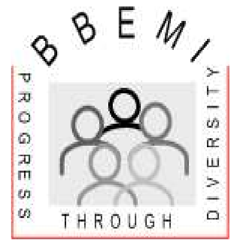

BBEMI

COMMUNITY ENGAGEMENT PROJECT: The NIMHE Mental Health Programme

Community Research in Mental Health

REPORT OF THE COMMUNITY LED RESEARCH PROJECT FOCUSSING
ON
Whether existing Mental Health services in Barnsley are appropriate and responsive to the needs of Refugee and Asylum seekers and Migrant workers?

BY

Barnsley Black and Ethnic Minority Initiative (BBEMI)

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Funded by NIMHE managed by BBEMI and supported by The Centre for Ethnicity and Health, University of Central Lancashire

National Institute for Mental Health in England

THE RESEARCH TEAM

Roya Pourali
I am 32 years old. I am Iranian but I was born in Kuwait and I have lived in Barnsley for two and half years. I have a diploma in Economics. My hobbies are Fine Art and Photography. I worked in a Mental Health clinic in Iran before coming to England. I am fluent in Farsi and Arabic; and my English is improving all the time. I attended ESOL /ECDL /Leader ship and first aid classes since I came to England. I am employed as a Community Development Worker at BBEMI. I am very interested in the mental health issues that have impacts on BME communities.

Mirban Hussain
I began working for Barnsley Black and Ethnic Minority Initiative in June 2006. This was a major change of direction in my life. I had worked in the statutory, voluntary and independent sectors. My last job was as a Business Quality Analyst for a large national organisation.
I first started voluntary work in the early 80's. I taught Indian cooking to people with learning disabilities. This gave me the opportunity to indulge my two passions: cooking and helping people.
I am committed to the philosophy of equity in service provision and delivery for disadvantaged people and groups.

Shoherah Muhammad
I arrived in England 10 months ago from East Africa
I then started attending a support group on arrival to the UK called Barnsley Refugee and Asylum Support Service (BRASS) and am now an active member of the group.
I recently completed training in First Aid and now a fully trained First Aider.
I started a project with BBEMI – Barnsley Black and Ethnic Minority Initiative in community researching for Mental Health.
I am really passionate about seeing changes happen in the BME community in Barnsley and have volunteered to be a part of a project called MARCO- Migrant Asylum Refugee Community Organisation to help improve services offered to Asylum Seekers and Refugees.
I am a single mum who enjoys reading watching movies and spending time with my daughter.

Carol Anderson
I have worked for a number of years as a BME community development worker in Sheffield. As a newly recruited mental health community development worker in Barnsley, I'm looking forward to sharing my knowledge and experiences of working with diverse community members and groups.

This research around the mental health needs of asylum seekers, refugees and migrant workers will help to increase my awareness around the factors that contribute to their mental well-being and their understanding of mental health issues.
With the other researchers we aim to identify ways in which we can support and help to contribute in a positive way to the overall well-being and mental health of asylum seekers, refugees and migrant workers in Barnsley.

Irina Laycock
During the last 6 years I have worked as a volunteer in various organisations, currently I am working as a mentor for a member of the Russian Speaking community in the Central Library in Barnsley.

Psychology has been a hobby in my life; it helps me to work with members of the Russian Speaking community. My own research interests include spiritual health, stress management and the measuring of the energy field of man. My participation in the project will help to find alternative forms of support for people with stress and mental health problems.

ACKNOWLEDGEMENTS

The research team would like to acknowledge and thank BBEMI for their continuous support and guidance in all aspects of the research.

We would also like to thank the following: Barnsley Metropolitan Borough Council (BMBC), Barnsley Primary Care Trust, University of Central Lancashire, and National Institute for Mental Health in England (NIMHE) for the opportunity to take part in this research project.

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Jonathon Trepzyck (Assistant Trainee Coordinator-BBEMI)

Selina Ullah (Race Equality Lead- North East)

Trenton Wiggan (Executive Director- BBEMI)

Most of all we want to thank all the research participants for sharing their views and opinions on what is a very sensitive topic.

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EXECUTIVE SUMMARY

Barnsley Black and Ethnic Minority Initiative (BBEMI) *were one of 40 community groups who took part in the National Institute for Mental Health in England's Community Engagement Programme between 2005 and 2007.* BBEMI is an umbrella organisation which is the main service provider for BME communities in Barnsley; it provides training and organises events which help to build the capacity of community groups. Currently there are 16 community groups who are members of BBEMI.

BBEMI exists to promote good race relations and racial harmony amongst black and ethnic minorities and the wider community of Barnsley. It will work in partnership, unilaterally and with individuals to enhance the quality of life and capacity to contribute to regeneration for local black and ethnic minority people. It will also do this through working collaboratively with specific agencies across South Yorkshire and beyond e.g. Barnsley Metropolitan Borough Council, Government Office Yorkshire and Humberside, Black and Ethnic Minority Network (Yorkshire & Humberside), South Yorkshire Open Forum, Yorkshire Forward and the various Community Development Partnerships across Barnsley.

The aim of our research was to identify the mental health needs of asylum seekers, refugees and migrant workers. This group was chosen because they represent the fastest growing BME community in Barnsley and anecdotal evidence suggests that members of this group suffer a higher than average percentage of mental ill health.

Many asylum seekers who had accessed any support services showed signs of vulnerability in terms of service accessibility and language barriers. The research supported the anecdotal evidence; of the 106 participants a large percentage exhibited the symptoms relating to mental ill health. Of those respondents who had accessed mental health support services as well as generic support services showed signs of problems in service accessibility. Access to all types of services was hindered by language barriers and lack of information.

Some participants expressed the view that they feared accessing services because of the social stigma attached to mental illness by their cultural and ethnic backgrounds. However, further investigations revealed that this was an excuse rather than a reason because when asked what could increase service uptake the majority of the participants stated: better information available in relevant languages and formats and staff who were more culturally sensitive to their needs.

The researchers were recruited from a range of ethnic backgrounds including African Caribbean, South East Asian, South and East African, Iranian and Eastern European this meant that they had a good understanding of the different cultures and ethnic practices. Some of the researchers were also actively involved in volunteer work with asylum seekers, refugees and migrant workers; this gave them better access to engagement with the target group.

To our knowledge this is the only Community Engagement Project in the north east which included Mental Health Community Development Workers (CDW's) in the research team. We felt that this was an added bonus as the CDW's brought specialist skills and knowledge around community engagement and development as well as access to various mental health service providers.

A research steering group was set up to offer support, help and guidance and most importantly to ensure that the findings and the recommendations were taken on board. Representation on the steering group included individuals from Barnsley Metropolitan Borough Council, Barnsley Primary Care Trust, Mental Health professionals and Third Sector organisations.

Findings

The results of this research project suggest the following recommendations. These recommendations are based on the key research findings, are linked to national policy and are targeted at local decision makers. This research has highlighted in current provision gaps that these recommendations seek to address; the six distinct themes and recommendations are:

Theme 1: Accessible and appropriate information

"Very hard to get information about it [mental health services]" (Polish-male)

"I didn't know where to go [for help]" (Iranian-male)

"You have to be very sick before they hospitalise you and by that time it becomes too late" (Other White female)

Recommendation 1

To ensure that information about mental health services in Barnsley is provided in an appropriate language and format which is available in the right places.

This can be achieved by making sure that Belmont Induction Centre as a first point of contact for Refugees and Asylum Seekers has information about mental health services in a number of community languages. For migrant workers the most appropriate place for information to be placed would be within Barnsley Hospital, Barnsley Central library, Barnsley College and within voluntary sector organisations such as Barnsley Black and Ethnic Minority Initiative (BBEMI) and Barnsley BME community organisations and groups.

Theme 2: Interpretation and translation services

"Provide more interpreters, so I can explain my problem easily" (Chinese female)

"I got an Urdu speaker who helped me. Social service staff was very good in showing me what to do" (Pakistani male)

"Very nice Pakistani worker" (Pakistani male)

Recommendation 2

Barnsley PCT need to reduce the time involved in accessing interpreters and translators (not just via telephone) this would entail a funding commitment to ensure provision of local services to meet local needs; as reliance on services from further a field is inefficient and costly.

One way of doing this is by developing the infrastructure of local organisations such as BBEMI, Belmont Induction Centre and Barnsley Refugee Asylum Seeker Support service (BRASS). Another way to meet this need could be by identifying, recruiting and training individuals from Barnsley's BME community to provide essential translation and Interpreting services for mental health service users.

Long term solutions are to ensure that ethnic minorities learn English. Therefore additional funding is required for the continuation of English classes for asylum seekers refugees and migrant workers. From September 2007 ESOL classes run by statutory bodies will no longer be free to a large number of asylum seekers and refugees and migrant workers. Currently there are provisions at BRASS to cater for a maximum of 18 pupils a day for 2 days a week. This is not enough as there are approximately 400 asylum seekers in need of this service and the numbers continue to grow.

Theme 3: Gender Specific Service.

"The treatment by staff was very patronising. At the hospital patients are mixed male and female I was not taken seriously and my problem was not sorted out [non mental health]" (Indian female)

Recommendation 3

This respondent was referring to general medical wards. The participant was unaware that Barnsley PCT provides single sex mental health wards.

With regards to gender specific service the majority of participants stated that they would prefer to be treated by same sex professionals, the reason for this is that they felt uncomfortable discussing confidential and gender specific problems with the opposite sex. The PCT can take this example of good practice further by promoting the option of requesting same gender professionals to the wider BME communities.

Theme 4: Increase satisfaction with GP services.

"I need to be taken seriously when I say I have a problem, I want people to listen to what I am saying and act on that and do a serious assessment" (African female)

"When I needed someone to help the doctor just gave me painkillers". (African female)

"Staff was helpful and they tried to do their best" (Russian male)

"They were helpful, supportive and reassuring" (Georgian male)

Recommendation 4

GP services should provide both mental health and psychological assessments that are culturally sensitive. Assessments should be carried out on the first visit. GP's should have relevant up to date information regarding Barnsley's BME population as well as relevant mental health services in Barnsley.

Theme 5: Help and Support for carers

"It has been a challenge and deep worry as well because I did not know if I could support appropriately". (Aymaran male)

"I am bored and I don't enjoy my life. He [the cared for person] affects me to have mental problem and I think he is the reason of my illness". (Turkish female)

"I am upset can't look after my dad at home because I am ill. My dad is in a home. I want him to live with me but it's not my house so I can't alter home for him". (Pakistani male)

"I can't go out I have to be at home all the time. I feel that I don't have a life of my own". (Indian female)

"I feel stressed and I want to go away from home" (Russian female)

"It hasn't affected me" (Israeli male)

Recommendation 5

The PCT should consider recruiting volunteers from BME communities in Barnsley who are interested in becoming a carer to provide support to individuals who are experiencing difficulties caring for friends and family member.

Theme 6: Educating and awareness raising for BME communities around mental health promotion and suicide prevention.

"Don't have much to say really because I don't know about mental problems" (Russian female)

This participant stated that she suffers from depression and stress, which makes her feel" very alone and sad". Even though she appears to understand the difference between mental illness and mental well-being, she does not associate these as mental illness.

Mental health promotion is paramount within BME communities to help identify early symptoms. This will ensure that appropriate responses are carried out within a primary

care setting to help reduce the over representation of BME service users in secondary and tertiary care.

A number of asylum seekers and refugees in this research have thought of committing suicide and some have attempted it. For example, one African-Asian female stated "I am never in a happy mood, I feel like committing suicide sometimes". This respondent had not heard of or used any mental health service because she had, "heard from friends that you are not treated with respect because you are an asylum seeker".

