

# **Bridging Cultures, Dissolving Barriers End of Year Evaluation Report 2009 / 2010**

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**Title of Scheme:**  
**BRIDGING CULTURES, DISSOLVING BARRIERS**  
Mental Health Promotion with BME communities

**Mind in Harrow**  
**End of Year Evaluation Report, 2009 / 2010**  
Dr Natalie Tobert, Seminar Coordinator

The Bridging Cultures, Dissolving Barriers programme, was the third in a series of BME mental health promotion projects, funded by NHS Harrow since 2008, to be carried out by Mind in Harrow, with BME community and religious groups. These projects included:

Needs Assessment (July – Sept 2008)

- This was to explore key messages BME groups wanted for mental health promotion, and their suggestions for delivery strategies. Participants emphasized the importance of religion and faith for mental well being.

People Like Us Project (Sept 08 – March 09)

- A media campaign to promote mental health awareness, with seminars to illustrate pathways to access health care services

People Like Us Project (April 09 – March 10)

- Bridging Cultures, Dissolving Barriers: Partnership seminars with service providers and community and faith groups to increase cultural understanding, and access to mental health care services

## **1. Aims**

The aims of this scheme (2009-10) were to undertake a Mental Health Promotion project, in partnership with Harrow's BME community and faith groups, and with health and social care professionals. Our intentions were to address health inequalities and inequalities in access to mental health services, with Harrow's BME communities, including refugees and asylum seekers; and to raise awareness about cultural and religious understanding of mental health.

## **2. Objectives**

Our objectives, as set out in the Service Level Agreement, were to engage with BME communities (e.g. Somali, Afghani, Iranian, African-Caribbean, and South Asian), to develop and deliver a programme for 360 people, of 24 new half-day mental health promotion seminars on:

1. Culture, diagnosis and mental well being
2. Religion, culture and mental health
3. Women, culture and healthy minds

During 2009 and 2010, Mind in Harrow delivered an innovative mental health promotion programme. We exceeded the target with 28 seminars, and 452 workshop places, which reflected the needs of Harrow's BME communities, as they themselves had identified in the 'Harrow Mental Health Needs Assessment' with Black and Minority Ethnic (BME) Communities of September 2008.

We ensured the programme had a wide impact, by working in partnership with BME community and faith leaders, and with social care and health professionals, in order to develop and deliver the programme. We engaged with some 'hard to reach' audiences through creative participatory activities, including a drama on domestic violence held at a temple, and facilitating storytelling about the effects of migration on people's well being. We ensured the health outcomes and benefits of this strategy of programme delivery were systematically monitored and evaluated. The results are presented within the body of this report.

### **3. Project Outcomes**

Seminars used a participatory approach, encouraging peer learning and open discussion. We achieved our outcomes with BME community and faith leaders participating in the development and delivery of the seminars. In this way they gained an increased awareness of mental health and of ways to access services in Harrow. This helped them to better engage with their communities and support them, when they needed to seek help for their mental health. We also welcomed medical and allied health and social care professionals' participation in the delivery of seminars, from both statutory and voluntary sectors. In this way professionals presented their knowledge about pathways to access and care, and gained increased cultural competency during seminars, to cascade to their teams.

#### **3.i. The Programme**

The programme of 3 new half-day mental health promotion seminars mentioned above achieved the following outcomes:

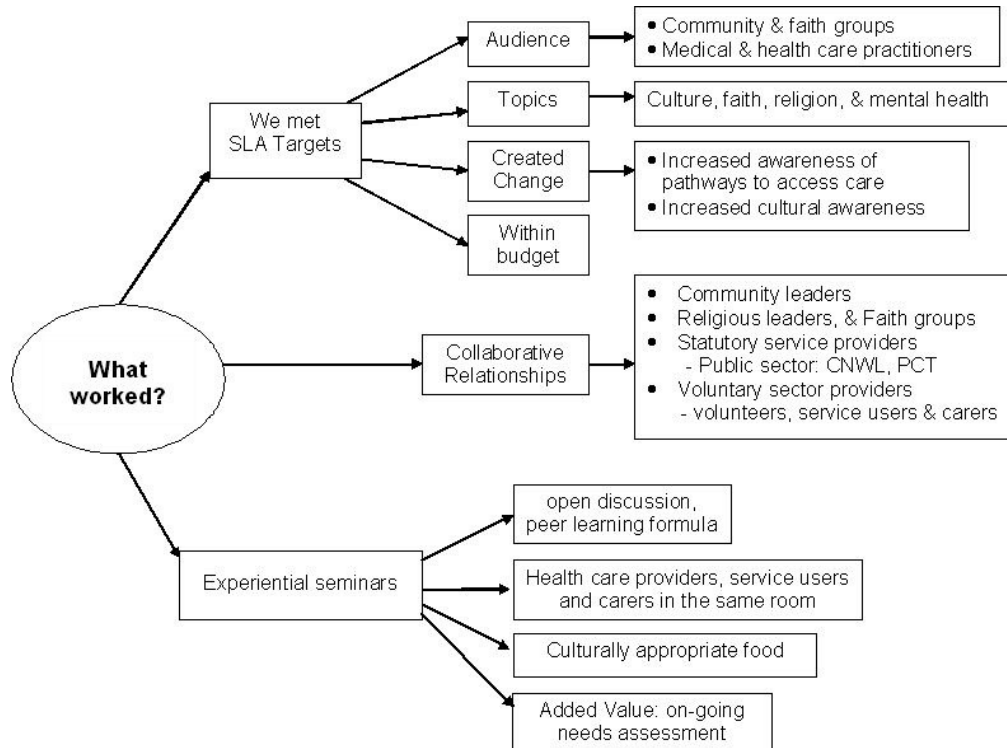
- Culture, diagnosis and mental well being: participants gained improved self-management of their mental health, and had better access to services, through their increased knowledge and understanding of mental health diagnosis. Service providers increased their knowledge of cultural beliefs about mental health.
- Religion, culture and mental health: participants gained an increased understanding of mental health, and of pathways to access help early, so that a deterioration of mental health was prevented.
- Women, culture and healthy minds: participants gained an increased awareness of mental health support services, which they could access in Harrow, and were more aware of social and community networks, resulting in more social inclusion. Health care providers were more aware of BME women's concerns.

The seminar leaflet of public events is given in **Appendix A** together with an outline of the content of each seminar. These and additional privately requested events were set out in the monthly reports, and are provided in **Appendix B**. The list of events and meetings where the seminars were signposted is given in **Appendix C**. Elements of the content of seminars were influenced by courses the Co-ordinator ran on Medical Anthropology, for medical students at Barts and the London School of Medicine and Dentistry, and BSMS, Brighton and Sussex Medical Schools.

### 3.ii. Settings

The seminars took place in secular, medical and religious settings: in the Healthy Living Centre in Harrow, and Kenton Learning centre; at the Swami Narayan Hindu temple in Kenton, the North Harrow Mosque; and in healthcare settings including Northwick Park Hospital, Cygnet Hospital, Honeypot Lane Clinic, and Roxbourne Complex and Rosedale Court. The full list of settings is given in **Appendix D**.

## 4. What worked?



**4.i. SLA targets.** We delivered 28 seminars on the required topics. We exceeded the SLA targets with 452 seminar participants, 84% of whom were from BME community and faith groups. We created change regarding increased BME community awareness of pathways to access mental health care, and all round increased cultural awareness of different ways of looking at the world and in particular health. The project was within budget, and forged collaborative partnerships with religious and community leaders, statutory health care providers, and voluntary services, service users, carers, and their families.

**4.ii. Partnership and Collaboration.** During the programme's early months, there appeared to be some reticence from mental health care professionals, to discuss topics like religion, culture and mental health, in an open public forum. However, as the project progressed, Central North West London trust (CNWL) staff, were regular participants. The CNWL Sector Manager, Carol Harrison Read was supportive of the project, and attended a couple of events, as did CNWL CDW Dominic Joannou. Shaun Hare, In-Patient Services Manager at Northwick Park Hospital, requested seminars for staff at six centres throughout the borough, and these included for the Crisis Resolution Team at Northwick Park Hospital, Community Mental Health Team - East Sector clinic at Honeypot Lane, and Inpatient Services at Roxbourne Complex and Rosedale Court. The poster for the seminars is given after appendices.

Collaboration worked well with statutory and voluntary organisations, with CNWL and with the director and staff at the private Cygnet Hospital; with Harrow Association of Somali Voluntary Organisations (HASVO), Harrow Carers, staff at the NHS Domestic Violence Unit, Harrow Association of Voluntary Services (HAVS); and with Community Development Workers (CDW) at Mind in Harrow and CNWL. One CDW (Nisha Wickramasinghe) started at Mind in Harrow during March 2009, and presented her role during each seminar event she attended. In this way, participants who needed to, approached her, and she signposted them on to different mental health services, or offered them one to one support. Later in the year, the Migrant and Faith worker, Josie Hinton, did the same. Partnership working between CNWL, Mind in Harrow and BME community groups was recognised in the Community Partnership Award Ceremony in 2010, see posters at end of document.

The SLA had mentioned that we could approach the PCT to use volunteer help from amongst their newly qualified Health Trainers. Those who did assist the seminars came voluntarily, as there was no formal support. It was difficult to run seminars without any assistance from health trainers, or volunteers. It was much more difficult to support participants, and ask them to do the ethnic monitoring form and the questionnaires, which provided an evidence base for this seminar programme.

**4.ii. Experiential seminars.** As facilitator, I took responsibility for the organisation, content structure, and timing. The seminars were participatory, and it was the participant's input that created the dynamic discussions about culture, religion and mental well being. These provided an experiential forum for peer learning. Participants brought their own insights into each discussion: the multiple perspectives of service users, carers and providers, made the seminars meaningful for all participants.

Seminars held with service providers illustrated key points about culture and health very clearly. Participants learnt that their own colleagues, with whom they worked side by side, practicing clinical care, had quite different understandings about human existence, life and death. Their training in health care was the same or similar, but their existential beliefs were often quite different.

