | | |
|---|------|-----------|------|--------------|-----------|
| Service | Used | Very Poor | Poor | Satisfactory | Excellent |
| Acorn Lodge | 2 | | | 1 | 1 |
| Befriending service | 1 | | | 1 | |
| Campion Place | 2 | | | | 2 |
| Care Co-ordinators | 2 | | | 2 | |
| Carers Service | 2 | | | | 2 |
| Culture Works | 3 | | | | 3 |
| Dietician | 2 | | | 2 | |
| Harmony group | 7 | | | 3 | 4 |
| Leisure services interaction | 1 | | | 1 | |
| Occupational Therapists | 1 | | | 1 | |
| PORT outreach team | 1 | | | 1 | |
| Portsmouth MIND | 2 | | | 1 | 1 |
| Resettlement & Accommodation | 1 | | | 1 | |
| Shanti group | 1 | | | | 1 |
| St. James's Hospital | 3 | | | 2 | 1 |
| The Beeches | 3 | | | 2 | 1 |
| Together | 1 | | | 1 | |
| Vocational Advisors | 1 | | | 1 | |

5ii. What was good / bad about these services?

| What was good / bad about these services? | |
|--|-------|
| Comments | Total |
| Central location of friendly support group | 1 |
| Doesn't apply never used services | 1 |
| Don't know / heard of never used | 3 |
| Have heard of through work and open days | 1 |
| I attend the women's group | 1 |
| They all provide standard care | 1 |
| Not stated | 124 |

6. Overall do you consider services to be acceptable?

| Overall do you consider services to be acceptable? | | |
|--|--------------|------------|
| | Total | % |
| Yes | 33 | 25% |
| No | 28 | 21% |
| Don't Know | 21 | 16% |
| Not Stated | 50 | 38% |



| Overall do you consider services to be acceptable? | | | | |
|--|------------|-----------|-------------------|-------------------|
| | Yes | No | Don't Know | Not Stated |
| Carer | 2 | 1 | 1 | 0 |
| Family member / Friend | 6 | 7 | 1 | 0 |
| Paid Interpreter | 1 | 0 | 0 | 1 |
| Professional | 2 | 2 | 0 | 1 |
| Service User | 4 | 1 | 1 | 1 |
| Voluntary Interpreter | 1 | 0 | 0 | 0 |
| Other / Not used | 0 | 1 | 1 | 1 |
| Not Stated | 17 | 16 | 17 | 46 |
| Total | 33 | 28 | 21 | 50 |

6i. Overall do you consider the services to be acceptable? Yes Comments.

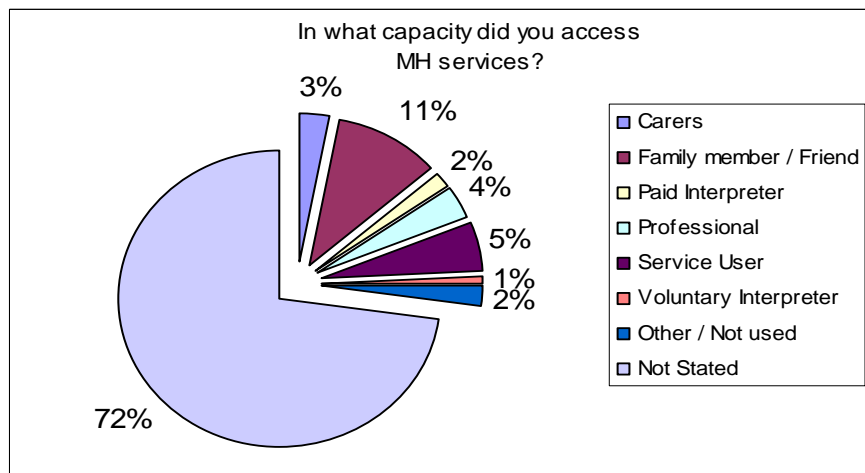
| If yes how: | |
|---|--------------|
| Comments | Total |
| I hope so but don't know haven't used them / I believe so | 2 |
| Need more community integration | 1 |
| Not good access / information on MH | 1 |
| Ok / Acceptable | 2 |
| Services available & accessible/ There when I need them | 7 |
| There are enough services, but not accessible enough needs publicity | 1 |
| There is a good service | 2 |
| They try & do their best / they do all they can to help, patient & carers | 4 |
| Would get help / advice & appropriate support when needed | 6 |

6ii. Overall do you consider the services to be acceptable? No Comments

| If no why? | |
|---|-------|
| Comments | Total |
| Don't reach the BME communities / Services not well known to the community / Could do more to engage with all communities | 3 |
| I don't know anything about MH services / don't know how to contact | 5 |
| I have never used / know of any one who has | 4 |
| Improvement needed / Education / clear information on resources | 7 |
| Language barriers | 1 |
| More specialist services such as a culturally sensitive & confidential counseling service | 1 |
| Not enough info & communication with carers | 1 |

6a. In what capacity did you access MH services?

| In what capacity did you access MH services? | | |
|--|-------|-----|
| | Total | % |
| Carer | 4 | 3% |
| Family member / Friend | 14 | 11% |
| Paid Interpreter | 2 | 2% |
| Professional | 5 | 4% |
| Service User | 7 | 5% |
| Voluntary Interpreter | 1 | 1% |
| Other / Not used | 3 | 2% |
| Not Stated | 96 | 72% |



7. How did you gain access to the service?

| How did you gain access to the service? | | |
|---|-------|-----|
| | Total | % |
| BME support groups / Open Days | 7 | 5% |
| Friend | 1 | 1% |
| GP / Referral | 19 | 14% |
| Interpreter | 1 | 1% |
| Networks / Work activities | 2 | 2% |
| Support Worker | 1 | 1% |
| Other / Not used | 1 | 1% |
| Not Stated | 101 | 75% |

7a. Was the service easily accessible?

| Was the service easily accessible? | | |
|------------------------------------|-------|-----|
| | Total | % |
| Average | 1 | 1% |
| Yes | 18 | 14% |
| Yes with external help | 4 | 3% |
| No | 5 | 4% |
| Don't Know | 2 | 2% |
| Not Stated | 102 | 76% |