Mental health service providers need to undertake and facilitate training around suicide prevention within BME communities. This training needs to be culturally appropriate and responsive to individual communities. For this to be successful it must have a commitment of long term funding.

> "[I] should be allowed to work. I came here to be safe. Not working stops me from reaching our full life. Forcing people to lie and work underground being a second class people. Food tastes better if you buy it with money you earn." (Speaker A)
>
> "I agree with this gentleman[R]. By not letting me work you are trying to kill me." (Speaker B)
>
> "Yes… yes. Let us work. Don't give me any rights just let me work. Some people work anyway. I want to buy nice things for my family" (Speaker A)

INTRODUCTION

This section describes the model used by the University of Central Lancashire's Centre for Ethnicity & Health.

BACKGROUND

We often hear the following words or phrases:

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

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

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

learn about drug related issues and about how to undertake a needs assessment. They would be able to benefit and learn from the training and support that the Ethnicity & Health Unit would provide, and they would learn from actually managing and undertaking the work. In this way, at the end of the process, there would be a number of individuals left behind in the community who would have gained from undertaking this work. They would have learned about drugs, and learned about the needs of their communities, and they would be able to continue to articulate those needs to their local service providers, and their local Drug Action Teams. It was out of this project that the Centre for Ethnicity and Health's model of community engagement was born.
The model has since been developed and refined, and has been applied to a number of areas or domains of work. These include:

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

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

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

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

THE KEY INGREDIENTS

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

[1] The target community may be defined in a number of ways – in many of the Community Engagement Projects that we have run we have defined it by ethnicity. We have also worked with projects where it has been defined by some

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

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

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

The final ingredient, according to the Centre for Ethnicity and Health's model, is the provision of appropriate support and guidance. We do not expect community groups to become involved for nothing. Typically we would make in the region of £15-20,000 available to the host organisation. We would expect that the bulk of this money would be used to pay people from the target community as community researchers[2]. We then allocate a named member of staff from our Community Engagement Team as a project support worker. This person will visit the project at for at least half a day once a fortnight. It is their role to support and guide the host organisation and the researchers through the project. We also provide a package of training – typically in the form of a

---

other criteria however, such as age (e.g. young people); gender (e.g. women); sexuality (e.g. gay men); service users (e.g. drug users or mental health service users); geography (e.g. within a particular ward or estate) or by some other label that people can identify with or rally around (e.g. victims of domestic violence, sex workers).

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

THE COMMUNITY ENGAGEMENT TEAM

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

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

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

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

THE FOCUS OF THIS PARTICULAR REPORT

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

Barnsley Black and Ethnic Minority Initiative (BBEMI) *were one of 40 community groups who took part in the National Institute for Mental Health in England's Community Engagement Programme between 2005 and 2007.* The objectives of the programme were to deliver improve equality of access, experience and outcomes for Black and minority ethnic mental health service users by:

- Less fear of mental care and services among BME communities and BME service users;
- Increased 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; and
- A workforce and organisation capable of delivering appropriate and responsive mental health service to BME communities.

The focus of our work is to identify the mental health needs of refugees, asylum seekers and migrant workers and to evaluate whether the available information about mental health services is relevant & accessible to their needs.

The views expressed in the report are those of the group that undertook the work, and are not necessarily those of the Centre for Ethnicity and Health at the University of Central Lancashire.

BBEMI Background Information

BBEMI is a voluntary organisation made up of a number of different member communities; these being, The African-Caribbean, Albanian, Azerbaijani, Bangladesh, Chinese, Eastern European, Gypsy and Travellers, Muslim, Pakistani, Russian speaking, Spanish speaking, Gujarati, Indian, Kashmiri, Zimbabwean, Iranian and the Polish community.

BBEMI exists to promote good race relations and racial harmony amongst black and ethnic minorities and the wider community of Barnsley. It will work in partnership, unilaterally and with individuals to enhance the quality of life and capacity to contribute to regeneration for local black and ethnic minority people. It will also do this through working collaboratively with specific agencies across S Yorkshire and beyond e.g. Barnsley Metropolitan Borough Council, Government Office Yorkshire and Humberside, Black and Ethnic Minority Network (Yorkshire & Humberside), South Yorkshire Open Forum, Yorkshire Forward and the various Community Development Partnerships across Barnsley.

'To ensure the full involvement of Barnsley's Black and minority ethnic community in the social and economic regeneration of Barnsley, enabling them to realize their full potential in employment, education, health, social/cultural, and or any other interests and or opportunities appropriate to the needs of Barnsley's Black and minority ethnic community.'

Barnsley Background Information

Geographically Barnsley is situated in South Yorkshire and covers an area of 32,863 hectares or 127 square miles, making it one of the most extensive metropolitan areas.

It has a population of 218,100 (2001) and strong contrasts between rural and Pennine countryside (68% of the borough is green belt, 9% is National Park land) and urban industrial areas, including the main town of Barnsley and other smaller towns and former mining villages.

The main local government body in the area is Barnsley Metropolitan Borough Council with 10,836 employees and a gross expenditure for 2002/3 of £397 million. An income of £173 million leaves a Net Cost of Services of £224 million. Barnsley has 18 Town and Parish Councils.

The population of the Barnsley area grew rapidly between 1850 and 1940 as the coal mining industry expanded. Between 1900 and 1930, the population living within the present Borough boundary increased by 45%. Population growth slowed after 1945 and Barnsley reached a peak of 226,350 in 1971. The population then declined gradually to 223,200 in 1991 and 218,100 in 2001. The population density of the Borough is 6.64 persons per hectare or 1,796 per square mile.

The age structure of Barnsley used to be younger than average but is now very similar to the national average. However, there are fewer young adults, partly due to 1,165 university students from Barnsley living elsewhere in term-time.

The total population of Barnsley is not expected to change much in the near future. However, there will be changes in the different age groups. Although the total number of children is fairly static at present, the number of children aged 0-4 has been falling due to declining births. Children aged 11-17 have been increasing in recent years but the number are now levelling off.

The total number of children will fall between 2001 and 2006, by about 5%, mainly affecting the 0-10 age range. The largest growth rate is amongst the most elderly. Between 1991 and 2001, the number of people over 75 years of age increased by 14% and is expected to continue rising.

The employment structure of the Barnsley economy has changed greatly over the last twenty years. In 1981, 24% of jobs were in the coal mining industry but by 1994 every mine had closed. This has resulted in a net reduction in the number of employee jobs from 78,000 in 1981 to 69,100 in 2001. Manufacturing employment has reduced by 27% and overall jobs in the production industries have declined by more than half. Service sector has grown by 40% 1981 to 2001, not counting the self employed.

Despite job losses, Barnsley still has a larger manufacturing sector than average and the construction industry is particularly large. The service sector is relatively small, especially in financial services.

Employment is concentrated in Barnsley town centre, especially services. Central Ward has 15,700 employee jobs (23.9% of the total) and 1.5 jobs per resident. The only other ward with more than 5,000 jobs is South West where Barnsley District General Hospital is located. Jobs are fewest relative to population in the east of the Borough where there are 5.1 residents per job.

ASYLUM SEEKER, REFUGEE & MIGRANT WORKER STATISTICS

The latest figures provided by Barnsley Asylum Team (May 2006)

(Table 1)

Status	Number
Asylum Seekers	480
Refugees	150
Migrant Workers	339
Highly Skilled Migrants	530
No Status/ Overstayers	30
Total	**1878**

Barnsley Metropolitan Borough Council holds two contracts with the National Asylum Support Service (NASS); firstly, the provision of an Induction Centre for newly arrived Asylum Seekers based at Belmont Induction Centre and second, 150 accommodation units in the community. Belmont Induction Centre staff runs the induction process including briefings, referrals to legal services and advice and guidance from the Refugee Council. Asylum Seekers average stay in the Induction Centre is 7-14 days. Barnsley Asylum Team, manage the community accommodation contract. Asylum Seekers will stay in their allocated community accommodation until they receive a decision on their asylum claim at which point, they will move on.

AIMS AND OBJECTIVES OF PROJECT

The aim of the research was to identify the mental health needs of Refugees, Asylum Seekers & Migrant Workers

The objectives to achieve this aim included:

- To identify needs Refugees, Asylum Seekers & Migrant Workers
- To identify how many of the group are accessing mental health services
- To identify levels of satisfaction with services
- To identify the mental health service providers in Barnsley
- To identify what mental health services are provided
- Establish a steering group of local agencies
- Recruit, train & support research volunteers from the local community
- Develop suitable research methods
- Complete data collection in the local area
- Volunteer researchers to complete package of training by UCLAN Centre for Ethnicity and Health
- Analyse the quantitative & qualitative data
- Produce a report to inform policy makers, commissioners and service providers
- Disseminate the report through a launch event

METHODS

Once the funding had been secured via application to UCLAN eight researchers were recruited by advertising the vacancies within local BME community groups in Barnsley. The eight researchers included three Mental Health Community Development Workers who were recruited in June 2006 and five from the local BME community. The researchers were recruited from various cultural and ethnic backgrounds, these included asylum seekers and refugees. By the end of the project three of the researchers had left the project due to differing reasons.

The researchers attended two mental health workshops and, three community research workshops with UCLAN, which equipped them with the knowledge and skills to undertake the research project, this included training on the analysis, evaluation and presentation of data. One of the training days gave the group the opportunity to discuss the research rational and population sample. The group focused on identifying the mental health needs of refugees, asylum seekers and migrant workers. Refugees, asylum seekers and migrant workers were chosen as the target group as the researchers felt they represented the fastest growing BME community group in Barnsley. Other research from across the county has highlighted that this BME group suffers disproportionally from mental illnesses.

The sample target was 100 men and woman over 18 years of age. Data was collected by using one to one structured interviews and focus groups; these methods would give qualitative and quantitative data. Once the questionnaire was designed it was piloted on ten individuals from BME communities. Using the data that was gathered a few minor alterations were made to the questionnaire. It was decided to offer each participant a five pound high street voucher as an incentive and appreciation of their time.

Each researcher targeted twenty individuals from various ethnic and cultural backgrounds. Each participant was informed about the research and was asked to give their written consent. Prior to the fieldwork taking place ethical approval was required and received from both UCLAN and BMBC. The completed questionnaires and focus group transcript was stored in a locked filling cabinet to which only the researchers and a senior member of BBEMI management had access to.

The quantitative data was analysed by using tally charts and summary sheets using MS Excel software and converting the data into pie charts and graphs.
We analysed the qualitative data (detailed answers to specific questions) by manually reading through each questionnaire and noting down any remarks and comments made by the interviewees. Qualitative data was also analysed by coding themes and selecting direct quotes recorded by hand at interview to illustrate the data. Feedback from the researchers was also used to further illustrate key points.
The Barnsley Implementation Group for Black and Ethnic Minorities (BIGBEM) accepted the role of acting as the steering group. Members of the steering group represented the following organisations:

- Barnsley Black and Ethnic Minority Initiative
- Barnsley Primary Care Trust
- Barnsley Metropolitan Borough Council
- South Yorkshire Focus Implementation Site
- Barnsley Asylum Team

The role of the group was to approve the aims and objectives of the research, monitor progress and give focused guidance for the duration of the project. There were regular steering group meetings held in order to monitor the researcher's progress and find solutions for any problems that arose. This meant that any problems were dealt with quickly and effectively.