There seemed to be a difference in core training between that available for psychiatrists, and training available for allied health care professionals, with the former receiving more input on trans-cultural issues concerning religion, faith and mental health. One way to address this would be for seminars to become a core part of diversity training, rather than as an added option.

**4.iii. Signposting.** Signposting took the form of conference lectures, presentations at training events, or running stalls at health fairs. It was carried out at the following events: World Mental Health day conference for GPs, Iranian mental health day, Harrow Council Under One Sky event, Samaritans staff training, and with Nisha Wickramasinghe at a women's health event at North Harrow Assembly Rooms Mosque.

At an Interfaith event at the Civic Centre with Harrow Council, I was invited to sit on a panel of religious and faith speakers at the Civic Centre. I spoke about the interface between religion and mental health. A summary of my talk was printed in the Interfaith booklet, on a page for Mind in Harrow. This was the first time that mental health promotion had been invited onto the agenda of a Harrow Interfaith event. [In previous years, the group felt that mental health was not a

suitable topic for incorporation with Interfaith and religion.] In November 2010 I gave a presentation on religious experience and mental health, on a platform alongside Harrow's faith leaders.

After speaking at the CNWL conference in February 2010 on Iranian mental health day, I was interviewed, with the psychiatrist Dr Mariwan Husni, for Iran television. The programme was broadcast directly to Iran, from the studios at the time of delivery. The following week, on Thursday, Friday, and Saturday, the programme was broadcast to Europe, USA, and Middle East.

**Training Seminar, Women, Culture and Mental Health.**

November 2009

A women-only seminar, which addressed some potentially controversial women's issues including cultural dress, honour and shame, forced and arranged marriage, FGM, and spirit possession. 20 women booked, and 10 came.

Participants included four black women, two of African Caribbean origin, one from Venezuela, and one from Somalia. There were two Asian women: one from Muslim India, the other from Catholic Sri Lanka. There was one woman from Afghanistan, three white women from UK, and one from Germany. Occupations included Hospital Link Worker, Support Worker, Met Police Reception Officer, and a Counsellor.

Comments included:

*"I found this seminar very helpful and enjoyed listening to other women's experiences";*

*"I have really enjoyed the seminars and feel I have now got a better understanding of the topics discussed";*

*"Enlightening"; "very interesting, learnt a lot about different cultures";*

*"Really good to come together and discuss issues with women and open up to sharing and supporting. It helps to have a space to break down taboos."*

**4.vii. Marketing.** The project's success was due to our working in partnership with BME community and faith leaders, as programme stakeholders to promote and participate in seminars. Those events which ran with the support of either Somali or Gujarati community leaders were particularly successful. Thanks are due to Fadumo Mohamad for her role in inviting colleagues to several events, and to Chandra Shah for inviting me to participate and offer seminars in the EKTA group he ran.

Our seminars were also advertised by Harrow Link, who sent details to people and organisations on their books. The Equalities and Diversity coordinator from CNWL, said participation in the seminars qualified staff as part of their training and development in inequalities and diversity, and seminars were advertised on the Intranet. Harrow Council Community Development Department advertised our events on their web pages, and included a written piece in their Harrow People magazine. We worked with one of the Harrow councillors Krishna James, who supported our request to the director of Cygnet hospital, and they hosted three seminars (see poster at end of document). The In-patient Manager at Northwick Park Hospital booked and advertised six seminars for staff. Vignettes are set out in the following page.

### **Cygnets Hospital, September 2009**

Eighteen people booked for this event and 38 turned up on the day, including 20 Somali women. Participants included a Community Liaison Officer from Harrow Met police, nursing home staff, community care workers, carers, social workers, children's services worker, occupational therapist, health trainer, care partnership manager, floating support worker, a psychiatrist and a GP.

Ethnicities and religions included black African Muslim and African Caribbean Christian; Asian Hindu, Muslim and Christian; white Jewish, Christian and Buddhist.

One person said they wanted staff training inductions to include the seminar material. Other comments included:

*"The workshop was well organised, was engaging, gave everyone the opportunity to participate. For me it was enlightening to hear about the issues that the Somali community has."*

*"Nice venue and food! Enlightening, better understanding now of potential barriers to seeking mental health attention from professionals,"*

*"very diverse tackling of an important and interesting subject".*

### **Training Seminar, Northwick Park Hospital, November 2009.**

Seventeen people attended mostly from Crisis Resolution Team. Participants included 12 members of CRT, Support worker, psychiatrist, nurse, and admin staff, OT student, and a volunteer.

Participants' countries of origin included: Nigeria, Kenya, Mauritius, Zimbabwe, Greece, UK, and Australia. Ethnicities included Black African, Asian, White, and dual heritage. Religions included: Christian, Catholic, C of E, Hindu, Muslim, and atheist.

Using a slide presentation, we discussed different peoples' understanding of culture, religion, life and death, and the way these impact on their access to services or compliance with treatment.

Comments included:

*"I enjoyed the seminar and found it very educational",*

*"well delivered, very interesting, and wouldn't it be great to be able to assess religions ... and work with psychiatry to benefit our clients",*

*"Excellent, interesting concepts. Needed more time for broader in depth discussions",*

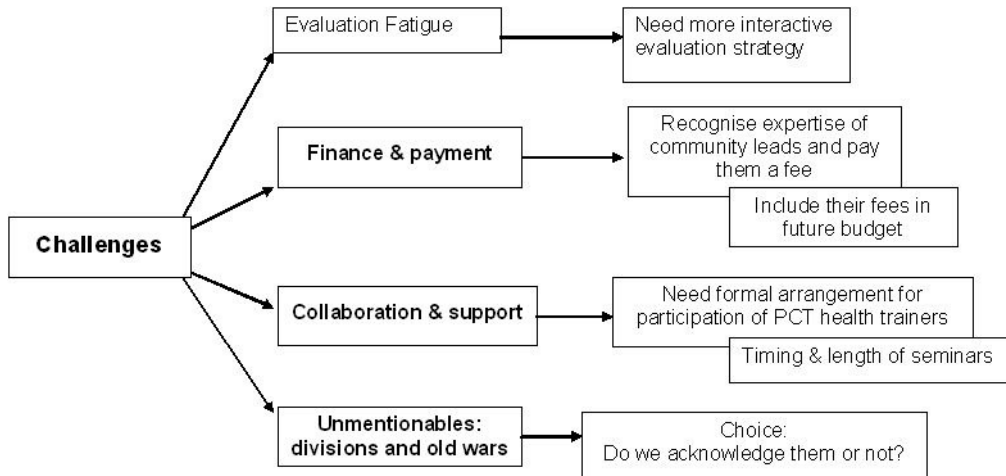
*"Very interesting and helpful in terms of looking at the religious and cultural population of the borough"*

*"Helped us to consider cultural differences when working with patients"*

*"very useful because we work with people from diverse religious and ethnic and cultural backgrounds".*

*"Good and relevant to my field of practice",*

## 5. Challenges encountered



**5.i. Evaluation Fatigue.** We need a more interactive technical evaluation strategy, to make data collection more efficient. Of the 452 people recorded as attending the meetings, just over half (242) filled in the monitoring and evaluation forms. I give several examples below. In August 2009, we were asked to run a seminar for the Asian People's Disability Alliance (APDA). During the seminar, 42 people were counted in the hall, and with two volunteer helpers, 34 people were named in the registers. Three people did the ethnic monitoring form, 3 answered the first questions sheet, and two the second. Of the two helpers, one assisted with the registration of names, the other with the first evaluation form. It was extremely difficult to collect data, as some people had mental capacity, but not physical capacity, and others had physical capacity, but not mental capacity.

I did not collect paper data at our event hosted by the Swami Narayan temple in Kenton. I was uncomfortable disseminating evaluation forms there, and I did not feel it was appropriate to use them at a seminar with the Hearing Voices Support Group. I used their own register, but did not use our ethnic monitoring or evaluation forms. Medication to control the Voices seemed to affect some service user's ability or will to speak, let alone read or write. [However, two men who'd been hearing voices for over 30 years, said they would like to work with Mind in Harrow, to educate people about what it was like to have schizophrenia, and how they managed to contain or control the Voices.]

Staff also had monitoring form fatigue. Sometimes staff did not sign the registers, and sometimes when they did, they were not willing to complete the monitoring or evaluation forms, though they might tick the gender box. Staff at Mind in Harrow did organise a meeting with Votech, a digital data capture system, who gave a demonstration at the offices, attended by the CEO, Services Managers, and seminar co-ordinator. We need to ask again for a 30 day trial of their equipment, to see how effective it is at capturing ethnic monitoring and evaluation data.

**5.ii. Financial resources.** There was one issue which came up several times, about working with community leaders and expecting them to work for nothing, to organise and invite their compatriots to attend the workshops. This is an ongoing issue, with regard to valuing community leaders, who are usually

expected to work voluntarily. Without their knowledge and expertise, it would be much more difficult for salaried workers to meet their objectives.

Lack of continuity: at conferences and signposting events people came up to me to ask me for more seminars and events, but because the funding of the project ceased, I was not able to offer anything further. This funding strategy may mean we lose goodwill and support of community and faith leaders.

There was not sufficient timing and funding this year to run a stakeholder and partnership feedback session. This still needs to be done to acknowledge participant input, and illustrate that we listened to their suggestions.

### **5.iii. Timing.**

I did not take adequate care about arranging workshops around the summer bank holidays, and religious festivals like Ramadan. During August there were fewer participants.

Later in the year, as well as community members attending from different religious and faith groups, there were an increasing number of medical and allied health care professionals who participated. Hospital and health care providers were only given a one hour slot for the training, and once it was underway, they found it was too short, and would have liked a longer to discuss the issues in more depth.