8. In your opinion which of the following could help to improve services?

| Which of the following could help to improve access / knowledge of MH? | | |
|--|--------------|-------------|
| | Total | % |
| Audio / Video information | 57 | 43 % |
| BWA Bangladeshi Welfare Association | 85 | 64 % |
| Community groups | 63 | 48 % |
| Culture Works / a BME specific MH service | 69 | 52 % |
| Doctors / GP surgeries | 89 | 67 % |
| Education on MH in Schools / Colleges | 73 | 55 % |
| MH information in different languages | 107 | 81 % |
| MH information leaflets | 77 | 58 % |
| MH outreach / community workers | 71 | 54 % |
| More BME trained staff | 82 | 62 % |
| Mosques / Faith organisations | 59 | 45 % |
| PALS Patient Advice & Liaison service | 34 | 26 % |
| Talks & Presentations on MH | 72 | 55 % |
| Talks & Presentations on MH in different languages | 76 | 58 % |
| Trained Interpreters | 77 | 58 % |
| Training for Staff on Cultural awareness | 71 | 54 % |
| Website | 33 | 25 % |
| Workshops & Open days | 76 | 58 % |

9. If you or someone close to you needed to get help for a mental health problem.
What would stop you from accessing services? (list question)

| What would stop you from accessing MH services? | | |
|---|-------|------|
| Concerns about services | Total | % |
| Being put on treatment for long term | 31 | 23 % |
| Lack of Interpreters | 61 | 46 % |
| Lack of MH information / knowledge | 113 | 86 % |
| Lack of trust of Interpreters | 34 | 26 % |
| Lack of trust of services | 25 | 19 % |
| Medication & treatments | 32 | 24 % |
| Not knowing how to access services | 108 | 82 % |
| Not understanding my cultural needs | 75 | 57 % |
| Not understanding my religious needs | 57 | 43 % |
| Staff do not understand BME issues | 70 | 53 % |
| Transport | 37 | 28 % |

| What would stop you from accessing MH services? | | |
|---|-------|------|
| Other Concerns | Total | % |
| Being sent away / abroad | 18 | 14 % |
| Being Shamed | 81 | 61 % |
| Concerns for family & children | 71 | 54 % |
| Cultural reasons | 57 | 43 % |
| Future relationships / marriage | 63 | 48 % |
| Language barriers | 101 | 76 % |
| Losing community standing / dignity | 55 | 42 % |
| Losing employment | 26 | 20 % |
| Religious reasons | 26 | 20 % |

9a. Any Other concerns (please state)

| What would stop you from accessing MH services? Please state | |
|--|-------|
| Any Other concerns | Total |
| Barrier to access | 1 |
| Don't know where to go to get help / who to contact / Not too clear of where to go to get support directly for MH problems | 11 |
| Family thinking I have a serious problem | 1 |
| Breach of confidentiality | 2 |
| Contact GP | 1 |
| If I felt the service was not professional or empathetic | 1 |
| Lack of knowledge of MH / Lack of understanding of service | 3 |
| Language barriers | 6 |
| Stigma & lack of understanding of my culture | 1 |
| Not knowing what would happen, would it be effective | 1 |
| Nothing | 1 |
| Word getting around, lack of confidentiality | 1 |
| Not stated | 113 |

Treatments

10. Have you used or are you aware of any of the following therapies / treatments used in MH?

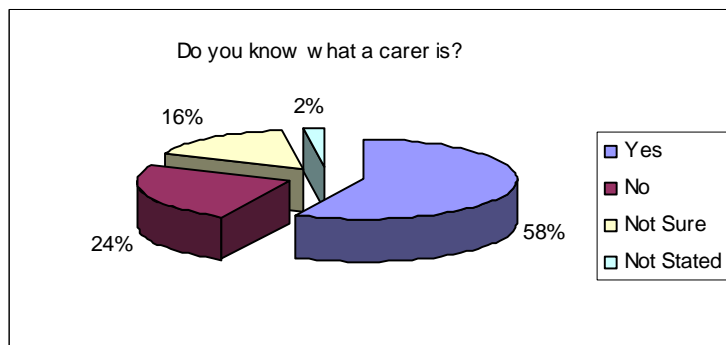
| List of MH therapies & treatments | | | | |
|-----------------------------------|----------|-----------|------------|------|
| | Heard of | Not heard | Not stated | Used |
| Antidepressants | 70 | 57 | 13 | 6 |
| Antipsychotics / neuroleptics | 21 | 109 | 11 | 1 |
| Art Therapy | 22 | 108 | 11 | 0 |
| Atypical antipsychotics | 16 | 113 | 12 | 3 |
| Behaviour therapy | 52 | 80 | 9 | 0 |
| Benzodiazepines | 10 | 120 | 11 | 0 |
| Carbamazepine | 6 | 122 | 13 | 0 |
| Care programme approach CPA | 20 | 109 | 12 | 1 |
| Cognitive therapy | 24 | 106 | 11 | 0 |
| Counselling | 86 | 43 | 12 | 2 |
| Depot medication injected | 15 | 114 | 12 | 0 |
| ECT electro convulsive therapy | 26 | 103 | 12 | 0 |
| Lithium | 18 | 111 | 12 | 1 |
| Mood stabilizers | 26 | 104 | 11 | 1 |
| Occupational therapy | 52 | 79 | 10 | 0 |
| Psychotherapy | 63 | 68 | 10 | 1 |
| Sleeping tablets | 111 | 19 | 11 | 4 |
| Talking therapies | 40 | 90 | 11 | 1 |

10i. If you have used these therapies / treatments how much did they help?

| List of MH therapies / treatments used & quality | | | | | | |
|--|------|-------------|--------|--------|-----|---------------------|
| | Used | Didn't help | Unsure | Little | Lot | couldn't do without |
| Antidepressants | 6 | | | 2 | 4 | |
| Antipsychotics / neuroleptics | 1 | | | 1 | | |
| Atypical antipsychotics | 3 | | | 1 | 2 | |
| Care programme approach CPA | 1 | | | | 1 | |
| Counselling | 2 | | | | 2 | |
| Lithium | 1 | | | 1 | | |
| Mood stabilisers | 1 | | | 1 | | |
| Psychotherapy | 1 | | | 1 | | |
| Sleeping tablets | 4 | | 1 | 2 | 1 | |
| Talking therapies | 1 | | | | 1 | |