Researchers had further support from Nadia Ahmed the UCLAN Support Worker and Selina Ullah the Race Equality Lead on a regular basis. Networking meetings with researchers from Doncaster and Middlesbrough involved in the community engagement project also provided additional support.

RESULTS

1.0 Core Questions

1.1 Age

(Table 2)

Age	Total	%
18-24	16	15%
25-29	22	21%
30-39	36	34%
40-49	19	18%
50+	13	12%
TOTAL	**106**	**100%**

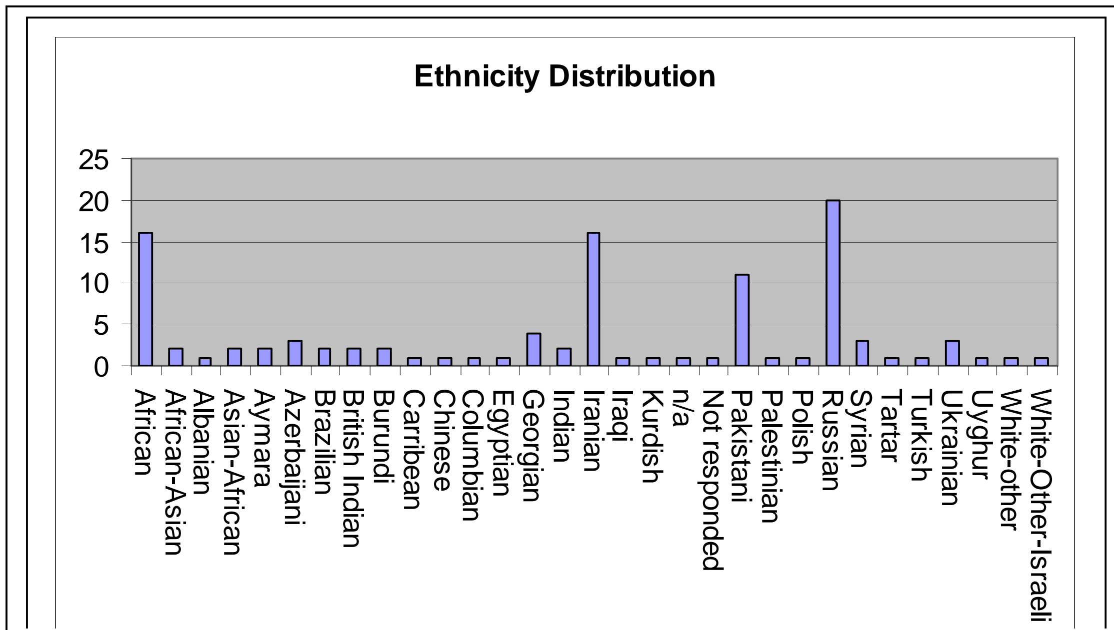
1.2 Gender

(Table3)

Gender	Total	%
Male	44	42
Female	62	58
Total	**106**	**100**

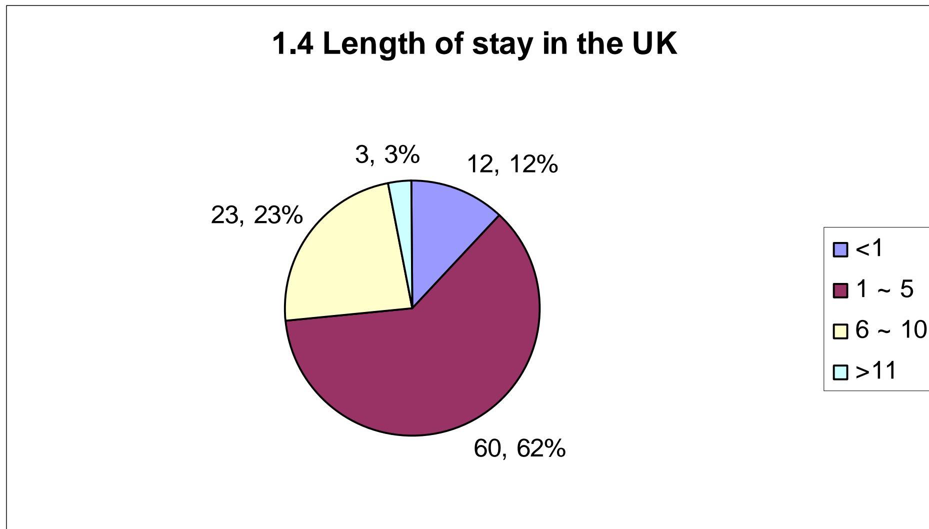
1.3Ethnicity

(Graph 1))



1.4 Length of Stay in UK

(Chart 1)



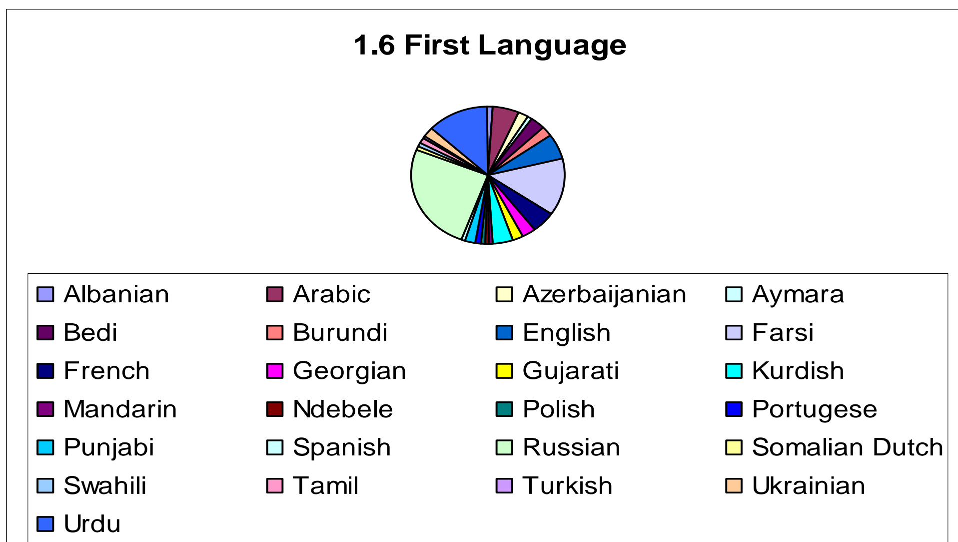
1.5 Citizen Status

(Table 4)

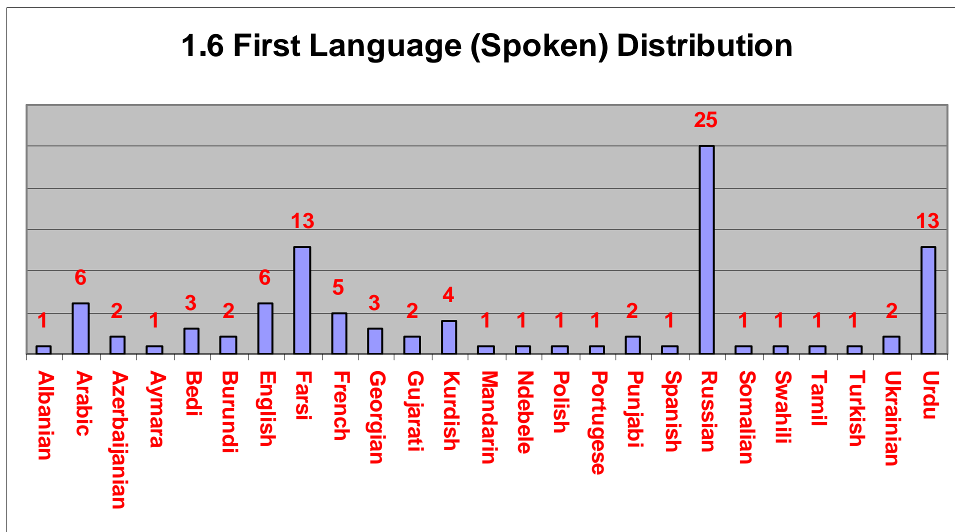
Citizen Status	Number	%
Asylum Seeker	73	68
British Citizen	9	8
EU Citizen	7	7
Other- stateless person	3	3
Refugee	6	6
UK Resident	8	8
Total	**106**	**100%**

1.6 First Language

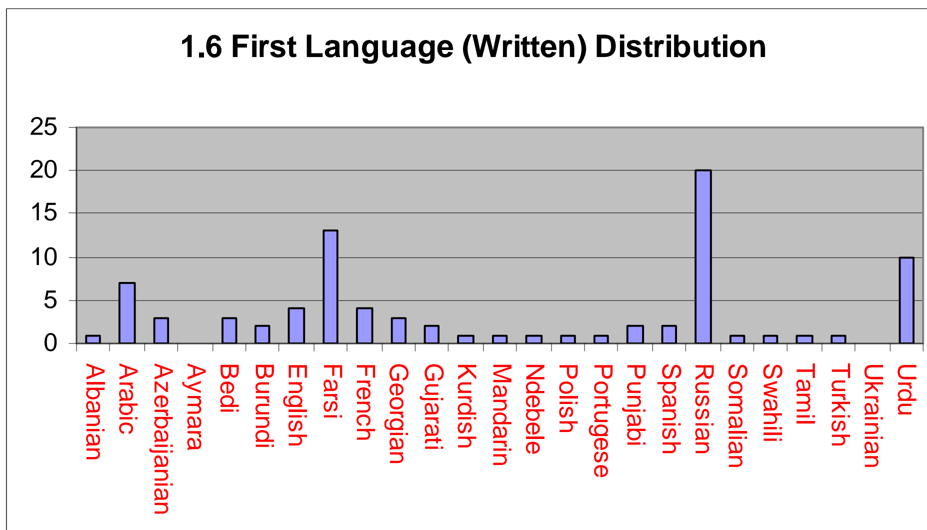
(Table 5)



(Graph 2)



(Graph 3)



1.7 Level of English

(Table 6)

Level of Speaking English	Number	%
Good	47	44
Average	37	35
Poor	20	19
Did not respond	2	2
Total	**104**	**100**

(Table 7)

Level of Understanding English	Number	%
Good	49	46
Average	40	38
Poor	15	14
Did not respond	2	2
Total	**104**	**100**

(Table 8)

1.7.3 Level of Written English	Number	%
Good	48	45
Average	38	36
Poor	18	17
Did not respond	2	2
Total	**104**	**100**

1.8 Religion

(Table 9)

Religion	Number	%
Buddhism	3	3
Christianity	34	32
Hindu	1	1
Islam	37	35
Jewish	1	1
None	18	17
Other -Holistic	1	1
Quaker	1	1
Sikh	1	1
zartochrain	3	3
Did not respond	6	5
Total	**106**	**100**

1.9 Sexuality

(Table 10)

Sexuality	Number	%
Did not respond	1	1
heterosexual	103	97
homosexual/gay	2	2
Total	**106**	**100**

1.10 Are you registered disabled

(Table 11)

Are you registered disabled	Number	%
Yes	4	4
No	100	94
Did not respond	2	2
Total	**106**	**100**

2.0 AWARENESS

2.1 What does mental well being mean to you?

(Table 12)

Themes	Total
1 Quality of Life	24
2 Emotional State	10
3 Mental State	16
4 Spiritual State	4
5 Physical State	8
6 Balance/Harmony/ No stress	57
7 Maintain Relationships	20
8 I Don't Know	9
9 N/A	10

2.2 Have you experienced any of the following?

(Table 13)

Experience	Total	Experience	Total
Depression	55	Eating problems	18
Guilt	21	Stress	60
Anxiety	34	Anger	20
Mood swings	31	Relationship problems	15
Suicidal thoughts	7	Tiredness	34
Suicide attempts	4	Poor concentration	23
Sleeping problems	29	Memory loss	22
Nightmares	17	Panic attacks	18
Physical aches & pains	13	Other, please explain	0
Emotional aches & pains	14		

2.3 How has any of above affected your Mental Well being? Please explain

(Table 14)

Theme		Total	%
1	Difficult to cope with everyday life and to achieve life's targets	25	27
2	Negative feelings and emotions	25	27
3	Emotional problems	10	11
4	Physical health problems	3	3
5	Mental illness	2	2
6	Suicidal thoughts	4	4
7	Concentration problem	8	9
8	Studying problems	5	5
9	Not affected	5	5
10	Stress psychological problem	25	27
11	Faith	1	1
12	n/a	10	11

2.4 Do you know of anyone who suffers / has suffered from any of the above?

Table (15)

	Total	% *
Yes	53	62
No	32	38

2.5 What do you understand by the words mental illnesses? Please explain briefly

(Table 16)

Themes	Total	% *
Mad / Crazy	15	16
Suicide	1	1
Out of control	24	26
Lack of confidence	2	2
Psychological problem	3	3
Need professional help	9	10
Need medication	3	3
Physical problem	5	5
Depression / schizophrenia	13	14
Mental health problem	7	8

2.6 Do you care for / look after someone who suffers from a mental health problem?

(Table 17)

Are you a Carer	Total	% *
Yes	14	16
No	74	80
No comment made	4	4

If yes, who do you care for?