#### **Timing: comments from CNWL staff**

*very interesting, wish we had more time as it bought up some good ideas',*

*'concise, informative; it would be useful to have a longer workshop',*

*'very interesting and worthwhile, but not enough time to have meaningful discussion',*

*'very interesting and informative, interactive. Time allocated too short',*

Some **signposting** events, required a considerable input of time and energy, and we felt that this didn't always translate to having people attend the seminars, although they did become more aware of the services that were offered. E.g. Under One Sky: two of us participated in this event (where we met the mayor of Harrow), and did result in some useful contacts made, but it required a whole day. However, Health Fairs at Harrow College only required a few hours of time, but resulted in the seminars being run as part of three ESOL classes for migrant youth and mature students.

### **5.iv. Marketing**

It took around three months to set up meetings with community and religious leaders, and with health care providers. There was goodwill left over from the previous project funded by the NHS Harrow (2008-9), from the People Like Us campaign. This resulted in quite a few workshops being confirmed that summer.

Quite a lot of time and effort was required to market and publicise the seminars at the beginning of the project. Community Leaders advised us not to use the term 'mental health', when we marketed the seminars to faith and community groups. We needed to find other ways of saying what we meant, like mental well-being, or healthy minds. Those events which were advertised as being about 'mental health' tended to have fewer participants.

We had meetings with Swami Narayan Hindu temple Neasden, to discuss working with their staff on an event, and the Hindu temple in Kenton, where we eventually ran an event which included a play in Hindi about domestic violence.

**5.v. Booking & Lunches:** We found that many people didn't book, either by phone or email, to attend the seminars, they just turned up. So sometimes it was difficult to plan lunches except at the last minute. There was a problem over the food and in some places, and we needed to emphasise that meals were either vegetarian or fish, and didn't contain any meat. Sometimes it felt as if there was a lack of understanding, about how any meat might cause offence to some Hindus, and meat which was not Halal, to Muslims.

Workshop participants begun to comment that my seminars only seemed to attract a handful of white service providers, and we were not sure what we could do to address this.

#### **Comments from Evaluation Forms**

*"Informative, relaxed atmosphere. Interesting perspectives from attendees. Speaker was very good and knowledgeable";*

*"very interesting and informative. I feel more equipped to work with people of other religions, with increased awareness & better understanding of different needs & backgrounds";*

*"very good, provided good insight into different aspects of health, religion and culture".*

*'very useful presentation and the information provided. Would welcome a follow up with the team to address and discuss practice in terms of working with users',*

*'Very Good, was most informative. Also made me aware of local developments in Harrow', '*

*'Interactive, interesting, good information sharing. Keep it in mind with my client dealings',*

*'(I'll) use information provided to contact the people who can help in cultural situations that arise',*

*'Informative, thought provoking. Let people know that they can access spiritual services and that these can work alongside the medical model',*

*"excellent"; "well organised and very informative"; "wonderfully informative workshop"; "I found it very informative and well presented. I will be happy to point others to experience the training".*

*"very thought provoking", and "I found it very insightful, it's good that the seminar was able to reflect on diverse Harrow. It has opened my mind."*

*"Helped me understand the importance for us as practitioners to address the cultural and spiritual needs of our service users."*

*"chance for everyone to contribute. Very thought provoking";*

*"have really enjoyed myself and learnt something new";*

### **Healthy Living Centre. February 2010**

Sudanese Partnership seminar with BTWSC and Wheat MST. The event was very successful, and ran from 1 – 5.30 pm, with speakers from partnership organisations explaining how they assisted African migrants, and speakers from Harrow's statutory and voluntary health care sector, who spoke on ways to access mental health care services.

Participant's countries of origin included: Sudan, Ethiopia, Ghana, Kenya, Rwanda, Sri Lanka, Scotland, and England. Religions included: Christian, Muslim, Hindu, and Roman Catholic.

Participant's occupations included: Community Leaders, Fellowship Group Leader, Director of WHEAT MST, Community Development Workers, Welfare Benefits Advisor, Trustee, a local councillor, and Medical Doctor.

Comments about the session:

*'very exciting and informative. This has to continue at a larger scale',*

*'Brilliant mix of speakers and presentations. Good content. Would like spiritual needs of African Christians recognised. They also go to church first and present very late'*

*'very good, learnt a lot about faith and mental health. It was good to know what the authority thought about faith'. 'Brilliant start to working together',*

*"Fab! Loved the networking, talks and enthusiasm, lots of scope for joint working",*

### **Healthy Living Centre**

#### **Women, Religion and Mental Health, August 2009**

Over thirty women of different ethnicities and religions attended.

Participants' countries of origin included Angola, Ghana, Somalia, Iran, Pakistan and England, and religions included Muslim, Hindu, Jewish and Christian.

People from all walks of life attended, and included professionals such as Community Support workers, Health Trainers, Teachers, Psychiatrists, and the director of Harrow Refugee Forum.

This seminar was special because delicious hot food for lunch was prepared by a group of Somali women. Thanks are due to Fadumo for organising this.

### **Swami Narayan temple, Kenton, October 2009**

42 people attended: 12 men and 30 women. Religions: 38 Hindus, 1 Muslim, 1 Jain, two white Jewish, and 1 Asian Catholic. Thanks to Councillor Krishna James for making contact.

We gave a seminar with slide show and interactive discussion, for the first part of the evening. This was followed by presentations from Harrow Carers, CDW's, and the PCT Domestic Violence lead. Towards the end of the evening, we offered a new play in Hindi, on domestic violence, organised by Chandra Shah, after which we discussed mental health topics raised.

The liaison officer at the temple felt we had organised a very professional event: *"I did find the event as a whole very well presented and very useful".*

## 6. SLA Monitoring and Evaluation Report

### Introduction: The Evidence Base

During the year of the project, a total of 28 seminar events were run (Appendix B), and the Seminar Programme exceeded its milestone targets of 360 participants at 24 seminars. The 28 events were attended by 452 participants. The total number of people who attended signposting meetings, conferences and health fairs was 1535. The smallest seminar was run for 6 participants and the largest for 42. Twenty five percent of the participants were from medical and allied health care providers in both statutory and voluntary sectors.

Although the SLA originally said the project would run 24 half-day seminars during 2009-10 (3 seminars per programme x 8 programmes), in fact the topics did not work out as evenly as that. The seminar topics depended on the requests submitted by BME communities and health care providers.

Monthly or bi-monthly monitoring reports, against targeted deliverables, were provided by the Seminar Co-ordinator, and quarterly progress reports of budget breakdown in line with outputs were submitted by Mind in Harrow's CEO Mark Gillham, to NHS Harrow.

### Evidence-based research:

The following outputs were recorded, monitored, and used for evaluation:

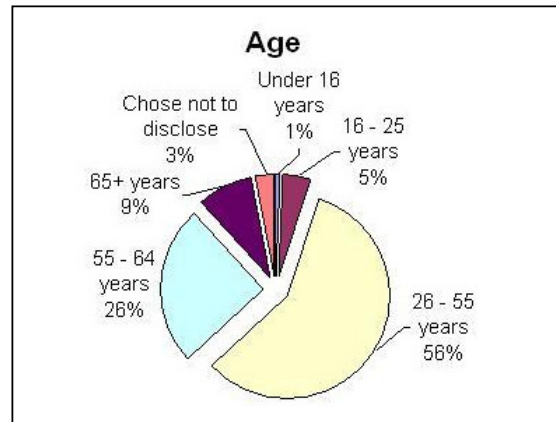
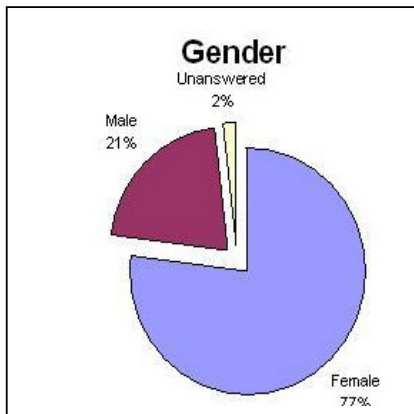
- Seminar registers
- Ethnic monitoring forms
- Questionnaire 1 (user knowledge about mental health before seminar)
- Questionnaire 2 (user knowledge after seminar)
- Questionnaire 3 (user learning and satisfaction months after seminar)

### 6.1. Registers

In the 28 seminars, 452 participants are recorded as attending, and of those just over half (242) filled in ethnic monitoring and evaluation forms. In section 5.ii above, I explain about evaluation fatigue, and why some participants did not, could not, or would not sign the registers, even though they were present in the room. This also included members of the Hearing Voices group, and some women who were supported by the Domestic Violence unit, and whose identities needed to remain hidden: the lead gave me a list their ethnicities.

## 6.2. SLA Outcomes: Ethnic monitoring information

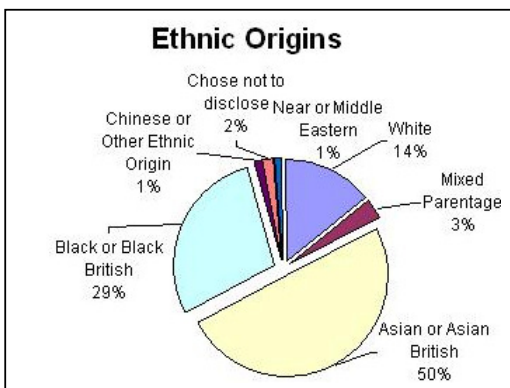
### 6.2.i. Gender and Age



During the year of the project 2009 to March 2010, a total of 452 participants attended the seminar meetings, and of those 77% were female and 21% were male. However, of the health care practitioners who attended seminars, 53% were female and 40% were male.

The majority of those who attended were aged between 26 and 55 years (56%), A quarter were aged between 55 and 64, and 9% were over 65 years. Only 5% were young adults between 16 and 25 years old, just a few children under 16 attended. Over 90% of health care practitioners were aged between 26 and 55 years, with 7% aged over 55.