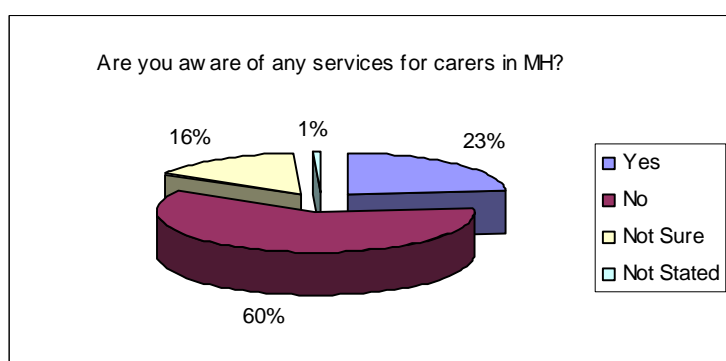
11. Do you know what a carer is?

| Do you know what a carer is? | | |
|------------------------------|-------|-----|
| | Total | % |
| Yes | 76 | 58% |
| No | 32 | 24% |
| Not Sure | 21 | 16% |
| Not Stated | 3 | 2% |



11a. Are you aware of any services for carers within mental health?

| Are you aware of any services for carers in MH? | | |
|---|-------|-----|
| | Total | % |
| Yes | 31 | 23% |
| No | 79 | 60% |
| Not Sure | 21 | 16% |
| Not Stated | 1 | 1% |



11ai. Are aware of any services for carers? Please state

| Are aware of any services for carers? Please state | |
|--|-------|
| Comments | Total |
| Can get a carer through a GP if required | 1 |
| Cannot remember | 1 |
| Carers service MH / carers centre / carers centre - northend | 3 |
| Day care/ day care services / care homes / personal carer | 3 |
| Early intervention team | 1 |
| I didn't know that carers get help at all / I didn't know but happy to hear this information / I didn't know there were services for carers / I didn't know this until now / I have only found this out recently after being a carer for nearly three years. | 5 |
| My family get help looking after me | 1 |
| Social service | 1 |
| Not stated | 109 |

General Questions

12. Have you ever experienced discrimination or racism?

| Have you ever experienced discrimination or racism? | | | | |
|---|-----------|-----------|----------|------------|
| | Yes | No | Not Sure | Not stated |
| In general | 66 50% | 49 37% | 12 9% | 5 4% |
| In Mental Health services | 3 2% | 94 71% | 9 7% | 26 20% |
| In the Workplace | 20 15% | 89 67% | 5 4% | 18 14% |
| In Schools / Colleges | 31 23% | 77 58% | 6 5% | 18 14% |
| In City Council | 12 9% | 90 68% | 7 6% | 23 17% |
| In dealings with the Police | 14 11% | 84 64% | 11 8% | 23 17% |
| In GP surgeries | 18 14% | 87 66% | 7 5% | 20 15% |
| In Hospital | 8 6% | 94 71% | 5 4% | 25 19% |
| In Shops | 25 19% | 81 61% | 6 5% | 20 15% |
| On Streets | 78 59% | 39 30% | 7 5% | 8 6% |
| Other | 9 7% | 39 30% | 0 0% | 84 63% |

12i. Have you ever experienced discrimination or racism? Please comment.

| Have you ever experienced discrimination or racism? | |
|---|-------|
| Comments | Total |
| After 9/11 it did get worse because I dress differently | 1 |
| GP assumes it is a cultural problem not a medical one/ At GPs discriminated by Dr & was given lower quality of medication / GP had discriminatory attitude towards me. | 3 |
| Comments / remarks / verbal abuse | 5 |
| Police discrimination / didn't turn up after phoned of complaints of racial harassment / attack | 2 |
| Being called racist names e.g. pakis, black & other | 11 |
| Depends on upbringing, most kids are racist because their parents are / I think racism isn't as bad as it was a few years back. "I've been in this country for 30 years it was bad before, but these days it is much less. It's mostly young kids trying to be funny – they don't understand the effects". | 3 |
| General bullying | 1 |
| I don't go out much | |
| I feel there is a lack of understanding of cultural & religious needs of individuals both inside & outside of the Bangladeshi community which is ignorance and lack of education | 1 |
| I get a lot of racial abuse because I wear the burka, some people just don't respect religions it's mostly young adults (teenagers) and that's what hurts because they should understand. | 1 |
| I have been racially attacked, my home was set on fire / My house being attacked. | 2 |
| I think that some people are racist because they feel that we have come to their country and now doing their jobs and doing well in life, sometimes even better than English people. | 1 |
| Mentioned it was children / kids | 6 |
| Neighbour / Neighbourhood problem, racial motivation | 2 |
| Public transport – on bus while going to the Mosque. I witnessed institutional racism in this country when I arrived in 1990 and we are living with it. | 1 |
| Racist comments / remarks | 1 |
| Suffered racial harassment | 1 |
| Swearing go back home, don't wear a cap | 1 |
| We face racial abuse almost everyday, everywhere in this country. | 1 |
| Not Stated | 104 |