(Table 18)

	Total	% *
Child	2	2
Parent	5	5
Partner	3	3
Relative	0	0
Friend	2	2
Neighbour	1	1
Other, please explain	0	0

2.7 How does this caring role affect you? Please explain briefly

13 people answered yes to this question: here are some of their responses.

"I am bored, and I don't enjoy my life, he affects my mental health and I think he is the reason of my illness. (Turkish female caring for partner)

"I am upset, can't look after my dad at home because I am ill. My dad is in a home and I want him to live with me but it's not my house so I can't alter my home for him. (Female Pakistani) parent

"Lost hope, don't enjoy my life" (Iranian male caring for partner)

"It has been a challenge and deep worry as well because I did not know if I could support appropriately. (Aymara Male caring for partner)

"This is my duty to care for and look after my parent" (Pakistani male caring for parent)

"I can't go out I have to be at home all the time. I feel that I don't have a life of my own" (Indian female caring for partner)

"It is very difficult" (Georgian male caring for neighbour)

"Stress and heartache" (Tartar female caring for child)

"I feel stressed and I want to go away from home" (Russian female caring for parent)

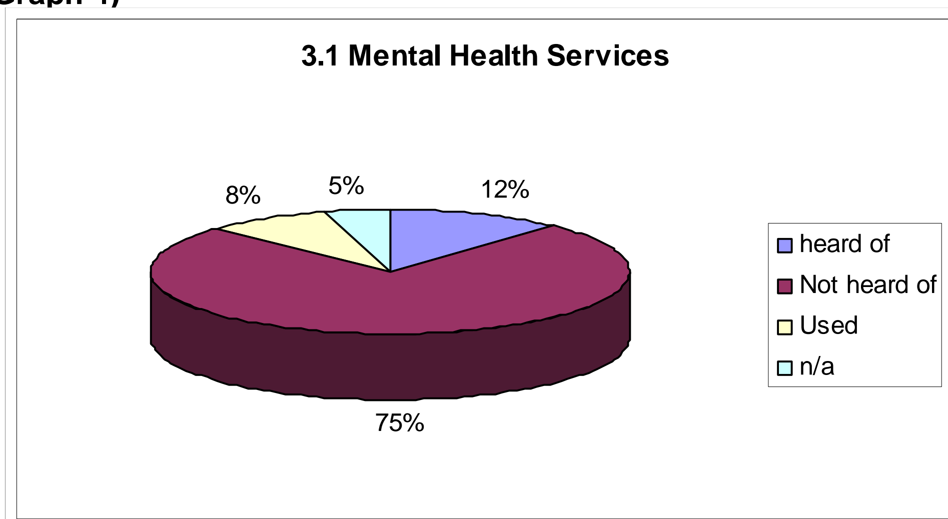
"It hasn't affected me" (Israeli male caring for child & partner)

"It is a very interesting experience according to my present condition" (Pakistani male caring for parent)

"It takes plenty of my time and strength put me into instability" (African male caring for partner)

3.0 Appropriate & Responsive Services

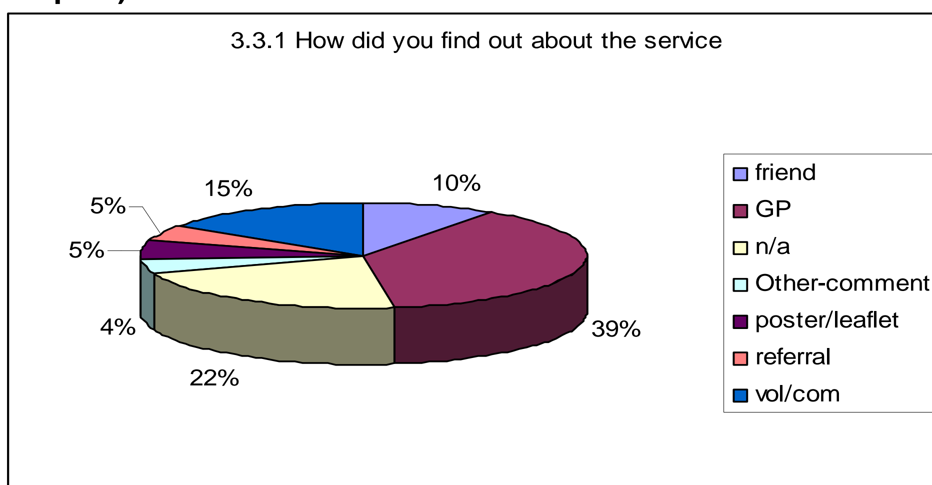
3.1 What do you know about the following mental health services in Barnsley? (Graph 4)



3.2 In relation to the service you have used please tick ✓ your satisfaction: (Table19)

Satisfaction with Services			
Service	Positive	Negative	Neither
GP Services	3	11	
Awareness			6
No Comment			25
Interpreter Services			8
Alternate therapies			4
More information			2
Other Services	10	12	

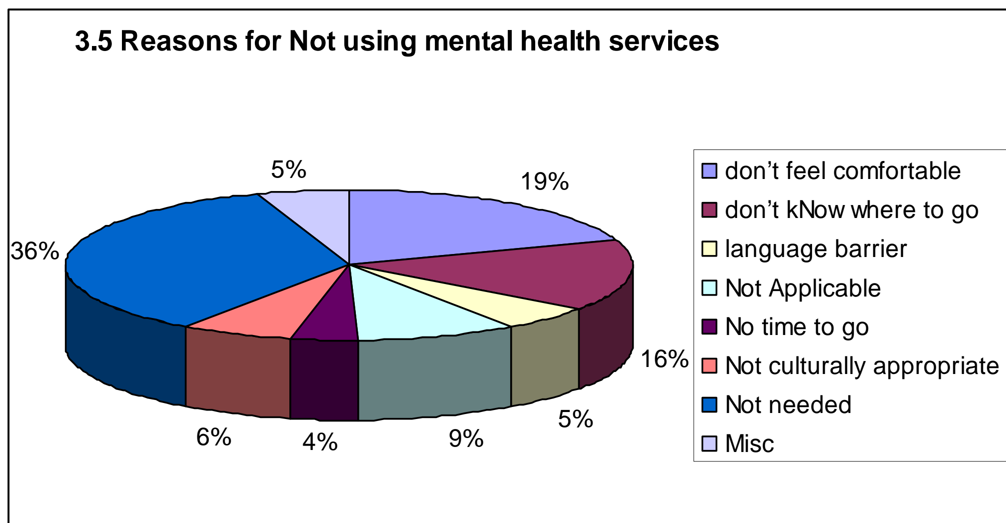
3.3 How did you find out about this service? (Graph 5)



Q 3.4 was the service accessible
(Table 20)

Options	Number	%
Yes	45	53%
No	24	29%
Not Answered	16	18%
Total	85	100%

3.5 Reasons for not using mental health
(Graph 6)



4.0 Recommendations

4.1 How can mental health services become more responsive to your needs? (Table 21)

Optional prompts	Female	Male	% *	Total
Cultural competence training for staff	15	13	30	28
Workers understanding of BME related health problems	10	4	15	14
Respect and dignity towards services users and carers	13	14	29	27
Multilingual information	14	10	26	24
Multicultural awareness work shops	12	7	21	19

4.2 Can you state three things that could be done to improve service provision for Refugees, Asylum seekers & Migrant Workers? (Table 22)

Improvement	Total	% *
Multilingual Staff	45	49
Multicultural Staff	32	35
Alternative medicine options, i.e. talking therapy	38	41
Information/leaflets in different languages	37	40
Mentors/support workers	16	17
Fear of Mental Health services	1	1
Stress caused by Home Office and Asylum claims	3	4

DISCUSSION

1.0 Core Questions

1.1 Age last birthday

34% of the respondents were between the ages of 30 and 39 years. This age range represents the largest age range of the participants.

Only 13 (12%) of the participants were over the age of fifty. People in this age range are more likely to be attached to their homes and family and are more reluctant to leave their country. In the case of having to escape to another country, it is most likely that the youngest or strongest are given a chance to leave.

1.2 Gender

Of the 106 participants 44(42%) were male and 62(58%) were female.

1.3 Ethnicity

There were 30 different ethnic groups within the research participants and 1 person did not respond. Of these ethnic groups 19% were Russian, 15% were Iranian and African and 10 % were Pakistani. The remaining 24 ethnic groups constituted less than 4% each of the total sample.

1.4 Were you born in U.K.?

100% answered no hence no discussion was generated.

1.4.1 Length of stay in UK

12 (12 %) Have been in the UK for Less than one year; 60(62%) Have been in UK for one to five years this is the largest majority; 23 (23%) Have been here for six to ten years and 3 (3%) have been here for over eleven years

1.5Citizen status

73(68%) people stated they were asylum seekers; 9(8%) stated they were British citizens; 7(7%) stated they were EU citizens (migrant workers); 8(8%) stated they were UK residents; 6(6%) stated they were refugees and 3(3%) stated they were stateless persons

1.6 First Language

The research participants spoke 25 different first languages.

1.7 Level of English

The participants were asked to gauge their level of English in speaking, understanding and written. The results were somewhat confusing because the majority of participants stated that their level of English in all three fields was good (spoken=44%; understanding=46%; written=45%). However, during the fieldwork the researchers recognized that the majority of people had lower levels than that reflected in the answers as most interviews were carried out in community languages because people did not speak English. This may be because they wanted to hide their abilities to speak English as it may affect their residency status.

1.8 What is your Religion?

The largest religious group belonged to the Muslim faith (37 – 35%), followed by Christianity (34 -32%). The third largest group followed no particular faith (18-17%). Three people each respectively followed the Buddhist and Zartochrain faiths. The following faiths had 1% of followers: Hindu, Jewish, Quaker, Sikh and other- holistic. Six people did not respond.

1.9 Sexuality

The majority 103 people (97%) identified themselves as being heterosexual. Two people (2%) stated they were homosexual/Gay and only one person did not respond.