### 6.2.ii. Ethnicity



ETHNIC ORIGIN SUMMARY		
White	35	14%
Dual Heritage	8	3%
Asian or Asian British	119	49%
Black or Black British	70	29%
Chinese or Other Ethnic Origin	3	1%
Chose not to disclose	4	2%
Near or Middle Eastern	3	1%
<b>TOTAL</b>	<b>242</b>	<b>100%</b>

Half of all participants who attended seminars (and filled in forms) were Asian or Asian British, 14% were white, 3% were of dual heritage while a nearly third (29%) were black or black British, of whom 15% came from Somalia. Ten percent of participants said their country of origin was Britain. Although half of participants had their family of origin in South Asia, which included India (24%), and Pakistan (6%), Bangladesh and Sri Lanka, some were economic migrants from African countries.

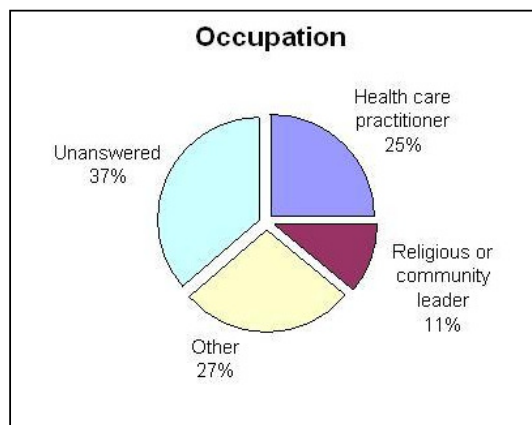
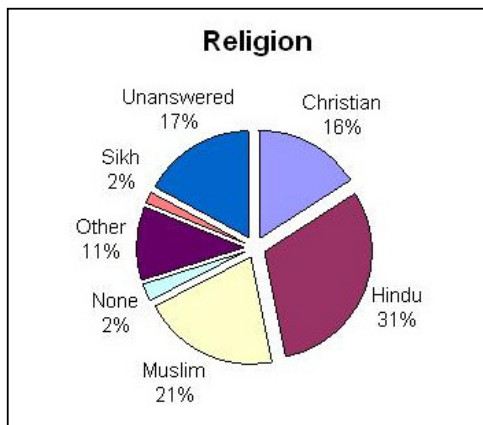
Those whose parents were from the Caribbean included the following places: Barbados, Jamaica, Puerto Rico, and Trinidad. African countries of origin included Angola, Ethiopia, Ghana, Kenya (5%), Mauritius, Nigeria, Rwanda,

Sudan, Tanzania, Uganda, and Zambia. Other respondents' countries of origin were given as Burma, China, Fiji, France, Iran, Ireland, Philippines, Poland, and Russia. These figures illustrate the breadth of Harrow residents' ethnicity, and their interest in participating in the topics of the seminars. The issue concerning the number of white staff who chose to attend these seminars, which explored cultural understanding and mental well being, is one that needs to be addressed.

Health Care Providers		
White	17	27%
Dual Heritage	2	3%
Asian or Asian British	22	35%
Black or Black British	15	24%
Chinese or Other Ethnic Origin	2	3%
Near or Middle Eastern	2	3%
Chose not to disclose	2	3%
<b>TOTAL</b>	<b>62</b>	<b>100%</b>

Just over a quarter of all health care providers who attended seminars were white, 35% were Asian or Asian British, and a quarter were black. The black health care practitioners who attended were from the following countries of origin: France, Ghana, Jamaica, Kenya, Mauritius, Nigeria and Sudan.

**6.2.iii. Religion.** Of the participant's religions, 31% were Hindu, 21% were Muslim, and 16% were Christian. However, 17% of the participants chose not to answer the question on religion. Only 2% said they had no religion. The religions put down on the monitoring forms also included: Anthroposophist, Born Again Christian, Buddhist, Humanist, Jain, Sikh, and United Reform.



**6.2.iv Participants' Occupations**

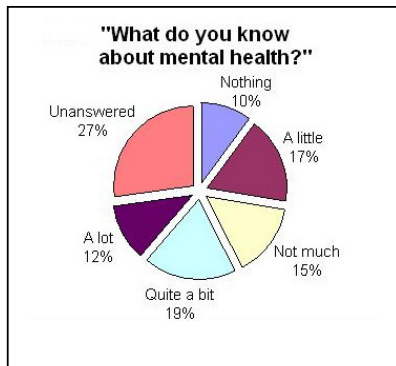
On the ethnic monitoring form, there was one question at the end for occupation. Of the forms received a quarter of participants said that they were Healthcare practitioners, and 11% said they were community or religious leaders. A further 27% had other occupations and professions, and these included members of the Crisis Resolution Team, In-patient services, support workers, counsellors, health care assistant, special needs worker for children, Youth Offending Team, Preventing Violent Extremism team, and the Community Liaison Officer for Harrow Police. The full list is set out in Appendix G.

### 6.3. SLA outcomes

#### Participants' knowledge about mental health

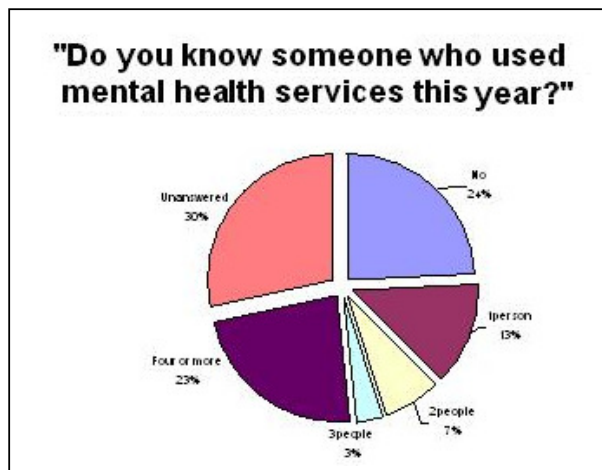
**Baseline questionnaire:** At the same time as being given the ethnic monitoring form, participants who attended seminars were given a base line questionnaire to fill in before the start of the event. We did this so that we could determine what kind of knowledge they already had about mental health services in Harrow. This form had three questions on it:

- What do you know about mental health?
- Do you know someone who has used mental health services this year?
- Do you know how to get mental health help in Harrow?



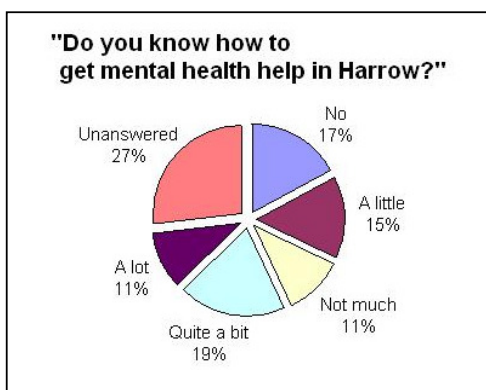
#### 6.3.i. What do you know about mental health?

Over a third of mental health care professionals did not answer this question, and 27% of the total number of participants did not respond either. Ten percent of participants said they knew nothing, 17% said they knew a little bit, and 15% not much. Of the participants, 31% said they knew either a lot all quite a bit about mental health.



#### 6.3.ii. Do you know someone who used mental health services this year?

Thirty percent of participants did not answer this question, 24% said they did not know anyone who had used services, 13% said they knew one person, 7% said they knew two people, and 3% said they knew 3 people. Finally 23% said they knew four or more people that used the services, although this could have been made up from healthcare providers.



**6.3.iii. Do you know how to get mental health help in Harrow?**

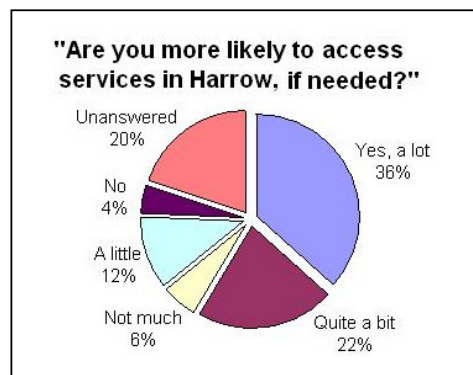
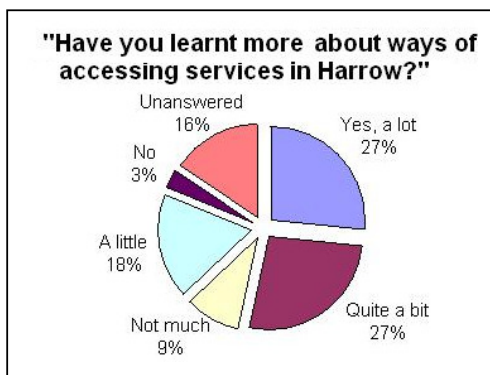
Twenty seven percent of participants did not answer this question, 17% said they did not know how to get help, and 15% knew how to get a little help. Eleven percent said they didn't know much, while 19% knew quite a bit about where to get help, and 11%p knew a lot.

**6.4. SLA Outcomes**

**What had participants learnt by end of seminar?**

At the end of the seminar or mental health promotion event, participants were invited to fill in another evaluation form, made up of five questions. These were as follows:

- Have you learned more about ways of accessing services in Harrow?
- Are you more likely to access services in Harrow, if needed?
- Will you be better able to manage your mental well-being?
- Do you have a better understanding of cultural concerns?
- Do you feel more able to make use of community support services?

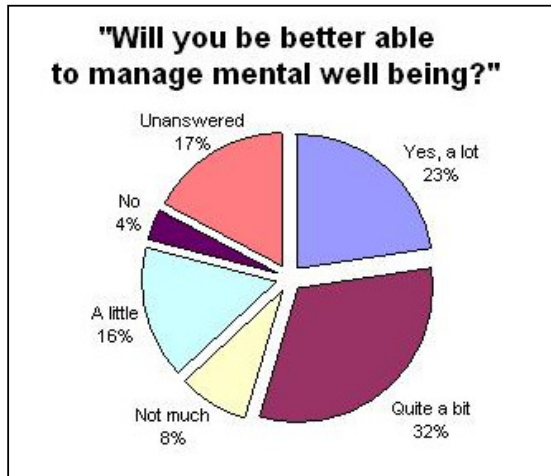


**6.4.i. Have you learned more about ways of accessing services in Harrow?**

These questions were on a separate sheet and were handed out at the end of each seminar event. Over half (54%) of participants said they had learned more learned a lot or quite a bit about accessing services, whereas 18% said they heard learned a little and 9% said 'not much'.