13. Do you have any other information you would like to share about your experience of mental health in Portsmouth?

| Experience of mental health in Portsmouth | |
|--|-------|
| Comments | Total |
| Awareness of cultural issues, gender related issues needs to be acknowledged | 2 |
| Difficult to access services/ don't know where to go/ need better info. sharing / direct mail distribution on all Bangladeshi groups from a local data base, to promote via marketing material/ in Bengali would help | 18 |
| Stigma / Cultural issues: Even the word MH is scary most of our community don't understand that it's an illness and not something to judge people by. / I don't think that in general the Bangladeshi people understand what MH is/ The problem is more common in collective families, too much family and culture bars a young woman, not enough enjoyment or relaxation. Disharmony of matrimonial life due to third party intervention. | 3 |
| I attend the Harmony group and can get advice and information if I need it. | 1 |
| I believe / know a large number of people suffer from this illness but they cannot identify the symptoms or are embarrassed to seek help / will not seek help. Even those within my family / I feel for people in our community suffering from MH. | 6 |
| Attitudes to people with Mental illness: I know someone with MH problems I don't think of them differently it's what is written in their fate It is important to listen to people suffering from MH otherwise they get more depressed | 2 |
| Help needed for families: More help should be available for family as well as user My family member has drug misuse issue. Do not know how to help him. We need to engage him with the services. My son is a service user I care for him. My daughters do all the paperwork, talking to the doctors, nurses etc. We are given information we ask for – nothing extra. We have only recently found out about the service for carers after 2/3 years. Sometimes it feel as though no-one cares (MHS) wont offer help unless me or my family come forward. | 4 |
| My understanding was that people who received treatment took too long. | 1 |
| Now that I know about these services I feel I want to use them, I always feel very lonely, I have a very big family but still feel alone, sometimes I want to get away from here. | 1 |
| Services have been helpful for me. | 1 |
| I think that this project is a brilliant opportunity to find out what our community | 1 |

| | |
|---|----|
| wants and provide that (hopefully) | |
| There need to be services specific to BME community, however strong links with mainstream services need to be made. | 1 |
| Youth have growing problem with drug issue. They need drug prevention and rehabilitation. | 1 |
| Not stated / No / No experience / No idea / None / Nothing special | 99 |

14. In general what do you feel are the Bangladeshi communities' needs in Portsmouth? What could we do better / improve? Please state

| What are the Bangladeshi communities needs? | |
|---|-------|
| Comments | Total |
| A community based team who will be the first or initial contact / outreach workers / more community involvement | 16 |
| Awareness and education within our community (mental health) Acceptance of change, growth and culture In BWA Leaflets distributed to individual address In community places and Mosque and schools | 35 |
| BME specialist mental health service: Bengali speaking counselors – sometimes I just want to talk about my problems without being judged. Bangladeshi carers Mental health worker trained professionals from the Bangladeshi community | 11 |
| Improvements in mainstream MH services Counseling – I'd like to be able to talk to someone about my problems besides my family / Someone we can talk to without having any fear / More sensitive approach needs to be taken, meet religious and cultural needs, intimidation language and cultural barriers | 6 |
| Specific community groups: Women's groups and Men's groups / Elders group / Groups for young people Cultural activities | 10 |
| Accessible Bengali and English language and training classes | 6 |
| Community Centre; A place for the children where they could go after school for further tutorial on their homework, community based tutors. Play groups permanent weekend school. | 16 |
| Social Inclusion measures Better policing, give attention to BME victims, try to sympathise when in problem. Better transport Employment, better schools, work related training, Economic development, | 10 |

| | |
|---|-----------|
| Technical skills like IT, Plumber, electricians etc. Housing, Safe place to live. | |
| Ideas for general development of Bangladeshi community: Female education, more exposure of Bengali women with mainstream services, more Bengali people working in the public sector, mixing with other cultures, Integrate more with society but maintain identity, reduce isolation and loneliness, There's no Mosque or other religious facilities around the northend area, maybe in the future there will be. | 7 |
| Give out more information in the post or leaflets at GP surgeries | 1 |
| Interpreters in various government services | 3 |
| Someone needs to open the window of opportunities | 1 |
| Stop drug trafficking, youths need help. Education on all aspects | 1 |
| Drop in weekly / monthly where specialists will come to talk | 2 |
| Not stated / don't know | 30 |

Discussion – Results 1

Some members of the Bangladeshi community have a sophisticated understanding of common mental illnesses, depression, anxiety, and stress. Few people describe mental health in positive terminology. Some describe the way it affects your life and social functioning. Some fairly vague notions still, regarding connections with the mind, head, or brain. Very few people focus on craziness

Overwhelmingly people have identified their GP or Doctor as the first contact for mental health issues, for most people though this was a calculated guess many were on the whole uncertain. It did highlight that the Bengali community and the Imam are not necessarily the first place people would go to seek help / advice. Although having information about mental health readily available at the BWA and community centres, meeting places would encourage discussion and improve knowledge.

Translation of health information needs to be considered carefully as the needs vary between a young audience and an older one 107 / 132 people requested that information on mental health be available in different languages. 61 / 132 said they were concerned at the lack of interpreters and 77 people said trained interpreters

would help to improve access as well as more BME trained staff. In general the majority of people are not aware of local MH services.

When asked if you or someone close to you needed to get support for a mental health problem what would stop you from accessing mental health services. Alarmingly 113 / 132 people stated a lack of mental health information and knowledge would stop them from accessing mental health services.

108 / 132 people did not know how to access services despite the majority having identified GP or Doctor in Q3.

101 / 132 identified language as a barrier. Other significant concerns were around being shamed, future relationships, marriage and the welfare of family and children.

“Sometimes it feels as though no-one cares (MH services) wont offer help unless me or my family come forward”

“My son is a service user I care for him. My daughters do all the paperwork, talking to the doctors nurses etc. We are given information we ask for – nothing extra”...

Many people did identify what a carer is but this was associated to day care / personal care for the elderly, again the majority of people did not know of services available. Culturally it is considered that the family will look after other family members in any state of health. In order to do this, external help is not required hence even the terminology of carer is a very western idea.

When asked are you aware of any services for carers in mental health:

“I didn't know that carers got any help at all”

“I have only found this out recently after being a carer for nearly three years”

For those who have used services and treatments general satisfaction levels are good, however is this a cultural phenomenon (Q6i – 4 people saying they “do their best”) historically and culturally this community does not tend to complain if they receive inadequate care or services.

About one third of the community have experienced racism, this varied from name calling, abuse, harassment, personal attacks and to attacks on home or property. Several people mentioned that there was involvement of young people. Another distressing fact is the perception of discrimination from the GP.

“I’ve been in this country for 30 years it was bad before, but these days it is much less. It’s mostly young kids trying to be funny – they don’t understand the effects”

Racism is a social factor that can contribute to poor mental health, if one third of the community are experiencing this there is a potential for raised levels of mental illness. Delays in obtaining services and lack of a more proactive stance about service options in consultations are clear concerns.

The community were able to discuss issues in confidence and did trust researchers enough to disclose personal information.