1.10 Disability

The majority 100 people (94%) were not registered disabled; however, the fieldwork identified a number of people with physical disabilities. Four people stated they were on the disability register and further investigations revealed that these people were receiving various benefits and services and they rated their satisfaction was as being good. Two people did not respond

2.0 Awareness

2.1 What does mental well being mean to you?

Our participants gave many and varied answers. Some of these were positive and some negative and some respondents did not understand this term.

.

Positive quotes

"Mental wellbeing includes emotional, psychological and spiritual wellbeing" (Russian-Female)

"To keep active and be creative. Do things better & work" (Brazilian-Female)

"Being able to cope with Stress" (Russian-Female)

"active/successful person, who eat, sleeps and live well" (Iraqi-Female)

"Quality of life, be happy, have a job" (Georgian-Male)

"Harmony-Good balance between the physical, mental and spiritual" (Aymara-Male)

"Good job, family support, love and care" (Russian-Male)

Negative quotes

"Not be able to take decision/Not Normal behavior/sleepless" (Iranian-Male)

"A slow poison. Waiting all the time. Not knowing what is going to happen" (Pakistani-Male)

"Sleeping problems, Depression" (Iranian-Female)

24 respondents both male and female stated that mental health was a good quality of life.
57 people stated that it meant balance and harmony in the absence of stress.
38 people stated that it was an emotional state which incorporated mental, physical and spiritual aspects.
Maintaining relationships was chosen by 20 people.
Some 9 participants did not know what was meant by the term "mental health"; and,
10 did not respond.

2.2 Have you experienced any of the following?

All the participants completed this question. It can easily be seen, that the highest type of mental health issues within the community are mainly stress related with 60 responses whereas the lowest is suicidal attempts which has 7 responses.

Stress (60), depression (55), anxiety (34) that have been identified as the main causes of mental illness scored high in the research undertaken. However, the people who had experienced these did not identify themselves as having mental illness.
From this it can be seen that the understanding of the BME communities of mental illness and mental well-being is not the same as that of the west.

Eating problems (18) Guilt (21) Anger (20) Mood Swings (31) Relationship problems (15) Tiredness (34) Poor concentration (23) Sleeping Problems (29) Memory Loss (22) Panic Attacks (18) Physical aches &pains (13) Emotional aches & pains (14)
From the results above it is easy to see that although these have scored high in the research undertaken they are symptoms of people suffering from depression.

Suicide thoughts scored (7) and Suicide attempts (4) these may seem like a low score but it needs more serious consideration than any other symptoms. A person who is in this stage in their lives need to be seen by a professional as soon as possible. The question to ask is why has it gone to such extreme levels and why was the situation not diagnosed earlier?

2.3 How have these experiences affected you?

Of the 92 participants the majority had been affected negatively by the symptoms. Of these following three each scored 25 i.e. Difficult to cope with everyday life and to achieve life's targets; Negative feelings and emotions; Stress psychological problem.

"Life has been disturbed. Feelings of loss of family & country home. Feeling of being very insecure." (Pakistani-Male)

"Put my family in danger. I can't provide money. I can't do any thing". (Iranian-Female)

"I wanted to be able to talk to someone but had No one to talk to so I felt really alone and scared". (African-Female)

"Sometimes I'm scared don't know why and feel very guilty". (Pakistani-Female)

Stress (60), 10 people had Emotional problems. Also of people did not respond this may mean that these people have a communication problem as well.

"I felt angry and stressed" (Polish-Male)

"I wish I could speak to a therapist to put my mind at rest" (African-Male)

"I was under a lot of stress" (African-Male)

10 people had concentration problems.

"Losing concentration and sleepiness "(Iranian-Female)

"I afraid of everything. I can't concentrate. Not be able to learn English. My children suffering". (Iranian-Female)

"I can't concentrate on my work. I feel angry". (Russian-Female)

"I can't concentrate on my work". (Azerbaijani-Male)

5 people had a study problem and also

5 people had responded that they had not been affected.

4 people had suicidal thoughts and 3 of people had physical health problems. 2 of responses had a mental illness. One of responded that they had their faith.

"I don't wish to continue my life and every day is same for me". (Turkish-Female)

“I can’t wake up. I don’t want to look at myself in the morning. I feel I don’t want to continue any more”. (Sudanese-Female)

“Sometimes I feel like committing suicide because I think about the future and that of my family”. (Pakistani-Male)

“I am never in a happy mood. I feel like committing suicide sometimes” (African Asian-Female)

2.4 Do you know of anyone who suffers / has suffered from any of the above?

Participants were asked if they new of anyone who suffers or has suffered from the list of symptoms for two reasons: one, it is easier to identify symptoms in other people; and two, to confirm the participants understanding of these terms.
53 participants (62%) stated “Yes” and 38 stated they did not. 7 people did not respond

2.5 What do you understand by the words mental illness?

The majority of responses described mental illness on a negative side of thinking.

24 of responses described mental illness as being out of control:

“No control on attitude” (Egyptian-Male)

“When someone can't cope in life and needs help” (Russian-Female)

15 of responses describe the mental illness as mad/crazy:

“When you are mad I think” (Iranian-Male)

“Crazy -some one doesn't have control on his behaviour and doesn't understand anything” (Turkish-Female)

13 of the responses describe mental illness as depression /schizophrenia:

“Depression and schizophrenia” (Iranian-Male)

“Every day depression, aggressive person” ((Russian-Male)

9 of responses describe mental illness as when people need professional help:

“When there is a need for physiatrist to intervene” (Georgian-Male)
“It must be diagnosed and treated by a doctor” (Polish-Male)

Of the remaining participants: 7 described mental illness as a mental health problem; 5 described mental illness as physical health problem; 3 said it was a psychological problem needing medication.; and, 2 people described mental illness as lack of confidence and the one person described mental illness as being suicidal or having suicidal thoughts.

2.6 Do you care for or look after someone who suffers from a mental health problem?

74 respondents, a huge 80% did not care for or look after a mental health sufferer. Of the 14 (16%) respondents who were carers: 5% cared for parent; 3% cared for a partner; 2% cared for a child and 2% for a friend; there was one person who cared for a neighbour and 4 people did not respond.

However, feedback from the research team highlighted the fact that many participants did not understand the term 'carer'. In many cultures looking after a family member is seen as a duty, "This is my duty to care for and look after my parent" (Pakistani-Male), it's just something that you do.

2.7 How does this caring role affect you? Please explain.

Of the 14 people who identified themselves as carer's.; their responses varied in intensity from happily taking on the task and coping well to being unhappy and not coping at all.

"This is my duty to care for and look after my parent" (Pakistani male caring for parent)

"I am upset, can't look after my dad at home because I am ill. My dad is in a home and I want him to live with me but it's not my house so I can't alter my home for him. (Pakistani male caring for parent)

"It is a very interesting experience according to my present condition" (Pakistani male caring for parent)

"It hasn't affected me" (Israeli male caring for child and partner)

"It has been a challenge and deep worry as well because I did not know if I could support appropriately. (Aymara male caring for partner

"I can't go out I have to be at home all the time. I feel that I don't have a life of my own" (Indian female caring for partner)

"I am bored, and I don't enjoy my life, he affects my mental health and I think he is the reason of my illness. (Turkish female caring for partner)

"I feel stressed and I want to go away from home" (Russian female caring for parent)

"It takes plenty of my time and strength put me into instability" (African male caring for partner)

From the responses given above it is clear to see that most people that are in a caring role are not coping very well and they would need more support and help.

Recruiting volunteers who are interested in becoming a carer would be very useful for these families that are coping on their own it would give them some time to themselves and would relieve some of their stress

3.0 Appropriate & responsive services

3.1 What do you know about the following mental health services in Barnsley? (Table 23)

Option	Number	%
Heard of	11	12
Not heard Of	69	75
Used	8	8
N/A	4	5
Total	92	100

3.2 What was your satisfaction of services?

From the results it can be easily seen that the most probable area for improvement is GP services and satisfaction of services, needs to be taken into consideration. Asylum Seekers believe that their main problem lies with these services not being up to standard and that service providers need to be made more aware of different cultures and needs of the people.

No Comment scored the highest on this particular question although the participants were asked they chose not to answer reason is not known whether this is a positive or negative response.

Awareness Workshops (6) with just 6 responses most participants requested that these be set up for service providers so that they could learn about the differences with the BME communities thus providing better services.
Interpreter Services (8) alternate therapies (4) more information (2) these 3 options if put in practice would make the relationship between service providers and service users easier and would make satisfaction with services a success.

3.3 How did you find out about this service? (Table 24)

Service	Number	%
GP	35	38%
Referral	5	5%
Poster/leaflet	5	5%
Friend/Relative	9	10%
Vol/com organisation	14	16%
Other	4	4%
No answer	20	22%
Total	92	100%

The majority of the respondents (35 responses 38%) stated that they found out about the services they had used via their GP. This number indicates that GP's play an important role in referring service users on to appropriate service. It is therefore essential that GP's have a good understanding of the mental health needs of asylum seekers, refugees and migrant workers.

As a first point of contact, GP's need to provide a cultural appropriate service, if potential service users do not receive the correct support and diagnosis at this stage a fear of service providers and provisions will increase as well as a lack of trust in services.

Amongst those who stated 'other' as finding out about services (4 responses 4%) the answers varied; these being: A asylum team advisor, A social worker, 999 emergency service and staff from the hospital.

Twenty of the respondents (22%) did not answer this question. An explanation to why respondents gave no answer maybe that the question was not clearly understood. Another explanation may be that if the respondents stated in Q.3.2 that they had used a service but then not answered how they found out about it, one may assume that the importance of how one finds out about a service may not be high on the agenda for this group.

Q 3.4 was the service accessible
(Table 25)

Options	Number	P %
Yes	45	38.25
No	24	20.4
Not Answered	16	13.6

As can be seen on table 3.4a and Chart 3.4a. 38.25 %of participants found services accessible. This makes up the biggest percentage while 20.4% did not find the service accessible. However 13.6 % of participants didn't answer this question.

It is important to note here that a number of the quotes around accessibility to services are describe as intangible services i.e. how the respondents felt, expressions of their feelings indicate how they felt about the services they received, Also within some of the responses accessibility is mentioned due to a cultural appropriate service, i.e. staff from the same cultural background and someone who speaks the same language, this reinforces the importance and how imperative it is that the service and its workforce is culturally appropriate for the service users.

(Table 26)

Positive comments	Negative comments
"I found quick appointment for doctor" (Asian Male) ***"I had immediate interview" (Asian-Indian Female)*** ***"They were helpful supportive and reassuring" (White-Other Georgian Male)*** ***"Very nice Pakistani worker" (Asian-Pakistani Male)*** ***"I got an Urdu speaker who helped me. Social service staff was very good in showing me what to do" (Asian-Pakistani Male)*** ***"Gave what was needed" (Asian-Pakistani Male)*** ***"They help me" (0ther-Aymara Male)*** ***"It was helpful" (White-Other Russian Female)*** ***"Staff was helpful and they tried to do their best" (White –Other Russian Male)*** ***"They care very much" (Asian-Pakistani Female)***	***"Very hard to get information about it" (White-other Polish Male)*** ***"You have to be very sick before they hospitalise you and by that time it becomes too late" (White British Female).*** ***"Language barriers" (Asian-Other Iranian Female)*** ***"I didn't know where to go" (Asian-Other Iranian Male)*** ***"I didn't feel comfortable" (White-Other Russian Female)*** ***"They were emotional and psychological barriers" (White-other Russian Male)*** ***"I strictly disagreed with the diagnosis" (White-other Russian Female)*** ***"Service not sensitive to needs" (White-other Russian Male)***

3.5 Reasons for not using mental health services

(Table 27)

3.5 Reason	Number	%
Don't feel comfortable	15	19
Don't know where to go	12	16
language barrier	4	5

No time to go	3	4
Not culturally appropriate	5	6
Not needed	27	36
Misc	4	5
Not Applicable	7	9
Not responded	5	6
Total	87	100

36% of the respondents stated that they did not need mental health services. Many of the respondents who stated that services were not needed had mentioned in the research previously that they had experienced some form of mental health or illness. It is therefore right to say that a number of respondents may not have been aware of the services available in Barnsley or the respondents were not aware that they were suffering from a mental health problem, which opens up questions around mental health perception within BME communities.