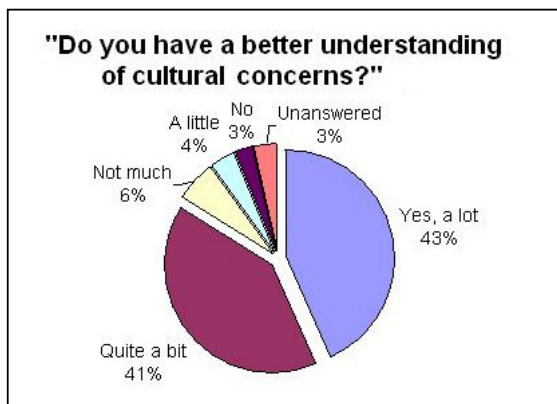
**6.4.ii. Are you more likely to access services in Harrow, if needed?**

Over half (58%) of participants said they would access services more, 36% said they were much more likely, 22% said quite a bit, and another 12% said they were more likely to access services a little more. Only 4% said they were not more likely to access services. The proportion of people who didn't answer the questions wavered between 16 and 30% for many questions.



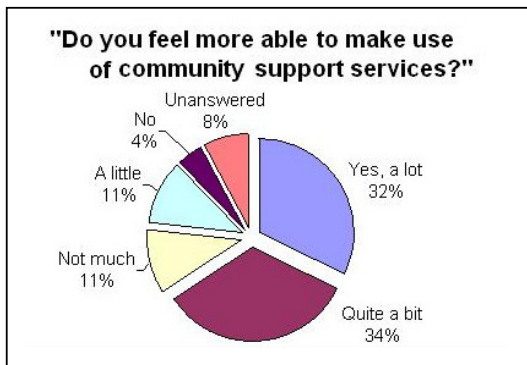
**6.4.iii. Will you be better able to manage your mental well-being?**

Of the participants, 55% said they would either manage their well-being either a lot better, or quite a bit better than before attending the seminar. 16% said they would manage it a little better, while 8% said not much, and 4% said no, it would not make any difference to them.



**6.4.iv. Do you have a better understanding of cultural concerns?**

Of the participants who attended, 84% said they had a better understanding of cultural concerns, either a lot, or quite a bit. Only 6% said they didn't have much of a better understanding, and 3% said they did not have any increase in cultural understanding.



**6.4.v. Do you feel more able to make use of community support services?**

66% of participants said they would be able either a lot or quite a bit to make more use of community support services, while another 11% felt they would make use, only a little. Only 11% said they would not make much use more use of community services and 4% ticked the No box.

**Participant's Comments:**

*"very interesting and informative. I feel more equipped to work with people of other religions, with increased awareness & better understanding of different needs & backgrounds";*

*"very good, provided good insight into different aspects of health, religion and culture".*

*Enlightening, better understanding now of potential barriers to seeking mental health attention from professionals,"*

*"Very interesting and helpful in terms of looking at the religious and cultural population of the borough"*

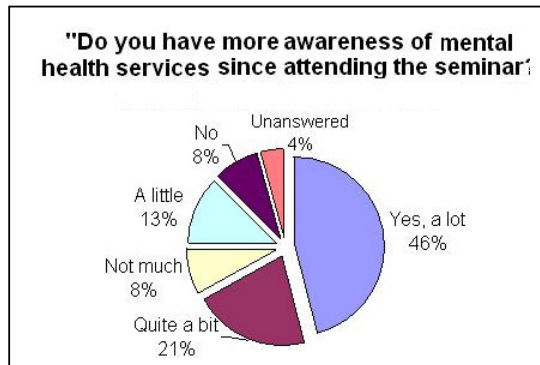
*"Helped us to consider cultural differences when working with patients"*

*"very useful because we work with people from diverse religious and ethnic and cultural backgrounds".*

## 6.5. SLA Outcomes Final questionnaire

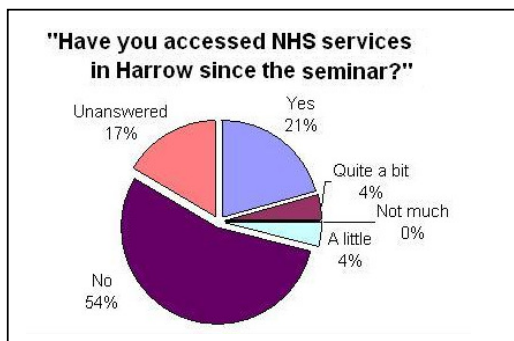
Several months after completing the seminars, a sample was taken of participants, who had given their email address on the registers. These people were contacted, to find out what kind of changes, if any, had occurred, as a result of them having attended the seminar. Twenty four former participants responded to this approach, both by email, and in person at a meeting hosted by a work colleague. The following five questions were put to them by email or on paper:

- Do you have more awareness of mental health services since attending the seminar?
- Have you accessed NHS services in Harrow, since the seminar?
- Since the seminar are you better able to manage mental well-being?
- Do you have a better understanding of cultural concerns since attending the seminar?
- Have you had access to community support services, since attending the seminar?



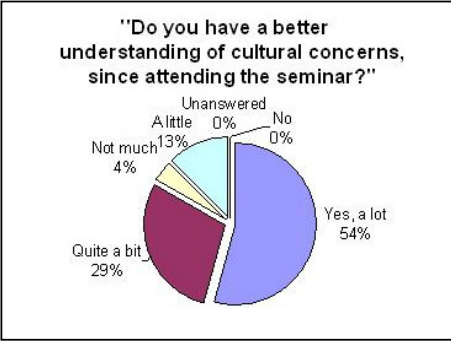
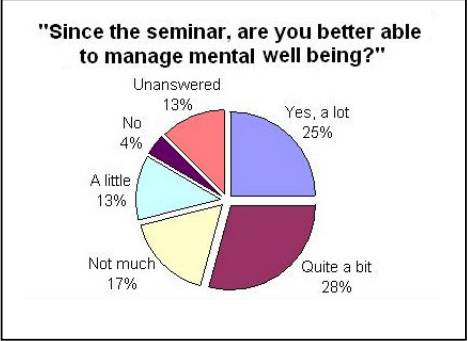
### 6.5.i. Do you have more awareness of mental health services since attending the seminar?

After attending the seminar, 67% of participants said they either had a lot more awareness of mental health services, or quite a bit more awareness of services. Another 13% they had a little more awareness of the service, while 16% said they had not much or none additional awareness of services.



### 6.5.ii. Have you accessed NHS services in Harrow, since the seminar.

Twenty one percent of participants said they had accessed the mental health services since the seminar, but 54% said they had not, and just a few (8%) said they had accessed the service a little, or quite a bit.

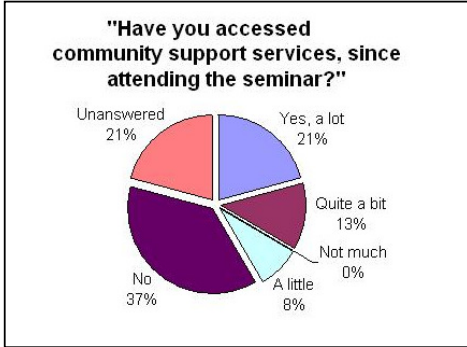


**6.5.iii. Since the seminar, can you better manage mental well-being?**

Of those who responded 53% said yes, they would be better able to manage their mental well-being, either a lot, or quite a bit. Thirteen percent said they were better able manage well being, but 17% said not much, and 4% said no.

**6.5.iv. Do you have a better understanding of cultural concerns since attending the seminar?**

The majority of all participants (83%) said they had a better understanding of cultural concerns since they had attended the seminar, while 13% said they had a little better understanding, and only 4% saying 'not much'.



**6.5.v. Have you accessed community support services, since attending the seminar?**

A third of all participants (34%) said they had accessed community support services since attending the seminar, a lot, or quite a bit. Eight per cent said they had accessed the services a little, and 37% said they had not accessed community services since attending the seminar.

#### **6.5.vi. Open comments**

The following comments were made by those who responded to the final questionnaire:

- *'A good workshop, meeting different people and hearing their views and suggestions.'*
- *'Really enjoyed the session. Great networking. Addressed concerns of Sudanese community very well. Good follow-up. A pity that faith leader/ reps were not able to attend'.*

Other respondents who were service users, felt more confidence in themselves, were less isolated, and became aware that they were not alone:

- *Have noticed lots of improvement in my self since I joined Mind. Got more confidence in myself.*
- *It made me aware that this condition is not unique.*

Some respondents had become more interested in the relationship between spirituality, faith and mental well being, and wanted to take action to promote support, for themselves and for patients:

- *Wonderful experience at Aurobindo Society Centre - would like to pursue further spirituality and mental health in greater depth, taking into account personal experiences.*
- *I have asked for services but little has happened yet. To get heard, I had to go to the acting sector manager!!!*

## 7. SLA Added Value to BME Seminar Programme

### What did we learn?

#### 7.1. Introduction

**Experiential forum.** The seminars offered during the 2009 – 2010 People Like Us project were participatory, with the facilitator taking responsibility for the organisation, structure, content, and the timing. However, it was the input of the participants that created the vibrancy and currency of the discussions, and this provided an experiential forum for much of the learning for those who were present. Participants brought their own dynamic personal, cultural, clinical and professional insights to every single discussion held.

At the end of the longer seminars, participants were usually asked about their views, and that session was like an on-going needs assessment. Questions were put to participants to enquire about:

- Their concerns about health
- The kind of changes that they would like to see
- Their recommendations on the ways to achieve change at an individual or group level

This section of the report supplements the original BME Needs Assessment, completed in September 2008, and offers added value to the Service Level Agreement. The points set out offer a useful means to explore the currency of ways, in which seminar participants themselves wanted to move forwards and create change with BME mental health promotion. I have included this section, on participant's comments about community needs, as it influences the recommendations made at the end of this report. These are useful reading for commissioners, policy makers, and planners.