There were various other needs identified, and on the whole there were lots of encouraging signs of people wanting to come forward to use services as a result of this project.

Results - Service Providers Evaluation

Training

1. Training needs

| Training | | | |
|--|---------------------|---------------------|---------------------|
| | Yes | No | Not stated |
| 1a. I have done cultural awareness training | 14 (52%) | 11 (41%) | 2 (7%) |
| 1b. I have done equality & diversity training | 20 (74%) | 6 (22%) | 1 (4%) |
| 1c. I have done training around religious issues | 5 (18%) | 21 (78%) | 1 (4%) |
| 1d. I have done other BME / cultural training | 7 (26%) | 17 (63%) | 3 (11%) |
| 1e. I would like more training around BME issues | 18 (67%) | 5 (18%) | 4 (15%) |
| 1f. I have had no training around BME issues | 3 (11%) | 5 (18%) | 19 (71%) |

1g. Did you find this training useful?

| Did you find this training useful | | |
|--|--------------|------------|
| | Total | % |
| Not at all | 0 | 0% |
| Little | 2 | 7% |
| Lot | 3 | 11% |
| Very Useful | 10 | 37% |
| Not stated | 12 | 45% |

1h. Have you been able to utilise any of this training in your area of work?

| Have you been able to utilise this training | | |
|--|--------------|------------|
| | Total | % |
| Not at all | 1 | 4% |
| Little | 3 | 11% |
| Sometimes | 7 | 26% |
| Lot | 3 | 11% |
| all the time | 2 | 7% |
| Not stated | 11 | 41% |

2. In the last 12 months approximately how many people from the BME communities have accessed your service? Approximate number...

| In the last 12 months how many people have accessed your service | | | | | | | | | | | |
|---|-----------|-----------|------------|------------|-----------|-----------|-----------|-----------|------------|------------|------------|
| No of people | 1 | 2 | 3 | 4 | 5 | 6 | 8 | 12 | 100 | 120 | 0 |
| Response | 2 | 2 | 4 | 3 | 1 | 1 | 2 | 2 | 1 | 1 | 8 |
| % | 7% | 7% | 15% | 11% | 4% | 4% | 7% | 7% | 4% | 4% | 30% |

2a. Approximately how many are from the Bangladeshi community?

| Approx. how many are Bangladeshi | | |
|---|--------------|------------|
| | Total | % |
| 1 | 2 | 7% |
| 3 | 2 | 7% |
| 6 | 2 | 7% |
| N/A | 21 | 79% |

3. In your opinion as a service how do you rate your relationship with the BME communities in Portsmouth?

| As a service what links do have with BME | | |
|---|--------------|------------|
| | Total | % |
| No Links | 7 | 26% |
| Bad | 3 | 11% |
| Poor | 7 | 26% |
| Good | 6 | 22% |
| Excellent | 0 | 0% |
| Not stated | 4 | 15% |

4. How does your service promote itself to the BME communities?

| Promotion in BME communities | | |
|---|--------------|------------|
| | Total | % |
| Actively engage with BME communities | 3 | 11% |
| Produce leaflets in different languages | 6 | 22% |
| Outreach / visit BME groups | 2 | 7% |
| Other methods | 1 | 4% |
| We don't | 12 | 45% |
| Not stated | 3 | 11% |

4i. Comments

| How does your service promote itself to the BME communities | |
|---|--------------|
| Comments | Total |
| Try to raise awareness of our services by targeting BME services in the city. | 1 |
| A Practitioner has a specific role in outreach to BME communities & groups | 1 |
| Interpreter services | 1 |
| Go to their meeting | 1 |
| Disseminate info. to Portsmouth Minority Ethnic Staff network | 1 |
| Networking | 1 |
| Cohesive partnerships within PCT | 1 |
| We are a provider service and take only those families referred to us | 1 |
| New publicity in progress | 1 |

5. In your opinion what do you feel are the barriers for BME communities in accessing mental health services?

| Barriers for BME in accessing MH services? | |
|--|--------------|
| | Total |
| Language barriers | 12 |
| Lack of information / not aware of services | 7 |
| Religion / Culture | 9 |
| Stigma / Stereotypical thinking / fear | 6 |
| Our meeting place (a church premises) | 1 |
| Possibly at the point of entry – primary care | 1 |
| Low secure services are generally not accessed, we are a tertiary service requiring referral from other MH services. | 1 |
| Lack of interpreters | 1 |
| No barriers our service is needs led & service is provided by commission | 1 |

5a. How do you feel services could overcome these barriers?

| Ways to overcome barriers | |
|--|----------|
| | Total |
| More BME staff / Employ BME staff | 3 |
| More early intervention. Better communication and user involvement | 1 |
| Produce appropriate leaflets in different languages | 1 |
| Education / Training | 3 |
| Interpreters | 2 |
| Is a 2 way process both need to understand where people are coming from – service provided versus need | 1 |
| Better and closer contact with BME communities | 1 |
| Outreach to BME / Partnership working / visit BME groups | 5 |
| Advertise services / in GP surgeries | 2 |
| Community Dev. Workers / link roles | 2 |
| Create New Opportunities | 1 |
| Ensure meeting place is neutral as possible | 1 |
| This is not appropriate to us because of our position in the service | 1 |
| Open days / working groups / forums / stage events | 2 |
| Healthcare practitioners somehow need to enable a more trusting relationship | 1 |
| Not entirely sure - my knowledge & experience needs to be improved | 1 |
| N/A | 1 |

6. What do you feel BME communities could be doing to access mental health services?

| What could BME communities do? | |
|--|--------------|
| | Total |
| Accepting and value the impact of mental health | 1 |
| Access services / contact us directly / visit services | 4 |
| Ask GP for further info | 1 |
| Get rid of stigma & allow services to help at an earlier stage | 1 |
| Links with providers / link person | 4 |
| Training, understanding, clear knowledge about expectations and what can be done | 1 |
| Enable access & familiarisation of service | 1 |
| I am not clear – my understanding is that BME communities find MH services unhelpful | 1 |
| Raise awareness / more ground work | 2 |
| Not appropriate to us | 1 |
| Publicity / Communication / invite services to open days | 3 |
| Sharing / Sharing common ground enlivening our experience by sharing theirs | 2 |
| Work with Community development workers & MH services | 1 |
| Learn English language | 1 |

7. What do you think the development needs are for you and your service?

| Development needs for you & service | |
|---|----------|
| | Total |
| Awareness / Core Training / Training & Information / Equality & Diversity training | 8 |
| Networking / Outreach / Talk to / meet communities | 4 |
| More BME workers / Volunteers / Offer voluntary work / Employ BME support staff | 3 |
| Publicity / activities co-ordinator / Promote services | 2 |
| Increase expertise | 1 |
| Link with relevant BME organisations / faith / community / other | 4 |
| Citizenship & integration for all people who live in the UK we need to understand others so that there is assimilation to British society | 1 |
| We must respond to the needs of commissioners and service users | 1 |
| None at present | 1 |

Discussion – Results 2

21 / 27 service providers have had no training around religious issues.