Raising the profile around mental health and mental illnesses as well as mental health promotion is vitally important with regards to informing refugees, asylum seekers and migrant workers about mental health services and provisions. A lack of knowledge and understanding around symptoms, available support, help and advice may prove to be detrimental to ones physical and mental well-being over a period of time.

19% of the respondents mentioned that they did not feel comfortable using services; this may reflect the need of cultural appropriate services when working with BME communities. 16% said they did not know where to go, again this number may indicate a need for more promotional awareness around services that are available in Barnsley. 9% answered 'not applicable' which indicate that they had used a service but this low number shows that not many refugees, asylum seekers and migrant workers access mental health service.

Language barriers made up 5% of the respondents reason for not using mental health services, which reinforces previous data around the importance of having interpreting services within service provisions. 4% said they did not have time to go and access services this number show that the respondents may not be taking they symptoms seriously and do not recognise the importance of maintaining their mental well-being.

4.0 AWARENESS

4.1 How can mental health services become more responsive to your needs?
(Table 28)

Optional prompts	Female	Male	% *	Total
Cultural competence training for staff	15	13	30	28
Workers understanding of BME related health problems	10	4	15	14
Respect and dignity towards services users and carers	13	14	29	27

Multilingual information	14	10	26	24
Multicultural awareness work shops	12	7	21	19

NB *All percentages throughout the report have been rounded to nearest whole number

As can be seen from the table, 30% of participants felt that it was important that staff receive cultural competence training, 29% felt that services users and carer's should be shown more respect and dignity and 26% that multilingual information about services and advice would go some way towards making services more responsive.

23% of participants responded without the aid of prompts. Their responses were themed into 3 distinct groups

(Table 29)

Themes	Female	Male	% *	Total
Translators/Interpreters	7	4	12	11
Counselling	3	0	3	3
GP	3	4	8	7

Translators/Interpreters

12% of participants stated that not being able to speak English was a barrier for them. They stated that although interpreters were available there were not enough of them:

"Provide more interpreters" (Iranian Male)

"More interpreters so that I can explain my problem easy" (Chinese Female)

"For them to have interpreters so there isn't any language barriers" (African Male)

"Expand interpreter service" (Russian Male)

"Provide more interpreters" (Russian Female)

This language barrier could be overcome by a, "Psychologist [who] can speak in my language" (Azerbaijani Male)

26% of participants stated that translated information was important to improve services, "Things in Urdu will help me" (Pakistani Male). The same person went on to state that even though his mother can't read Urdu herself she can still understand.

Counselling

3% of participants stated that they wanted "More counselling more understanding" (Russian Male), and, felt that service providers should "Listen to us [and give] counselling, not just medication" (Iranian Female, and, went on to further state that, "If the services were more accessible to people then it would be good especially counselling" (African Asian Female)

General Practitioners

7% of participants stated that GP's did not understand them, "I want doctor to understand me…" (Somalian Female) and it did not help as, "Every time I had to go to different doctors and explain same issues again, so you don't know which one knows your situation" (Turkish Female).

Some participants wanted to, "Spend more time with the GP" (Georgian Male), because, "I want someone to recognise that I have mental health problems first and then address my needs" (African Female). This could be realized by allocating extra time for BME patients with language problems.

Participants also felt that, "GP's should be more understanding towards [patients] cultural needs." (African Asian Female); this would enable the GP to see that I, "… need therapeutic help not medicines" (African Female).

But, most of all, "I need to be taken seriously when I say I have a problem. I want people to listen to what I am saying and act on that and do a serious assessment" (Latin American Male).

4.2 Can you state three things that could be done to improve service provision for Refugees, Asylum seekers & Migrant Workers?
(Table 30)

Improvement	Total	% *
Multilingual Staff	45	49
Multicultural Staff	32	35
Alternative medicine options, i.e. talking therapy	38	41
Information/leaflets in different languages	37	40
Mentors/support workers	16	17
Fear of Mental Health services	1	1
Stress caused by Home Office and Asylum claims	3	4

From the table above it can be seen from the 106 participants who took part in this research the majority have expressed themselves of having a language barrier. They also said that if there were more multilingual and multicultural staff then they would be very happy to use the service and believe that service provision would be more successful.

Many participants also were adamant about not wanting to be given medication and expressed their hope that more options are given to them like talking therapy or counselling.

Out of 106 participants 37 (40%) said that they want information in different languages to make for a better understanding. 16 (17%) people have said that if they had mentors and support workers they would feel more secure to access services.

One person had shown fear of services and wished to be seen at home rather than go to a hospital, "I would like it if someone came to see me at home because I don't want people to see me as a Mental Problem" This shows that the stigma has an effect on a person.

Asylum Seekers are under stress all the time due to the Home Office and appeals not being heard on a fair basis it would be nice to see some funding going into support groups for asylum seekers and at the moment we have one such service in Barnsley which is in need of funding and it caters for asylum seekers and refugees and it offers support and friendship to new arrivals and asylum seekers and refugees.

FOCUS GROUPS

Focus Group 1 Female

1. What does mental health/illness mean to you?

Recurrent responses regarding m/h well being: N/A, good planner, happiness, good life, good job, good relation ship, has hobby, crazy, behaviour disorder/isolated.

The majority of responses focused on the positive side of mental health. Here is the evidence:

A) N/A
B) Good planer in life. (Palestinian/Female)
C) Crazy /behavior disorder /isolated /contribute good physical health. (Iranian Female)
D) Balance in every part of my life, personal development (Azerbaijanian Female)

E) Happiness, good life, job, friends, hobby (Azerbaijanian Female)

2. What does mental health illness mean to you?

Recurrent responses regarding m/h illness: N/A, crazy, lose his mind, mad, disorder behaviour, mind disorder, isolated, stress, making problem, depression

**All the Reponses focused on the negative side of mental health.
Here is the evidence:**

A) N/A
B) Crazy /lose his mind and behaviour / mad/ he has problem in his mind/ illness related to mind. (Palestinian/Female)

C) Creasy /behavior disorder /isolated /contribute good physical health. (Iranian Female)

D) Stress, making Problems. (Azerbaijanian Female)
E) Depression (Azerbaijanian Female)

3. Mental health. (What are the causes?

Recurrent Responses: anger, stress, loneness, behavior disorder, isolated, home sick, pressure
The responses focused on the negative side of mental health.
Here is the evidence:

A) getting angry from every thing (Pakistani Female)
B) stress/pressure /loneliness (Palestinian Female)
c) Chaining to negative/behaviour disorder (Iranian Female)
D) Stress, isolation (Azerbaijanian Female)
E) Home sick(Azerbaijanian Female)

4. Cultural norms and expectations

Recurrent responses: uncomfortable, be listen to, unhappy marriage, relationship problem, gender issue, language barrier
The majority of response focused in language barrier and relationship problem and the other people think in negative side of cusses
Here is the evidence:

A) need to some body tell me do you feel comfortable to talk about your issues/unhappy marriage relationship/they are not open to your situation and culture, so if you have problem need to talk to somebody /gender issues(Pakistani Female)
B) language barrier(Palestinian Female)
C) have unhappy relationship(Iranian Female)
D) language barrier (Azerbaijanian Female)
E) language barrier (Azerbaijanian Female)

5. Help and advice where do we go or not go ,why

Recurrent responses: GP ignore, help to integrate, relative support, bad experiences
The majority of responses focused on GP ignore and the other people need support.
Here is the evidence:

A) GP ignoring us /help integrate(Pakistani Female)

B) Support from family or friend make difference(Palestinian/Female)

C) Bad experience in terms of GPs(Iranian Female)

D) GP not interesting in my problem (Azerbaijanian Female)
E) Not enough time to describe my problems for the GP (Azerbaijanian Female)

6. **Helping to shape service providers need to do to provide a cultural appropriate service for asylum seekers and refugee?**

Recurrent responses: being friendly, lacks of information, being safe, have confidence, regular communication
The service providers not cultural appropriate for the asylum seeker and refugee
Here is the evidence:

A) friendly environment/ don't know where to go (Pakistani Female)
B) they need to feel safe and secure /have confidence and self teem(Palestinian/Female)
C) N/A
D) Multilingual GP and more social support for the asylum seekers. (Azerbaijanian Female)
E) GP must have regular contact with the support workers from Belmont (Azerbaijanian Female)

7. **What changes have you experiences with service providers**

Recurrent responses: information in different languages, meet people needs, gaudiness, cultural appropriate, alternative treatment, sped more time, regular assessment, easy access
The majority of responses need information in different languages and Alternative treatment
Here is the evidence:

A) Alternative need leaflet and some general information in different languages(Pakistani Female)

B) start to meet people and develop ourselves gaudiness/information /culture appropriate(Palestinian/Female)

C) try to change don't put you in medication other consultation rather than put you in waiting list/Gp should understand and responsible and spend more time but they are spending less than 5 min / use people who have idea from university and can deal with m/h problem(Iranian Female)

D) Regular mental health assessment with qualified doctor or nurse. Alternative medicine options. (Azerbaijanian Female)

E) Information about the structure of Mental Health service in different languages. Free access to psychologist. Multilingual Mentors, support workers. (Azerbaijanian Female)

Focus group 2 Mixed

8. What dose mental health/illness mean to you?

Recurrent response: nightmare, anger, confused, memory less, sleepless, good life, good health, health environment

The majority of responses focused on the negative side of mental health
Here is the evidence:

A) Thinking too much /nightmare /getting angry from everything (Syrian Male)
B) Get angry from any thing(Syrian Female)
C) Can't take any decision always confused/memory loss/sleepless/night mare(Iranian Male)
D) Good life< money, job, friends (Columbian Female)

E) Good health, happy family life, healthy environment, job. (Iranian Female)

9. Mental health. (What are the causes?)

Recurrent response: suicide thought, careless, mad, confused, stress, anger
The responses focused on the conciseness cause illness
Here the evidence:

A) suicide thought/ they don't care about any one even people who loved (Syrian Male)
B) out of control (Syrian Female)
C) he is always lost don't know where to go like a child(Iranian Male)
D) Depression, suicide thoughts (Columbian Female)

E) Stress, anger, brine problems or nervous system problems. (Iranian Female)

10. How is mental health viewed in your country according to your culture

Recurrent response: careless, stigma, GP ignore
The majority of the responses focused on the GP ignore and stigma
Here is the evidence:

A) we treated them with respect and we were kind to them(Syrian Male)
B) they don't care (Syrian Female)
C) no one care and even talk about it (stigma) (Iranian Male)
D) GP doesn't care (Columbian Female)

E) GP professional and attentive. (Iranian Female)

4. Describe your satisfaction from mental health services.

Recurrent response: discrimination, isolation lack of information, lack of trust,
The majority of responses focused on the lack of information, lack of trust
Here the evidence:

A) discrimination/bad environment don't feel comfortable at home
how we can go to this people and talk about our issues they don't like us (Syrian Male)
B) Very good services and very useful (Syrian Female)
C) Lack of information (Iranian Male)
D) Don't feel real help from the service (Columbian Female)

E) Don't know where to go (Iranian Female)

5. What changes you want to see happen in terms of services.

Recurrent response: interpreters, more services, support, language barrier

The responses focused on the interpreters and support
Here is the evidence:

A) Provide the interpreters/looking after us(Syrian Male)
B) language barrier(Syrian Female)
C) provide the interpreters/ more services) (Iranian Male)
D) (Columbian Female)
E) Provide the interpreters, support for carers (Iranian Female)

Male Focus Group

This focus group was very difficult to set up. Twice participants were identified and dates arranged but no participants turned up. At the third attempt the focus group went ahead with four participants. However, when the first question was asked two members stated that they were not happy to take part and left. Hence, the focus group was conducted with just two participants.