**Seminar support.** During seminar sessions either a volunteer or a member of Mind in Harrow's staff recorded participants' comments on a flip chart. Those who recorded the data included volunteers: Kavita, Fariha, Nagma, Liz, Michelle, and staff: Nisha and Arvind.

**Settings for data collection.** The data set out below was generated by participants at the following seminars:

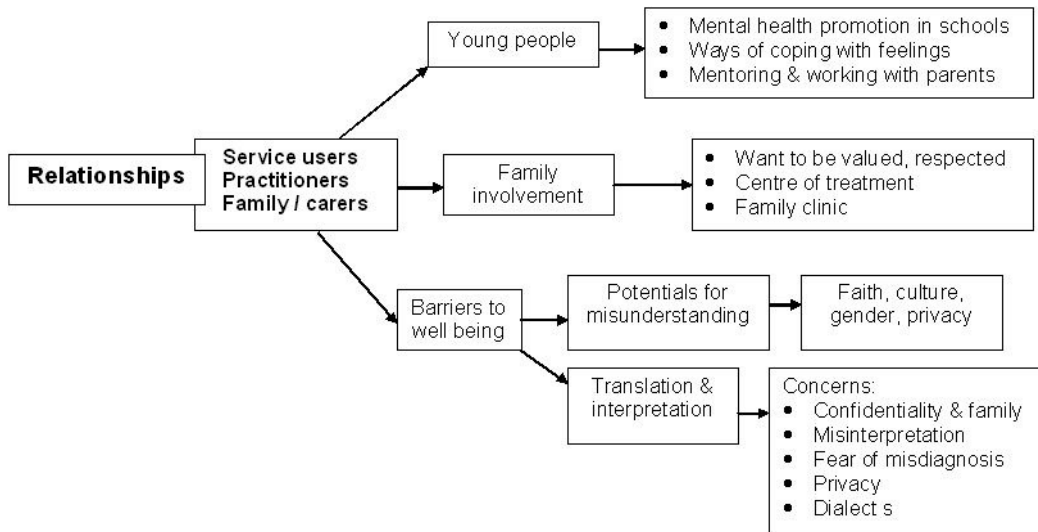
- EKTA, 22<sup>nd</sup> July 2009
- HAVS, 28<sup>th</sup> July 2009
- HAVS & Somali Women, 6<sup>th</sup> August 2009
- Asian People's Disability Alliance, 27<sup>th</sup> August 2009
- Healthy Living Centre, 29<sup>th</sup> August
- Cygnet Hospital 24 September 2009
- Cygnet Hospital, 23<sup>rd</sup> November 2009
- Recession event at HAVS, with NW, Dec 2009
- Sudanese event, Healthy Living centre, February 2010
- NT NW JH meetings, 3<sup>rd</sup> Feb & 3<sup>rd</sup> March 2010

The following section of the report presents topics on participants' input to the seminar discussions, and sets out their needs and concerns, and their recommendations for mental well being in the future.

## 7.2. Participants input to discussion

Participants' concerns about the influences on mental distress, and the strategies to address well being, are included in summary form in **Appendix H**. They are dealt with in this brief way, as they were already addressed as part of the 2008 BME Needs Assessment. The material here is not exhaustive, but it sets out the issues brought up in the last moments of the seminars. This material is participants own concerns and their suggestions to address them. Participant's concerns on three topics are presented:

- Relationship of patient, practitioner and family
- The role of translators and interpreters
- Religious beliefs about diagnosis and treatment



### 7.2.i. Relationship of Patient, Practitioner, & Family

**Young People.** In the meetings participants made various suggestions of ways to create change for young people and offer them practical help:

- Address bullying in school
- Discuss how to cope with feelings, not bottling them up.
- Work with parents so they are aware of pressure on children.
- Take responsibility to work with both mothers and fathers.
- Offer guidance and mentoring to find a way out from problems
- Help them understand mental distress, before it escalates to suicide
- Acknowledge that some of our children and youth have distress and behaviour problems
- Give talks to children at school, raising awareness of mental health problems and where to get help.

**Role of Family.** People wanted the family to be involved in decisions about a person with mental health problems. They wanted family to be at the centre of a treatment, compared to Eurocentric view, where the family may be sidelined. They felt the choice of whether or not to include family should be given to patients. They wanted health care providers:

- To explore the various ways the family deals with situation when a person has mental health problems.
- To provide a family clinic so that patient's mental health problems can be addressed together with relatives. They could adopt good practice as seen in an Indian model of health, where the whole family was involved in mental health.

**Fear of misunderstanding.** Participants expressed concerns about different kinds of misunderstanding which they feared might occur between doctor, patient and family. They felt there may be cultural differences in understanding of beliefs, between patients and practitioners, which could cause barriers. These included concerns about different perceptions of privacy between a patient and their family; and different understanding about culture, faith or gender. Worries were presented that a practitioner may not have awareness of their culture, of the importance of faith and the role of religious activities. They were concerned that doctors may only practice a scientific model of health. Comments included:

- Everyone should be working together
- Health care staff must respect needs of the family
- Doctor may not value family or feel their input is worthy
- Need to respect family wishes, and wishes of patients
- There may need to be a compromise on privacy between the doctor, patient, and family member
- Doctors do not take family member's word for their concerns. They should have an appointment with patient first, and then follow up with family. Family may have insight into psychotic symptoms
- Somali women were keen to point out, that there different concerns needed to be identified between Somali male and female patients.
- Concerns around home birth and postnatal depression
- Patients are not aware of possibility to request second opinion
- People need to come forward early, before a problem escalates, to receive psychological support, rather than psychiatric attention.
- Therapies developed in west not always applicable to other cultures

A sheikh who attended the seminar explained: *"the Somali family is very important. Whatever action taken which puts the family at the centre, is important, because family knows the history of patient. When a patient talks to a health professional he or she is an individual only. We want mental health treatment to be inclusive of cultural needs of patients"*.

Another person said: *"When the community treats a person, it is better, as we know the history, the relatives, and the spiritual aspects"*.

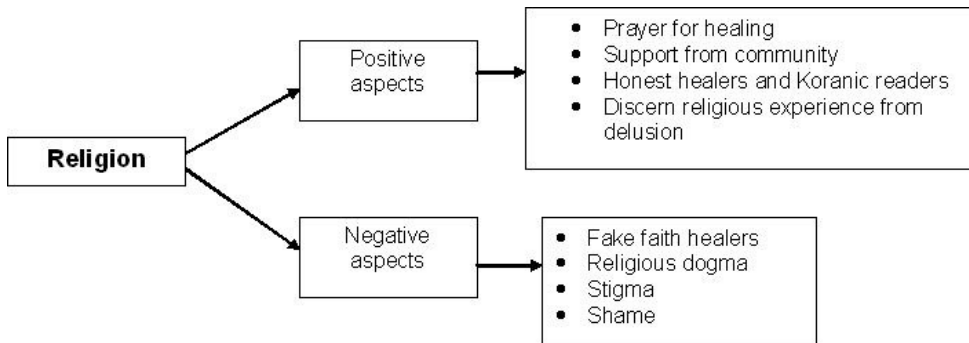
However, a Community Psychiatric Nurse who was present said: *"If any one came to me, I'd look at what they wanted as an individual. It is different for us because we use a very secular model."*

### **7.2.ii. Translation and Interpretation**

Participants asked whether the doctor could adjust to a patient's needs, by simplifying words, and conducting the interview in a simple format. They felt language barriers and problems with interpretation could cause difficulties, which they felt might result in misdiagnosis. They were worried that interpreters may put their own spin on a patient's words, or a patient may respond with incomplete reporting in front of an interpreter, due to shame. They were concerned that:

- Translation may get lost with interpreters
- There may be a disadvantage if family members are asked to interpret, especially regarding confidentiality
- Privacy between patient and doctor may be compromised
- In a country like Somalia, where there are different dialects used in the north and south of the country, attention needs to be paid to the dialects of each person.
- There may be a lack of mental health awareness among interpreters that may cause misinterpretation and result in misdiagnosis.

### 7.2.iii. Role of Religion, Spirituality and Faith



During one discussion, some participants said they felt that religious beliefs helped to heal them, though they wanted both sides to be understood. They were aware it was shameful to be disabled in certain countries, and religion could 'brain wash' people. There were fears about religious dogma influencing treatment, that some faith healers may be con artists, and some were worried that perhaps neither the treatment of the doctor or the faith healer would work.

One woman said *"Religious beliefs help, they calm me down. I am getting help from my creator, the Almighty. I believe in soul and spirit, it is constantly alive, no one can kill it"*. While another feared religious practitioners may be intolerant: *"Suicide is against Islam, when I tried, I was told I did something against my religion"*

There were concerns that psychiatrists didn't always respect religious beliefs in patients. They acknowledged that there were sometimes problems identifying exactly what was religious practice, and what were symptoms of mental health. They said staff may need to get a priest in to confirm whether an activity is delusional or not. Participants identified potential areas of conflict between religion and mental health practitioners, and these included the following:

- doctors own understanding of religion and culture
- gender issues, regarding religious requirements
- clinician's understanding v. patient's understanding of symptoms
- Patient compliance re medication, preference for religious solution

Participants suggested that health care professional might work more with imams and priests in religious organisations, and educate communities more in mental health awareness and pathways to access care. They said medical professionals should open a dialogue with trusted family members, and be supported to recognise and accept family influences. They could:

- Find ways to bridge the gap between community and medical profession in terms of accepting cultural differences, i.e. if family opt for prayer treatments.
- Open spiritual care homes, for each of the faith communities
- Create a space or place where people can go, to get confidential spiritual or religious support

#### **7.2.iv. Women and well being**

What pressures do women have? They hold an important position in the family, and are the holders of family values. They serve as a role model for children, and after marriage tend to neglect their own needs. There are outside pressures: some women leave their maternal home on marriage, some get blamed if anything goes wrong, and their own extended family is not there to help. Daughters are expected to be carers for their parents. In either on marriage or in their maternal home, women have problems standing their ground. They are silent and have to show that they are strong. Positive attention is given to those women who are pregnant. Women say:

- Women have tasks, but men have power
- Women have lots of responsibilities, but fewer rights
- Some youngsters are reluctant to follow customs & traditions
- Depression is a luxury for those living in small villages
- Differences between men from old generation and new generation

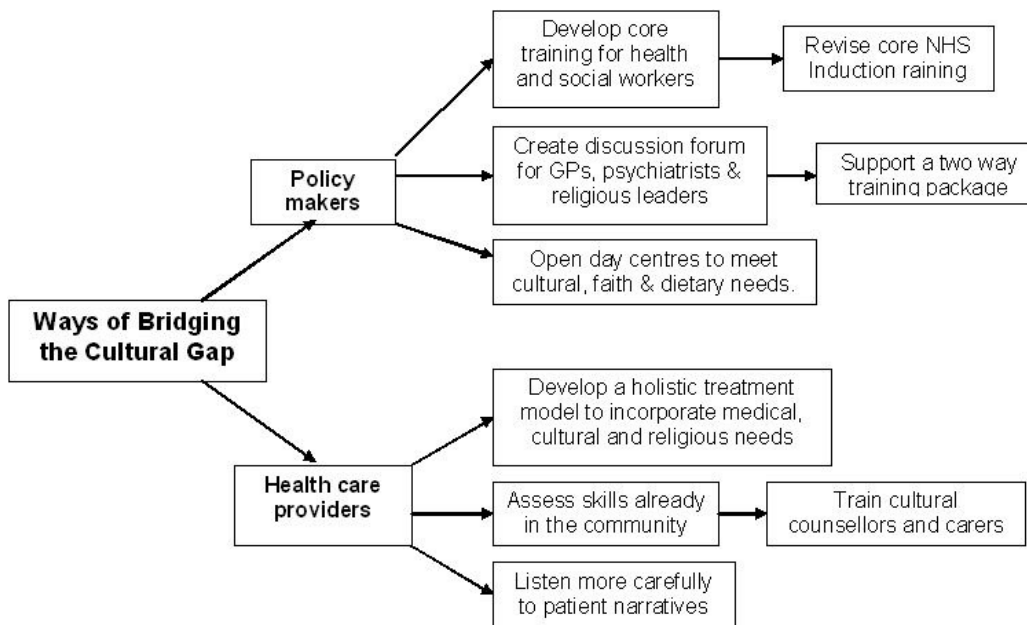
What suggestions do women have to create change? They know that things do change over time. One suggested that we need to teach men domestic tasks. Comments about the role of religion and faith included the following points:

- Religion is more calming
- Religious men help women more
- Different ways of interpreting religion
- Different cultures have different interpretations of religion
- What stops our communities from using health services?
- Written materials are not enough, we need community champions to build trust, and offer mental health first aid
- Find imams and religious leaders, and ask them to include mental health issues in their sermons. Focus on imams to do outreach work.
- We need to find practical things we can do to bring religious leaders, professionals and families together.

#### **What kinds of help do women want?**

- We need front line assistance and support
- Help with recognising ill health, and where can we go for help
- Concern about gossip, confidentiality but language same, cultural background but not local or we won't admit we are suffering
- To avoid duplication, is it possible to share information among statutory services with written consent?
- Use extended family as part of counselling, uphold family values
- Need more sharing between genders
- Yes, there is a lot of stigma. People bring their religious and cultural stigmas to Harrow. Community can stigmatise, or have judgement.
- Some people might have strange beliefs about the ill person (cursed, bad stars) and therefore might treat them like an outcaste or take them to a faith healer instead of a doctor.
- Create change with respect (not conflict)

### 7.3. Community Recommendations: Ways to Create Change

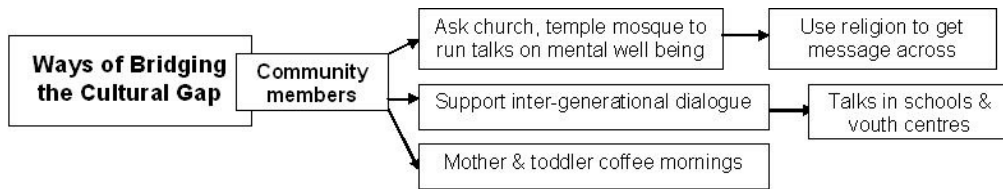


**Bridging the Cultural Gap.** Participants were asked how we could bridge the gap between different cultures and different models of health. They wanted to develop a treatment model that was inclusive of cultural and religious needs, and that offered a more holistic approach. Their suggestions included:

- Take time to hear a patient’s narrative
- Pay attention to others beliefs in a non-judgmental way
- Seek more information and raise awareness about cultural understanding
- Address points raised in the Memorandum of Understanding, from the local government and the different communities in borough to discuss cultural diversity issues and mental health.
- NHS Trust Induction should include more cultural awareness: staff in statutory bodies need to have training built into their job description
- We need to identify Religious Leaders, and train community members in 1:1 religious counselling, and have faith healers who are attached to medical departments

**What change can health care providers create?** Participants who were health care providers made suggestions during the seminars, about ways they thought they themselves could create change:

- Find out about key religious facts of people we treat. With permission and consent, ask if they would like us to contact their community or religious group
- Be aware of clients’ possible discomfort at discussing spiritual things, and also that they can change their perception
- Ensure patients are aware you prepared to listen to and hear their perspective about health and life
- Sensitive cultural action depends on the belief and acceptance of us as service provides, as to whether client is heard, from their own perspective
- Pay attention to our assumptions about visual indicators of ethnicity, as a person’s culture may be complex
- Informally interest your colleagues
- Join special interest groups, SIGs
- Challenge media perceptions



**Ways to create change as an individual.** Participants wanted gaps in information to be addressed through giving talks to young people on mental health promotion at temples, churches, mosques and *madrasah*, and in schools and community centres. They wanted to acknowledge differences between generations, and invite younger and older generations to do activities together at community premises and on projects. They suggested:

- Use our religion as a way to get the message across
- Approach our temples, mosque, and churches and invite them to put up messages and posters about mental well being. Talk directly with groups running in our religious organisations.
- Provide information so that all cultures can be more aware.
- Ask them to provide space for inter-generational dialogue, and practical courses to raise awareness, advertise on leaflets and in newsletters.
- Mothers can have discussions at ladies coffee mornings, mother and toddler groups, evening talks, and lunches.
- We can engage in storytelling, about migration and shared experiences
- Open more day centres which meet cultural, dietary, and language needs of BME community

**Two way training.** Participants wanted two way training for professionals and faith leaders, although they were aware that some psychiatrists and psychologists already get training in culture and diversity. Suggestions for medical and health care professionals:

- Create a forum for psychiatrists to interact with religious leaders
- Develop core training for trainee psychiatrists, social workers, non specialist workers, hospice and palliative care staff, and health visitors
- Work with professional training bodies, e.g. Royal Colleges of Psychiatry, Medicine, Nursing.

Suggestions for community and religious leaders:

- To raise awareness of options for pathways to health care with community and Faith leaders, of partnership approaches to medical and religious therapies
- To develop community based training for carers, and ensure the skills that are already there are used.
- Involve hospital chaplaincies including the imam, sheikh, and African Caribbean leaders, in case they are in front line for a crisis response.
- Train and employ diverse ethnic counsellors, so they can engage culturally with service users

**Spirituality and Faith Training.** Community participants wanted to train specialists so that they were more aware of faith and diversity, and involve the faith and spiritual leaders formally at hospital, and in the GP surgeries. They also wanted training for spiritual and religious leaders in mental health awareness and treatment options. This training should be offered inside the religious establishments. They said: *'Go to where the leaders are'*.

They wanted education needs to be met both ways: for the spiritual leaders in mental health awareness, and also the health professionals in cultural and faith awareness. Some wanted health professionals to deeply consider the background of the person and their family, which affected that individual's health, while others were unhappy at the idea of religion and faith influencing mental health care. There were concerns about health care practitioners' levels of understanding:

- Doctors need to understand how religious beliefs affect our perception of mental health. We need to raise awareness of this in Western culture.
- If doctors do not believe in religion, how can they refer people to get religious support?
- GPs don't have enough time to address religious support people need. In that group. In one group no one had had any input from doctors regarding religious support, which they felt was so essential.
- There is a fear that some patients depend on the culture and ethnicity of the particular mental health teams
- Financial benefits: improve compliance and well being, by using appropriate cultural and religious therapeutic interventions

**Support and Training.** The seminar participants wanted better support for patients, families and the community, with appropriate training to raise awareness of cultural norms and the role of spirituality. They expressed the ways in which they wanted support, with more resources of personnel, for capacity building with more advocacy services, more outreach work by community development workers, and more community champions. They expected more police support for those who were abused, and more time given, so that health care providers could better understand the patients. They wanted appropriate training, and considered it important that both males and females were trained in the various roles, so that carers were better equipped. They requested more training:

- to explore sensitivity and cultural differences
- to challenge the stereotype that it is not possible to hold scientific and spiritual beliefs at the same time.
- To identify different paradigms: 'objective' science v. 'subjective' personal experience, the spiritual v. the mundane.
- To acknowledge different ways of understanding, and different models of health, diagnosis and treatment

## 8. Mind the Gap.

After considering the participant responses set out in the previous section, it seems there are some key areas where we need to mind the gap, in order to create faster progress. These are:

- The academic and education gap
- The practice gap
- The ethnicity gap
- The religion and culture gap
- The finance and commissioning gap

The first is the academic gap, where things are known in academic circles. For example, ethnographic evidence about cultural understanding is widely published as are cultural explanatory models for mental distress, and cultural mental health seeking strategies. There is a gap between what is known in the literature (in published reports, books, and the grey literature) and front line practice. The first gap to address would be to ensure that what is known at the research and literary 'top' of the academic hierarchy is made familiar to those who work at the front line of health and in social care.