18 / 27 would like to do more training around BME issues. Of the training completed 37% felt it was very useful, 26% have been able to utilise this training sometimes in their work.

17 / 27 service providers rated their relationship with the BME communities as poor, bad or as having no links. 6 people felt they had good links. When asked how their service promotes itself to the BME communities almost half said they didn't 45%. Some services however are actively engaging with BME communities in different ways and are disseminating information through BME work networks. Examples of good practice include having a designated staff member with specific roles to outreach in the BME communities, as well as visiting BME groups.

“Ensure meeting place is neutral as possible”

“Try to raise awareness of our services by targeting BME services in the city.”

“A Practitioner has a specific role in outreach to BME communities & groups”

12 / 27 commented that language was a barrier for BME in accessing services. 9 felt that religion and culture were a barrier although what they mean by this was not explained. 7 stated a lack of information was a barrier and 6 said that stigma, stereotypical thinking and fear were stopping BME communities from accessing services. Other comments to barriers for BME in accessing services include:

“Culture, religion.....seeing very few BME workers”

“Possibly at the point of entry – primary care”

“There are no barriers, our service is needs led and service is provided by commission”

Looking at ways to overcome these barriers focused on education and training for staff also identified was a need to outreach to and promote, advertise services in the BME community. Need for interpreters and employing more staff from the BME community was also identified.

“Be more proactive in engaging with all BME communities and stage events inviting all communities”

BME communities need to find out more about and contact or visit services, they need to increase their knowledge of what is available, to reduce stigma and accept mental

health, to share their experiences. On the whole there were very positive comments with some good ideas.

“Learn English language”

“Sharing common ground enlivening our experience by sharing theirs”

“Accepting and value the impact of mental health”

When asked what are the development needs for you and your service;

“We must respond to the needs of service users and commissioners”

“None at present”

“Citizenship and integration for all people who live in the UK we need to understand others so that there is assimilation to British society”

“To link with community groups and perhaps offer voluntary work”

Development needs of services focused on education, training, and knowledge. Again the need for publicity and networking were mentioned. The need for more BME workers and opportunities to link with BME groups were all mentioned.

Recommendations

20. For this fairly established community it would seem that mental health promotion can be couched in Western terms, so long as cultural differences are acknowledged.
21. Make appropriate mental health information easily available to the community by distributing in the relevant places.
22. Where possible information on mental health services should be in dual language both Bengali & English to engage a wider audience.
23. Education, information and opening doors to approachable community mental health services would help to reduce fear.
24. There is a huge information deficit about and on services, which the services need to address.
25. Training for all staff on cultural awareness and BME issues. Engage with local BME communities and empower them to inform services of their cultural and religious needs through training for staff.
26. Designated staff from services to outreach to BME communities. Community development workers, to act as a bridge to accessing services.
27. Encourage active involvement and partnership / link between service provider and the community. To enable a two way exchange of learning and sharing

between service and the community. Those working on ground level should endeavour to visit BME community groups.

28. Hold workshops / open days give talks and presentations on mental health if required in first language at a suitable venue or location.
29. Active promotion about mental health issues and information about support services availability and access is an urgent need in the community. Look at alternative confidential support structures such as cross cultural counselling.
30. Address and acknowledge issues of shame, fear and stigma around mental health are of significance. These needs to be examined in greater detail and in collaboration with the community, faith organisations and community leaders.
31. Enable and encourage participation and open discussion to address cultural issues such as shame, stigma etc. Consultation through workshops or talks, possibly facilitated by community development workers.
32. Support available to families, children and carers need to be highlighted as soon as possible and at the forefront.
33. More promotion of what and who is a carer, and differentiating between the roles of carer.
34. Engaging with this community and developing strong links could yield positive results in terms of satisfaction with services and recovery levels.
35. Information about services and efforts to improve access to secondary care where appropriate should be targeted at primary care.

36. GPs need to be mindful of the cultural needs of this client group, work needed with GPs.
37. Employ more BME staff and offer opportunities for volunteering in the mental health services.
38. Need for BME specialist mental health services, support groups and drop-in services looking at various issues of concern to the community. For example the need for a community centre, isolated women, the needs of families and drug abuse issues.

Appendix

Ethical proforma

Background information

Consent form

Questionnaire

Service providers' evaluation

Project Plan

List of steering group members

Section 1

| | |
|-------------------------------|--|
| Name of Group | Bangladeshi Welfare Association (BWA) & Culture Works. |
| Address | Portsmouth Jami Mosque Building, Unit 1 – 3, 75 Bradford Road, Portsmouth, PO5 1AA |
| Name of Support Worker | Anthony Kollie |
| Date | 7 th September 2006 |