1. **What does mental health/illness mean to you?**

   “Mental illness is many wide things…like low moods worrying all time not happy with life. Mood swing to madness. In my country it's people who are ‘paagal’. That means ‘mad’. (Speaker A)

   “That is the same in my country as well. I think that this is two different words.

Illness is negative and mental health is when everything is good in life…" (Speaker B)

"Yes when you can cope with all problems and sort them out." (Speaker A)

"I agree but one important point is that you can sort with problems by yourself… with no help from anyone else." (Speaker B)

2. Mental illness- What are the causes?

"Worrying about future life. Not being able to look after and provide for my family. Being discriminated against because of my [legal] status. Been waiting for decision for 6 years." (Speaker A)

"The inability to solve your problems by yourself. Not being able to reach your full potential. It is a balance in life with physical and psychological" (Speaker B)

3. Cultural norms and expectations

"Should be allowed to work. I came here to be safe. Not working stops me from reaching our full life. Forcing people to lie and work underground being a second class people. Food tastes better if you buy it with money you earn." (Speaker A)

"I agree with this gentleman[R]. By not letting me work you are trying to kill me." (Speaker B)

"Yes yes. Let us work. Don't give me any rights just let me work. Some people work anyway. I want to buy nice things for my family" (Speaker A)

4. Help and advice where do we go or not go why?

"I go to the GP and hospital. A lot from BBEMI worker. Also library and some from internet." (Speaker B)

"I take all my advice from my community. Friends and contacts. I too ask BBEMI worker." (Speaker A)

5. Helping to shape service providers need to do to provide a cultural appropriate service for asylum seekers and refugee?

"Policy of health services must take into account they must be client centered where client is valued. Some medical staff say that asylum seeker pretend they have problem so they get better treatment from home office." (Speaker B)

"Training about my religion and my tradition. Sometimes interpreter for special things. You should make me feel at home and respect me like I respect you.

Sometime I just want to talk but not with family and people I know. Talk about private things.” (Speaker A)

6. **What changes have you experienced with service providers?**

“Since I am getting involved with many things. I meet many important people. I tell them what I want. What is good for me and my community? I am also having special function and celebration myself and also going to many places and learning from workshop. But even if I know my right by law… it not mean that I get them. But some things getting better. More people know about me and ask for my help” (Speaker A)

“Yes I think is important to get involved. I have seen many things get better but this has been a very long and painful process. Because you have to talk to all staff involved. Explain over and over. When staff leave all begins again. I seen (sic) improvements now some staff listen and respect me. But I asked for support from voluntary group and they point to other possibilities for help. You know that migrants and asylum seekers by same things as British people. We have to survive. It’s a question of life and death.”

Reflection

Carol Anderson

During this research I have achieved a number of skills and have gained a mountain of different experiences that has enabled me to work with the other researchers. This is the first time that the group has worked together as a team, due to the various skills and differential knowledge base of the researcher's, one of the key things that the group has achieved is working together in partnership.

There were a number of obstacles that I had to get around whilst carrying out this research. One of the obstacles being, doubting whether I had the ability and confidence to carry out the project; being as this is the first time, that I am working in the mental health field. One of my fears was whether I would be able to speak and convey in a conversation confidently about mental health issues. These fears became less of a concern as I gained more of an understanding of the contributory factors and issues that had an impact on ones mental well-being.

The personal quality that has brought me to where I am in this project has varied in a number of ways. I have often view myself as a reflective practitioner; in my working role I have learnt that it is not always a bad thing to have a sense of uncertainty about the way forward and to be reflective in my approach to work. I have learnt to be patient and have a sense of trust and belief in myself.

Every day I have learnt to appreciate new understanding and awareness around working with individuals in the community at grass root level. I have learnt to value all contributions anyone can make in society no matter how great or small.

What this means to mean is that it is never too late to learn from others who may be less fortunate than me. I have learnt to respect and value different standards, values and expectations that comes from individuals in this diverse community.

Roya Pourali

My main achievement in this project is the improvements in both my speaking and writing of English through interaction with the community and representing my findings in writing. I developed my knowledge of research and the stages involved whiles being able to develop inter personal qualities able to work as part of a group, sharing ideas whiles still maintaining the ability to work as an individual.

I have also developed statistical and analytic qualities used in interpretation and presenting the information collected.

My awareness of mental health and the role of a CDW has improved, allow me to dress a wider community which I would have otherwise overlooked improving my abilities in engaging the communities and individuals.

By using the internet as a resource, I have improved my computing and internet skills which is beneficial to my role as a CDW and a researcher.

However I faced many difficulties in reading and understand of the handbook due to the quality of my English. Most of my time was consumed in this requiring me to work into the late hours of the morning in order to complete the work necessary for the portfolio.

The research was a very good experience for me in terms of attending university. My fear was the level of my English, which was low and I tried hard to catch-up and understand all issues around research and mental health. I have improve significantly in all my weaknesses

Due to my improved skills I am currently leading the drug and alcohol project and am interested in doing more projects in the future.

I would like to thank Nadia Ahmed (research supporter) and also Vladimer Sanadze (line manger) for supporting me during the project.

Shoherah Muhummad

At the beginning of the project time was of the essence and the most common problem that we as a group experienced was making the time to meet all at once due to everyone having other commitments. We had support from our community development manager and Uclan support worker and between us as a team we managed to get the project on track.
We set up a steering group which during the nine months of the research project offered us help and support, and having networking meetings with other groups, which was set up by our Race Equality Leader.

Meeting every week we delegated tasks to each individual and putting in some hard work we had our report almost completed

At the moment all fieldwork had been completed and analysed and we are in the process of completing our report, which should be ready to send off in a day.
After staring this research I have increased my confidence and found my potential and I have found great satisfaction working with the BME communities
My experiences during this research were frustrating, rewarding, learning and working as a team. I have many feelings towards this research and the one that I can say effected me the most was having a friend who was a mental health sufferer and hearing her stories about the services really made me passionate to help change the view and stigma surrounding mental health. Working with asylum seekers and being one myself I was able to relate to the feelings and fear that asylum seekers are going through in this country

What this means for me now is securing a future for me and my daughter by getting a job and by passing my first year degree in community research has helped me up the ladder to success and I hope in the future I can complete the certificate in mental health as well.

Mirban Hussain

I now have a better understanding of the guiding principles of community research and how these can be adapted to different areas and topics. I have carried out research previously but that was as an individual. This project involved working with a group of researchers from different cultural backgrounds, identities and levels of education; and, this was at first very difficult. I have increased my knowledge base of cultural issues; and, increased my skills and abilities of inter-personal relationships. I have been humbled by the determination of my research colleagues. Some of whom being asylum seekers are burdened with problems of language, housing, finance, personal safety and welfare and yet overcame these to participate in this project.

RECOMMENDATIONS

The results of this research project suggest the following recommendations. These recommendations are based on the key research findings, are linked to national policy and are targeted at local decision makers. This research has highlighted some gaps that these recommendations seek to address.

Recommendation 1

Provide accessible and appropriate information about Mental Health Services.

To ensure that the information regarding mental health services in Barnsley is provided in an appropriate format that is relevant and available in the right places. This can be achieved by making sure that BELMONT as a first point of contact for Refugees and Asylum Seekers; has information about Mental Health services that are available in different languages i.e. Farsi, Arabic, Urdu, Spanish, Russian, Polish, Lithuania and Latvian.

For migrant workers the most appropriate place for information to be placed would be within Barnsley Hospital, Barnsley Central library, Barnsley College and within voluntary sector organisations such as Barnsley Black and Ethnic Minority Initiative (BBEMI) and Barnsley BME community organisations and groups.

Recommendation 2

Ensure carers of mental health patients have access to help and support for themselves

"It has been a challenge and deep worry as well because I did not know if I could support appropriately". (Aymara male caring for partner)

The PCT should recruit support/advocacy workers and volunteers from BME communities in Barnsley who are interested in becoming a carer to provide support to individuals who are experiencing difficulties caring for friends and family member.

Recommendation 3

Provide and improve interpreting and translators services (not just via telephone)

"Provide more interpreters, so I can explain my problem easily" (Chinese female)

Barnsley PCT should improve resources to reduce the time involved in accessing interpreters and translators. The PCT should ensure that through infrastructure support organisations such as BBEMI, Belmont and BRASS, individuals from Barnsley's BME community are identified, targeted, recruited and trained to provide essential translation and Interpreting services for mental health service users.

We will like more funding put into more English classes. Currently there are provisions at (BRASS) Barnsley refugee asylum support service to cater for maximum of 18 pupils a day for 2 days a week. This is not enough as there are approximately 400 asylum seekers in need of this service.

Recommendation 4

Increase satisfaction with GP services.

"I need to be taken seriously when I say I have a problem, I want people to listen to what I am saying and act on that and do a serious assessment" (Black African female).

GP services should provide initial mental health and psychological assessments that are culturally sensitive. Assessments should be carried out on the first visit. GP's should have relevant up to date information regarding Barnsley's BME population as well as relevant mental health services in Barnsley.

Recommendation 5

Provide Gender a Specific Service

"The treatment by staff was very patronising. I tried to at the hospital patients are mixed male and female I was not taken seriously and my problem was not sorted out". (Indian female)

Patients in mixed gender wards may face many difficulties due to sensitive issues around culture. PCT and mental health service providers must ensure that services for BME patients are gender specific positive and images of BME workforce should be reflective of the community served.

Recommendation 6

Mental health promotion and suicide prevention within Barnsley's BME communities

"Don't have much to say really because I don't know about mental problems" (Russian female)

The participant stated that she suffers from depression and stress, which makes her feel, "very alone and sad". Even though she appears to understand the difference between mental illness and mental well-being, she does not associate her stress and isolation with mental illness.

Mental health promotion is paramount within BME communities to help identify early symptoms. This will ensure that appropriate responses are carried out within a primary

care setting to help reduce the over representation of BME service users in secondary and tertiary care.

A number of asylum seekers and refugees in this research have thought of committing suicide and some have attempted it. For example, one participant stated:

“I am never in a happy mood, I feel like committing suicide sometimes”. (African-Asian female)

The respondent had not heard of or used any mental health service. The reason she gave was that she had, “heard from friends that you are not treated with respect because you are an asylum seeker”.

Mental health service providers need to undertake and facilitate training around suicide prevention within BME communities. This training needs to be culturally appropriate and responsive to individual communities. For this to be successful it must have a commitment of long term funding.