Another education gap is the lack of training with BME groups about the relationships between religion, spirituality and mental health, and how this might influence access to health care. The understanding about delayed access is key for both faith groups and service providers. Note: some of the most effective seminars I did, during the 2008/09 project were with ESOL teachers and their students, in class. I was invited into the classroom three times at Harrow College. Students who were new migrants, refugees and asylum seekers, did not have a great deal of English, and were neither familiar with strategies to address mental health, nor with pathways to access care.

The second gap is the practice gap, where things are 'under discussion' by senior managers, but are not yet implemented. Therefore front line staff may not be aware of them, and service users and carers are not aware of them. This is also a time gap, due to the time it takes to put a plan into action. For example in January 2009, the Department of Health published a report (Religion or Belief, a practical Guide for the NHS) on the role of religions and faith in health care, and spelt out its benefits for mental health. The NIMHE Project (National Institute for Mental Health in England) explored role of spiritual beliefs in the assessment, support and recovery of mental health service users.

CNWL has taken action based on these and the New Horizons documents, to put in place a Faith and Spirituality Support Co-ordinator, whose role it is to develop a faith policy to support service users and staff. Mind in Harrow has also employed a Migrant and Faith worker to engage with faith communities and raise awareness of pathways to access mental health services. In order to address this gap, we need to ensure that changes are implemented at grass roots level, and seen to be happening. Religious and Faith leaders are willing to work with the health care services, but frustrated by the delays in training, although CNWL's intentions for training are well underway.

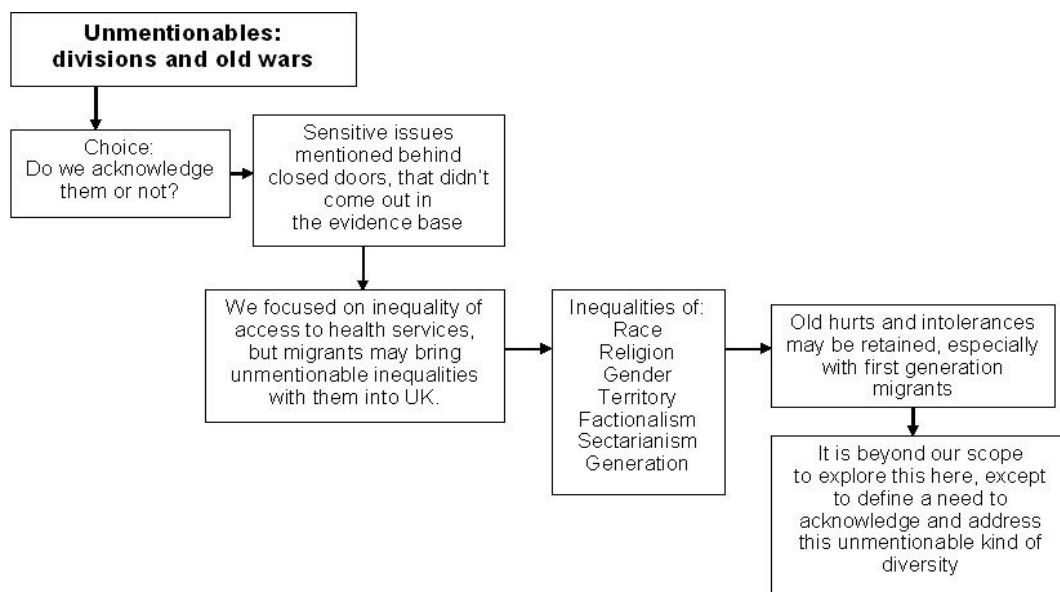
The third gap is the ethnicity gap. Tools for ethnic monitoring are not very sensitive. For example, due to British Foreign Policy, there are more people in Harrow from the Near and Middle East. They are not Asian, African or Chinese, and should be included in future ethnic monitoring forms.

There is also a gap of silence, of those sensitive things we may prefer not to talk about. One of the concerns is the numbers of white health care providers who

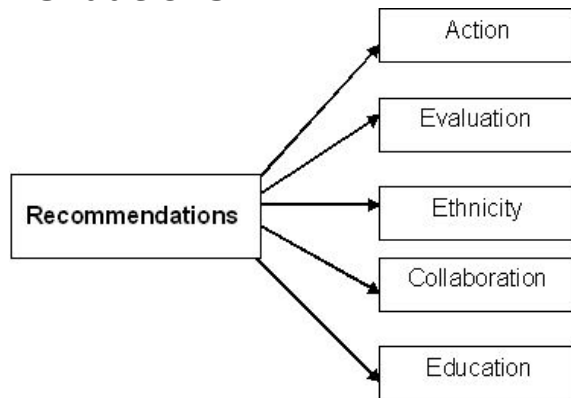
chose or didn't choose to attend seminars. The others seem to be more unmentionable: the divisions and frictions which may be generated in a recent migrant's country of origin, and seem to be played out, behind closed doors, in Harrow. For example the divisions between those who come from Somaliland and Somalia may remain here amongst the Diaspora. Also, in spite of attempts at healing in Sri Lanka, there may still be tensions between Tamils and Sinhalese in Harrow. Of course, everyone politely insists any differences like these don't remain. However, if there is a working party to carry out recommendations here, I suggest its leads ensure members are fully representative, so no one feels excluded.

Within the religion and culture gap there may also be sensitivities, again behind closed doors, between Shia and Sunni Muslims. The original differences date back to the 7<sup>th</sup> century, but they can be live and polarised in Harrow. There are other issues within religion, culture and gender: for example Muslim women from Asian countries of origin may have quite different cultural experiences from Muslim women from East Africa. Again, if there is a working party to continue this or begin another project, we need to ensure it takes these differences into consideration, as well as generational differences. For example, first, second and third generation migrants may look ethnically the same, and may practice the same religion, but may be quite different culturally.

Then there is the finance gap. BME mental health promotion seems to suffer from an annual commissioning and funding hiatus. There does not appear to be a long term strategy for projects, which results in raised expectations and then a potential loss of good will with the target group. Community and faith groups are contacted, willing to work in partnership to raise awareness, and then the funds stop. For example, detailed plans have been submitted for a Pan-African mental health promotion seminar, which is now on hold. There is also a funding gap concerning the remuneration of community leaders: programmes like 'Bridging Cultures Dissolving Barriers' could not have been done without their considerable input of time and effort, for which they receive no fee. Perhaps it is time to address this in the new budgets?



## 9. Recommendations



Recommendations are made in five key areas:

- Action
- Evaluation
- Ethnicity
- Collaboration
- Education

### 9.i. Action

The seminar formula is successful; and meets its targets. It works, to hold a dialogue over lunch, with service users, carers, and providers. The seminars are an excellent forum for learning.

- Define when the Mental Health Partnership Board will assess the evidence here, to develop a continuation schedule, address the recommendations and take BME mental health promotion forward.
- Develop a longer term strategy for BME mental health promotion, to address the annual commissioning and funding hiatus, and potential loss of good will with target group.
- Prepare a budget to take account of fees and remuneration for community leaders.

### 9.ii. Evaluation.

We need a new strategy for data collection. The use of paper monitoring and evaluation sheets is not the most effective way to collect data.

- Learn about digital data capture systems, ask for a demonstration, and a 30 day trial of equipment, to assess how effective it is at capturing ethnic monitoring and evaluation data. If it is effective, include the cost in the budget.

### 9.iii. Ethnicity

Honour the intention for social inclusion:

- ensure working party leads are sensitive to social and political histories of new migrants, refugees, and asylum seekers, when recruiting team members
- Modify the ethnic monitoring forms, to acknowledge Near and Middle Eastern migrants in Harrow

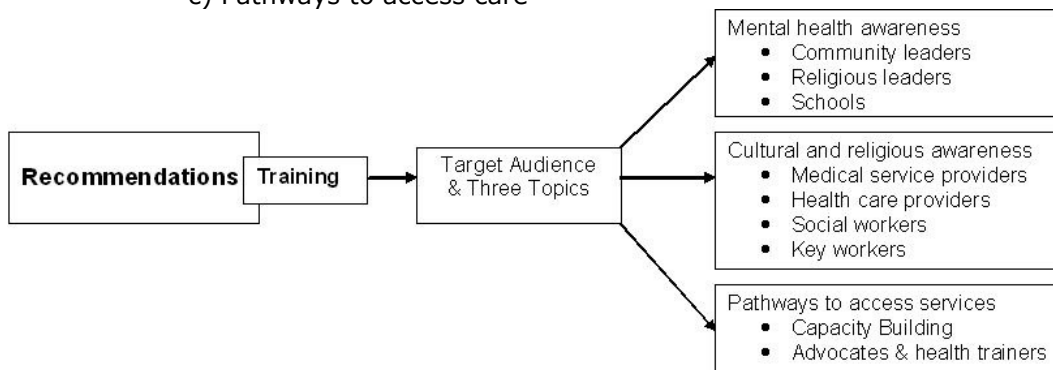
#### 9.iv. Collaboration

Continue multi-agency partnership working as an effective way to achieve outcomes, without duplication of effort. Good targets can be achieved working the Community Development Team, CNWL, and each of the appropriate statutory and voluntary agencies in the borough.

- Ensure working parties for projects are ethnically and religiously inclusive, and not divisive.
- Develop strategies so that policy changes can be implemented at all levels, including grass roots.
- Feedback, to illustrate the results of collaboration, should be built into any project, so that community and religious groups can see their suggestions are listened to, assessed, and acted upon as required. A talking table workshop would be suitable.

#### 9.v. Education

- Develop three training packages for core diversity education training.
- See the diagram below, for which audiences would benefit from which training package
  - a) Mental health awareness
  - b) Cultural and religious awareness
  - c) Pathways to access care



- Mainstream the approach of exploring religion and mental health together. To this end, approach Education Deans, post graduate and undergraduate deans of medical schools, and Royal Colleges.
- Contact Professional Bodies of nurses, doctors, social workers
  - Define stakeholders required to mainstream this training strategy
  - Train school teachers in mental health awareness: junior, primary and secondary
- For community projects, find another way of saying 'mental health', e.g. mental well being, healthy minds.