Section 2

| | |
|---|---|
| What kind of work does the group intend to do as part of this project? | <p>To research the mental health needs of the Bangladeshi community in Portsmouth. To determine the levels of awareness of mental health issues as well as investigating the access and barriers to local mental health services.</p> <p>To fit in with the DRE 12 point action plan:</p> <ul style="list-style-type: none"> • Less fear of MH care and services among BME communities and BME service users; • Increase satisfaction with services. • 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; |
| How do they intend to do this? | <p>The research will be conducted through a structured questionnaire, delivered by researchers in pairs. We will also send out a structured questionnaire to MH services in Portsmouth.</p> |
| Who will the respondents be? | <p>150 – 200 individuals from the Bangladeshi community in Portsmouth. Aged between 18 – 70 years. This number to include service users, ex service users & carers. With the service providers questionnaire we aim to target 50 local service providers.</p> |
| Who will they get to do the | We have 6 trained researchers of which 2 are lead |

| | |
|--|---|
| work? | researchers. The researchers are from the local Bangladeshi community, with a range of experiences. |
| Where will they undertake the work? | We will approach the community through various routes including community groups/ centres, the mosque and the BWA. The interviews will be carried out predominantly at the BWA offices, or at other venues with prior arrangement. |
| How will those who are doing the work be supported and supervised? | We have regular support through UCLan and our support worker Anthony Kollie. As well as support from Poppy Jaman South East Race Equality Lead. We also are supported by our steering group made up of various bodies led by the Focused Implementation Site Co-ordinator, Beverley Meeson. As a team we have weekly meetings where we support one another and have individual supervision through BWA & Culture Works. |
| How will they ensure that participants in the project have given consent? You should have an information sheet about the project which is read out and given to potential participants which explains to them (a) What the project is about (b) that participation is voluntary (c) what will happen to the information they provide (d) that they can stop the interview at any time and (e) that they do not have to answer any questions that they do not want to. | <p>Before the interview we will be explaining our project to the respondents in writing through an information sheet as well as verbally, due to the needs of our particular sample. Our questionnaire will be translated into Bengali to help the respondents fully understand the questions. All our researchers are fluent in Sylheti Bengali and are able to interpret. (We will be training the researchers around interpreting the questionnaire).</p> <p>The respondents will all receive an information pack with various leaflets on local MH services in Portsmouth. The pack will include:</p> <ul style="list-style-type: none"> • Background information sheet on the project. To include and explain the following: <ol style="list-style-type: none"> a) What the projects aims are. b) that participation of respondents is voluntary c) Confidentiality, anonymity, safe keeping of completed questionnaires, collation and dissemination of findings through report. Shredding once project results collated. d) Respondents able to terminate interview at any time without reason. e) Respondents do not have to answer any questions they feel uncomfortable to do so. <p>We will read and explain the above to respondents prior to interview and gain signed consent if they wish to continue with the project. We have decided to ensure that our information sheet is not too</p> |

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| | <p>detailed or complex in order to meet the language needs of our community.</p> <p>Respondents will also be asked if they would like a copy of the final report once it is finished. We will also be offering a free prize draw for all respondents. There will be 3 prizes of £50 of vouchers. The draw will take place at the end of the project. There will be a separate form to be included in the pack, which we will give to the respondent at the end of their interview.</p> <p>(Please find attached documents)</p> |
| <p>Please enclose the information sheet and confirm that it addresses issues (a) (b) (c) (d) and (e) above.</p> | <p>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</p> |
| <p>How will the project ensure confidentiality?</p> <p>Note: you will not usually need to know (or collect) the names or address of respondents.</p> | <p>For our research we do not need to know the names or addresses of our respondents. We will not record any such information so this will limit any breach of confidentiality. Once questionnaires are completed they will be sealed in an envelope and stored in a locked cupboard at the BWA offices. No one except the lead researchers will have access. At the end of the project the research team and our support worker will have access to collate findings.</p> |
| <p>If you know them already, or if you are going to ask names as a matter of courtesy, these should not be recorded on the 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>We do not need any names on the questionnaires. We are aware of many community groups in Portsmouth as well as having direct links with the local mosques, community organisations and women’s groups. We will carry out an advertising campaign / outreach work prior to the research to promote the project to the community.</p> <p>The respondents will be men and women from the Bangladeshi community in Portsmouth aged between 18 – 70 years. We will make contact with respondents via community groups. Respondents will be also able to contact the project directly.</p> |
| <p>How will data generated by</p> | <p>The completed questionnaires will be sealed in</p> |

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| <p>the project be handled and stored?</p> | <p>envelopes and stored in a locked cupboard at the BWA office. They will be opened once we are ready to collate data, these will only be accessed by the research team and our support worker Anthony Kollie from UCLan. Once we have collated all data we will shred the questionnaires in the presence of the whole research team.</p> |
| <p>What risks are there? How will the risks be identified and managed?</p> <p>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?</p> <p>THIS IS ONE OF THE MOST IMPORTANT SECTIONS OF THE FORM.</p> | <p>We have regular research team meetings where we discuss issues of risk and look at solutions to these risks. If we are unsure we have consulted with our support worker from UCLan and know that we can also get support from our FIS sub group. We have looked at our interview procedure and the way we can minimise any potential risks.</p> <p>Possible risk situations identified:</p> <ul style="list-style-type: none"> • <u>Researcher goes alone to interview respondent:</u> No researcher will go alone to interview a respondent. All interviews will be conducted in pairs, one researcher will take the role as interviewer and the other as an observer/ note taker. • <u>Respondents become distressed at interview:</u> Researchers to talk to respondent prior to interview highlighting their right to terminate. If respondent is distressed or uncomfortable the interview will be terminated immediately by the researchers. Inform lead researchers and Support worker, offer any other further support through MH services or talking therapies. • <u>Respondent discloses information which suggests that either they or someone else is at risk of serious and immediate harm or of child abuse:</u> The interview to be terminated immediately, the lead researchers and support worker to be informed and the relevant authority. A statement will be required from all those present highlighting the risk posed. • <u>Researcher discloses confidential information:</u> This should not happen as we have had training around these issues and regularly discuss |