Appendix 1
Questionnaire Cover Sheet

BARNSLEY BLACK AND ETHNIC MINORITY INITIATIVE
(BBEMI)

ARE EXISTING MENTAL HEALTH SERVICES IN BARNSLEY APPROPRIATE AND RESPONSIVE TO THE NEEDS OF REFUGEE, ASYLUM SEEKERS AND MIGRANT WORKERS?

THIS QUESTIONNAIRE IS FOR MEN AND WOMEN OVER THE AGE OF 18

This Community Engagement Research Programme is being carried out on behalf of NIMHE, UCLAN and BBEMI

WE WOULD BE GRATEFUL IF YOU COULD ANSWER ALL OUR QUESTIONS

ALL ANSWERS WILL BE CONFIDENTIAL AND ONLY USED FOR RESEARCH PURPOSES

YOUR NAME WILL NOT BE ENTERED ON THE FORM

Appendix 1

BBEMI COMMUNITY ENGAGEMENT PROJECT
Mental Health Research Questionnaire

1.0 Core Questions

1.1 Age last birthday:

□ 18-24 □ 25-29 □ 30-39 □ 40-49 □ 50+

1.2 What is your gender?

□ Female □ Male □ Transgender □ Transsexual
□ No comment

1.3 What is your ethnicity?

White	□ British □ Irish □ Other, please explain: …...………………...………….
Asian or British	□ Indian □ Pakistani □ Bangladeshi □ Other, please explain: …………………………………...
Black or Black British	□ Caribbean □ African □ Other, please explain: …………………………………
Chinese or Other Group	□Chinese □ Other, please explain: ……………………………………

1.4 Were you born in the U.K.?

□Yes □ No

If no how long have you lived here?

□ Less than 1 year
□ 1 – 5 years
□ 6 – 10 years
□ 11 years or more

Appendix 1

1.5 Are you?

□ British Citizen □ Asylum Seeker
□ Refugee □ UK Resident
□ EU Citizen
□ Other please explain
………………………………………

1.6 What is your first language?

□ Spoken:
……………………………………….
□ Written:
…………………………….............

1.7 Describe your level of English?

Understanding	Good□	Average□	Poor□
Speaking	Good□	Average□	Poor□
Written	Good□	Average □	Poor□

.

1.8 What is your religion?

□ None □ Jewish
□ Christianity □ Muslim
□ Buddhist □ Sikh
□ Hindu □Other please explain:
……………………………………………………………………

1.9 What is your sexuality?

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

1.10 Are you registered disabled?

□ Yes □ No
If yes please explain your disability
…………………………………………………………………………………………

Appendix 1

2.0 Awareness.

2.1What does mental well being mean to you? Please explain
…………………………………………………………………………………………………
…………………………………………………………………………………………………
…………………………………………………………………………………………………

2.2 Have you experienced any of the following? please tick ✓

□ Depression
□ Guilt
□ Anxiety
□ Mood swings
□ Suicidal thoughts
□ Suicide attempts
□ Sleeping problems
□ Nightmares
□ Physical aches & pains
□ Emotional aches & pains

□ Eating problems
□ Stress
□ Anger
□ Relationship problems
□ Tiredness
□ Poor concentration
□ Memory loss
□ Panic attacks
□ Other, please explain
……………………………………………
……………………………………………

2.3 How has any of above affected your Mental Well being?
Please explain
………………………………………………………………………………………………..
……………………………………………………………………………………………….

2.4 Do you know of anyone who suffers / has suffered from any of the above? please tick ✓

□ Yes □ No
If yes who?
□ Child □ Parent □ Partner □ Relative □ Friend □ Neighbour
□ Other, please explain ……………………………………………………………

2.5 What do you understand by the words mental illnesses
Please explain briefly
....
....
…………………………………………………………………………………………………
…………………………………………………………………………………………………

2.6 Do you care for / look after someone who suffers from a mental health problems?

Appendix 1

□ Yes □ No

If yes who?

□ Child □ Parent □ Partner □ Relative □ Friend □ Neighbour
Other □ please explain
…………………………………………………………………………

2.7 How does this caring role affect you? Please explain briefly

…………………………………………………………………………………………………
…………………………………………………………………………………………………
…………………………………………………………………………………………………

3.0 Appropriate & Responsive Services

3.1 What do you know about the following mental health services in Barnsley? Please tick ✓. Can you prioritise the services you found most useful?.

	Heard of	Not heard of	Used	Not used
GP	□	□	□	□
Psychiatrist	□	□	□	□
Psychologist	□	□	□	□
Counsellor	□	□	□	□
Community Psychiatric Nurse(CPN)	□	□	□	□
Barnsley District General Hospital(BDGH)	□	□	□	□
Social Services Emergency Duty Team	□	□	□	□
Barnsley Mental Health Helpline	□	□	□	□
Community Mental Health Team(CMHT)	□	□	□	□
Psychiatric Emergency Team(PET)	□	□	□	□
D.I.A.L Barnsley	□	□	□	□
Ethnic Minority & Traveller Achievement service	□	□	□	□
Social Services Community Care Team	□	□	□	□
Moorland Court	□	□	□	□
Mind in Barnsley	□	□	□	□
Mental After Care Association(MACA)	□	□	□	□
The Arena Drop In	□	□	□	□
Welfare Rights Service	□	□	□	□
Women's Support Group- Mental Health	□	□	□	□
Health Visitors	□	□	□	□
Clients Alliance	□	□	□	□
Making Space	□	□	□	□

Appendix 1

Barnsley Arena	☐	☐	☐	☐
Mental Health Social Worker	☐	☐	☐	☐
Other service provided by voluntary or community groups	☐	☐	☐	☐

3.2 In relation to the service you have used please tick ✓ your satisfaction :

Very poor	Poor	Satisfactory	Good	Very good
☐	☐	☐	☐	☐

Can you explain in more detail your answer to the above question

3.3 How did you find about the service? please tick ✓

☐ GP ☐ Referral ☐ Poster/leaflet
☐ Friend / relative ☐ Vol /Com organisation ☐ Other, please explain
……………………………………
……………………………………

3.4 Was the service accessible?

☐ Yes ☐ No
Please explain your answer………………………………………………………………
………………………………………………………………………………………
………………………………………………………………………………………

3.5 If you have not used a mental health service please tick ✓one or more of the following:

☐ Not needed
☐ Not culturally appropriate
☐ Don't feel comfortable using services
☐ Worried about confidentiality
☐ Don't know where to go
☐ No time to go(opening times)
☐ No time to go(carer)
☐ Language barrier

4.0 Recommendations

4.1 How can mental health services become more responsive of your needs? please explain briefly
………………………………………………………………………………………
………………………………………………………………………………………
………………………………………………………………………………………

Optional prompts

Appendix 1

□ 1.Cultural competence training for staff
□ 2.Workers understanding of BME related health problems
□ 3. Respect and dignity towards services users and carers
□ 4. Multilingual information
□ 5.multiCultural awareness work shops

4.2 Can you state three things that could be done to improve service provision for Refugees, Asylum seekers & Migrant Workers?

1.
2.
3.

Optional prompts:

□ 1.Multilingual Staff
□ 2.Multicultural Staff
□ 3.Alternative medicine options, i.e. talking therapy
□ 4.Information/leaflets in different languages
□ 5. Mentors/support workers
□ 6.Evaluate the importance of family, friends and social support networks.

Please tick box ✓ if you would like to take part in a focus group discussion □

Thank you for taking the time to fill in the questionnaire. Your participation is highly valued.

Appendix 2

Focus Group Questions

1. What does mental health/illness mean to you?

2. Mental health what are the causes?

3. Cultural norms and expectations

4. Help and advice where do we go or not go & why?

5. Helping to shape service providers need to do to provide a cultural appropriate service for asylum seekers and refugee?

6. What changes have you experienced with service providers?

Appendix 2

BBEMI Community Engagement Project

Confidentiality Statement for Interviews

This research aims to look at what mental health problems are present within Refugee, Asylum Seeker & Migrant Worker populations in Barnsley, and how statutory organizations need to work in order to provide a service which meets the needs of these communities.

All the information you provide will remain confidential.

We will only use it for the purpose for which it was provided.

Confidential information will not be disclosed to any unauthorized person or persons.

We recognize that any information disclosed by you may be sensitive, whilst most valuable to BBEMI's research, and we will take all reasonable measures to protect it whilst in our care.

The identities and any identifying markers of participants will remain confidential and anonymous.

Exemptions to Confidentiality Statement

Where the participant agrees to waive their rights to confidentially,

Where the information would jeopardize the safety of anyone, a limited disclosure of information may be made; where at all possible, after a discussion with the participant(s).

Voluntary Participation and Withdrawal

Your participation in this research is entirely voluntary.
You may discontinue your participation at any time by informing the researcher or other senior BBEMI personnel.

Appendix 2

BBEMI Community Engagement Project

<u>Confidentiality Statement for Focus Groups</u>

This research aims to look at what mental health problems are present within Refugee, Asylum Seeker & Migrant Worker populations in Barnsley, and how statutory organizations need to work in order to provide a service which meets the needs of these communities.

All the information you provide will remain confidential.

We will only use it for the purpose for which it was provided.

Confidential information will not be disclosed to any unauthorized person or persons.

We recognize that any information disclosed by you may be sensitive, whilst most valuable to BBEMI's research, and we will take all reasonable measures to protect it whilst in our care.

The identities and any identifying markers of participants will remain confidential and anonymous.

<u>Exemptions to Confidentiality Statement</u>

Where the participant agrees to waive their rights to confidentially,

Where the information would jeopardize the safety of anyone, a limited disclosure of information may be made; where at all possible, after a discussion with the participant(s),

We as researchers can guarantee confidentiality however we cannot guarantee that all participants will maintain confidentiality. Please do not reveal anything you wouldn't want disclosing outside of the group. We ask that all participants respect each other's privacy and respect the ground rules for the focus group.

<u>Voluntary Participation and Withdrawal</u>

Your participation in this research is entirely voluntary.
You may discontinue your participation at any time by informing the researcher or other senior BBEMI personnel.

Appendix 3

BBEMI Community Engagement Project

INFORMED CONSENT FORM

This consent form is to make sure that you understand what is involved in this research project, and how we intend to use the information you are giving us.

We will not use any names or other identifying features when we write about what we have found out. All identities will be kept confidential, unless you specifically give us permission to acknowledge you. We will not do anything with this information that you do not give us permission to do.
I understand that my participation in this BBEMI (Barnsley Black & Ethnic Minority Initiative) research project is voluntary and I understand that I can withdraw at any point without giving a reason. I have had the opportunity to ask questions about my involvement in this research project.

I agree to the research team transcribing the interview or using any other information that I may wish to disclose, keeping it safe electronically, and using it for the purposes of this BBEMI research study. I understand that only members of the project research team will be allowed access to the interview transcript.

Providing my identity is kept confidential, I hereby give permission for BBEMI researchers to use the information that I disclose in the following ways:

- In preparation of a research report for the National Institute of Mental Health in England and University of Central Lancashire.

- In any written reports or events which inform the communities who have contributed to the research about the research findings.

- For academic or policy related purposes, which help to make the findings of the research known.

I have read this consent form and the research brief has been explained to me. All my questions about the research and my participation in it have been answered. I freely consent to participate in this research.

By signing this consent form I have not waived any of the legal rights that I otherwise would have as a subject in this research study.

Participant's Name: …………………………………………… (Please print)

Participant's Signature…………………………………………Date: …………….........

Researcher's Name: …………………………………………… (Please print)

Researcher's Signature …………………………………………Date: ………………….

If you consent to participate in this research project, would you like a copy of any of the following?
Interview transcript [ ] Report summary [ ] Full report [ ]

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