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| <p>YOU MUST THINK CAREFULLY ABOUT WHAT THE POSSIBLE RISKS ARE AND ARE ABOUT WHAT STEPS CAN BE TAKEN TO REDUCE AND MANAGE THEM. THE ETHICS COMMITTEE UNDERSTAND THAT IT IS USUALLY IMPOSSIBLE TO ERADICATE EVERY RISK, BUT THE ETHICS COMMITTEE MUST BE SATISFIED THAT ANY RISKS ARE REASONABLE, AND THAT STEPS HAVE BEEN TAKEN TO MINIMISE THEM.</p> | <p>confidentiality at our team meetings. Should this happen the researcher will be taken off the project immediately. The lead researchers and our support worker along with our steering group will investigate through set procedures. If allegations are found to be true the researcher will be dismissed from the project.</p> <ul style="list-style-type: none"> • <u>Researcher is a close relation of the respondent.</u> <p>In order to prevent any incidents where personal and professional boundaries may be blurred. We will not allow researchers to interview any of their close relatives. In these cases we will ask our other researchers to conduct the interview.</p> <ul style="list-style-type: none"> • <u>Researcher overwhelmed with emotional respondent.</u> <p>Ensure regular supervision and offer extra support available through local services to the researcher. This may be particularly important nearer the end of the project; we have links and access to counselling services locally should it be needed.</p> |
| <p>Please confirm the make up of the steering group.</p> | <p>Our steering group is part of the Focused Implementation site's – satisfaction sub group which is made up of the following organisations: FIS Co-ordinator. Public health Southampton CPCT. Hampshire Partnership trust PALS. East Hants, Fareham and Gosport PCT cluster PALS. Portsmouth CPCT PALS. Portsmouth Hospitals Race Equality Lead. IOW race equality Lead. PRENO – Portsmouth racial equality network org. Empathy. Wiltshire trust community engagement project. Including ourselves BWA and Culture Works.</p> |

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| <p>How often does 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>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 FIS steering group meets every month, where the group is updated on the progress of the project and any issues linked to the project is discussed. We also have links to the SE Race equality lead Poppy Jaman, who is regularly updated on our project. As well as meetings every fortnight with Anthony Kollie our support worker from UCLan. We are able to look at the progress of the project and at any ethical issues, which may arise.</p> <p>The focussed implementation site – steering sub group is fully aware of our project we have sought their approval with regards to this pro forma and project. The steering group are aware and will ensure that the project is following all the correct procedures in line with the DRE protocols.</p> |
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Section 3: To be completed by UCLan internal committee

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| Date received: | |
| Reviewed by: | |
| Decision: | |

Bangladeshi Welfare Association (BWA) and Culture Works Community Engagement Project.

Funded by the National Institute for Mental Health in England (NIMHE)
through the University of Central Lancashire (UCLAN)

Information Sheet

In December 2005 the Bangladeshi Welfare Association (BWA) and Culture Works submitted a joint bid to the University of Central Lancashire (UCLAN). The bid was proposed to undertake a Mental Health research project with the Bangladeshi Community in Portsmouth. In April 2006 we were notified that we had been successful with our project bid.

What do we want to research?

Our aim is to investigate the Mental Health needs of the Bangladeshi Community in Portsmouth.

We want to determine the levels of awareness and access / barriers to current mental health services.

We hope to interview around 150 – 200 people aged between 18 – 70yrs who are from the Bangladeshi Community. We will approach various community groups/centres the mosque and individuals in the community. The research will take place during end of September and throughout October 2006.

Why do we want to do this research?

With the results we collect from this research we will produce a report.

This report will be distributed widely to the community and to local Mental Health services. We hope that this report will help to influence existing and future Mental Health services to meet the Bangladeshi Communities needs in Portsmouth.

Also by taking part in this project we hope to raise an awareness of mental health issues within the local Bangladeshi Community.

Who & how will we collect the information?

We have a trained Bengali research team made up of 6 people.

We will collect information through a structured questionnaire this will also be available in Bengali.

There will be two Bengali researchers present at the interview one will ask the questions and the other will observe and record answers.

What do we want from you?

We would like **you** to be involved in this project as a **respondent**. Your involvement will be on a voluntary basis, we cannot pay you for your time. However if you have to travel to take part in the research we are able to reimburse your travel within Portsmouth City providing you keep your receipt.

What are your rights as a respondent?

If you choose to be interviewed, and then change your mind this is okay, please let us know in advance.

If during the interview you feel uncomfortable with any of the questions we ask - you do not have to answer.

You are also able to **terminate the interview at any time**.

We only need your answers we do not need your name or address on the questionnaire so it will be **anonymous**.

Only the research team and our support worker from UCLAN will have access to the completed questionnaires, these will be stored in a secure place until we have collated the data. Once this has been done we will destroy the questionnaires.

The research team will maintain **confidentiality** at all times this is of utmost importance to our project.

When will we break confidentiality?

There are instances when we are bound to break confidentiality. This applies if during the interview you disclose information, which suggests that either you or someone else is at risk of serious and immediate harm, including child abuse, in which case we will terminate the interview and share this information with the relevant bodies to prevent the harm.

How can you get involved?

To be involved in the research you must be over 18 years of age and from the Bangladeshi community in Portsmouth.

If you would like to be interviewed, want further information or would like a copy of the report once it has been produced - please contact the following lead researchers:

Shipa Ahmed Khan **t: 023 9273 7106** **m: 0795 891 3256**
Shipa.AhmedKhan@portsmouthcc.gov.uk

Mr. Syed Aminul Haque at the BWA offices, Portsmouth Jami Mosque
t: 023 9229 5448 **m: 0794 749 8356**
bwaportsmouth@hotmail.com

REF.....

Bangladeshi Welfare Association (BWA) & Culture Works
Mental Health Community Engagement Project

CONSENT FORM

Dear Respondent

Thank you for taking the time to read our projects Information Sheet.

If you would like to be interviewed for the above project please tick the following to show that you understand your rights under this project.

Checklist:

- a) I understand the aims of the BWA & Culture Works Mental Health Project. []
- b) I understand that my participation is voluntary. []
- c) I know that you will not use any of my personal details on the questionnaire. []
- d) I am able to cancel the interview at any time. []
- e) I know that I do not have to answer any questions if I feel uncomfortable. []
- f) I understand that all the data collected will go into a report at the end of the Project. I am able to obtain a copy of the report once it is finished by contacting the BWA offices or the lead researchers. []
- g) I understand that the information that I give will be treated in confidence unless I disclose information about a serious and immediate risk of harm to myself or someone else, in which case I understand that you as a research team may need to take further action, such as contacting the doctor or the police. []
- h) All of the above points have been explained to me by the Researchers. I have understood and agree to take part in this research project. []

Thank you

We will now interview you.

At first we will ask a list of core questions then we will ask a few questions around mental health.