Mental Health Needs Assessment
with
Black and Minority Ethnic (BME) Communities

Author
Dr Natalie Tobert

Harrow PCT
1st September 2008

Mental Health Needs Assessment
with Black and Minority Ethnic (BME) Communities

CONTENTS LIST

1. Overview **4**

1.i Definitions
1.ii Harrow Population and Deprivation.
1.iii Mental Health and BME populations
1.iv Research with BME Groups in Harrow
1.v Reducing Isolation
1.vi Needs related to Muslim communities

2. Results of Needs Assessment Workshops **12**

2.i Introduction: Research technique
2.ii Workshops and Meetings

3. Beliefs about Triggers for Mental Ill Health **13**

3.i Life in Country of Origin
3.ii Transition between country of origin and Harrow
3.iii Daily Life in Harrow
- General Stressors
- Women's Stressors

4. Messages To Promote Well Being **16**

4.i Positive Ways Forward
- Being Normal
- Episodic nature
- Recovery Model
- Behaviour and Coping Strategies
- Women in Health

4.ii Negative Aspects of beliefs
- Invisible
- Denial and Isolation
- Stigma and Taboos

4.iii Recognising cultural presentations of mental health
- Eurocentric and Culture Specific
- Terminology and Symptoms

4.iv Services and ways to access them
- Signposting pathways
- Statutory and voluntary sector
- Training and Education
- Access to female practitioners

5. Dissemination of Oral information **22**
5.i Oral v. Written Dissemination of Information
5.ii Societies where oral communication is valued
- Personal contact
- Contact via. Elders and Community leaders
- Grounds roots community based

5.iii. Audio Visual
- Television and Radio
- Films & Cinema
- Plays, drama, and documentary

6. Dissemination of Written information **25**
6.i Validity and effectiveness
6.ii Leaflets
6.iii Local Newspapers
6.iv Internet
6.v Language Barriers and Translations

7. Places to disseminate information **27**
7.i. Religious institutions
7.ii Secular places

8. Suggested Innovations by BME Communities **30**
Re. current mental health care system
8.i Places of change
- Pathways to access
- One Stop Shop
- Drop in Centre
- GPs Surgery & PCT

8.ii Treatments
8.iii Education & training
  - Cultural Brokers
  - Cultural Diversity

9. What does the data mean? **35**
- Plural Ways of Understanding Knowledge
- Theories of Causation
- Therapeutic Approaches
- Confidentiality and Privacy
- Models of Mental Health
- Different Approaches to Mental Health Promotion

10. Recommendations **39**

Bibliography **42**

Appendices **44**
A World Health Organisation on FGM
B Selected notes on promotion with Muslim Audiences
C Models of Understanding
D Key Differences in Approach
E Ways of Presenting Information

Mental Health Needs Assessment with Black and Minority Ethnic (BME) Communities

Dr Natalie Tobert

1st September 2008

This needs assessment focuses on BME groups in Harrow. It has the following aims: to assess mental health needs of BME groups living in Harrow; and to explore strategies to improve mental health and reduce health inequalities.

Harrow is the 9th most ethnically diverse local authority in England & Wales, with over 40 different ethnicities making up its population[1].

- 58.8% white
- 29.6% Asian or Asian British
- 2.6% Chinese or other ethnic group
- 6.1% Black or Black British
- 2.8% Dual Heritage

One third of Harrow's residents were born abroad, in 137 different countries, including Iran, Afghanistan, Eastern Europe, Somalia, and the Middle East. Harrow has the highest level of religious diversity of any local authority in England & Wales:

- 47% Christian
- 20% Hindu
- 7% Muslim
- 6% Jewish
- 16% no stated religion

Religion plays a central role in peoples' lives, but ethnicity is not necessarily an indicator of religion: a high proportion of black people are Christian; there are over 1300 white Muslims; most Indians are Hindu or Sikh, some are Muslim. The PCT recognises the need to provide appropriate mental healthcare services, to consider the population's multiplicity of cultural and religious beliefs, and to appreciate similarities and differences between ethnic groups

The first part of this report presents information on the borough's population and deprivation, an overview of mental health and BME populations, and a summary of specific research done in Harrow.

1.i Definitions

According to the World Health Organisation mental health is "*a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity*[2]". Physical well-being and mental well-being are inseparable, as part of a package of achieving a state of wellness. In the foreword to their report, the authors note that "*mental health is paramount to personal well-being, family relationships, and successful contributions to societies*."

In 2002, the Department of Health commissioned CVS Consultants and the Migrant and Refugee Communities Forum to make a study of the mental health needs of refugees and those newly arrived in the country[3]. The authors offer an excellent literature review on mental health needs of refugees in UK, and they include literature produced by community organisations themselves. They have a detailed bibliography. Their data is based on 38 interviews with different groups in UK.

---

[1] Census 2001, Harrow's Diverse Communities, June 2006

[2] WHO, mhgap 2007

[3] CVS Consultants & DOH 2002

They wanted to determine what refugees understood by mental health and well-being. They give working definitions of the terms refugee and asylum seeker[4], which I repeat below.

According to the 1951 UN Convention the legal definition of a refugee is:

> *"a person who owing to well founded fear of being persecuted for reasons of race, religion nationality, membership of a particular social group or political opinion, is outside the country of nationality and is unable, or, owing to such a fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, unwilling to return to it"*[5]

According to the Immigration Act (1971) an asylum seeker is:

> *"a person who may apply for asylum in the United Kingdom on the ground that if he were required to leave, he would have to go to a country to which he is unwilling to go owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion. Any such claim is to be carefully considered in light of all relevant circumstances".*

1.ii Harrow Population and Deprivation.

This project addresses issues raised in the following publications. Harrow Primary Care Trust published an annual report in 2003, which summarised mental health needs of the borough[6]. The government published its white paper[7] 'Choosing Health' in 2004 with the aim of tackling inequalities and inviting people to look after their own health. In 2006, the DOH 'Health Profile of England' set out key indicators on UK health, and presented the scale of the problem, and the geographical variables in health inequality[8].

One of the most important documents to consider for presenting details on specific areas of deprivation in the borough is Harrow Vitality Profiles[9]. The data was first published in 2004, to help develop priorities and plan a strategy for mental health promotion. It provides maps illustrating differences between the various geographical areas.

The most densely populated areas of the borough are in the most southerly wards. These include Kenton East, Wealdstone, Roxbourne, and Edgware with densities of over 70 people per hectare[10], while West Harrow and the Rayners Lane estate have population densities of over 100 pph. According to the Census of 2001, more people of white ethnicity are resident in the north of the borough.

Asian populations numbering over 45,000 people (30% of total, including Indian, Pakistani, Bangladeshi, Sri Lankan and East African) are more resident in the southern part of Harrow, in Kenton, Queensbury, and Edgware wards[11]. Those of Black ethnicity (7% of residents, including Caribbean, African, and dual heritage) live around central and south Harrow in Roxbourne, Roxeth, and Marlborough, whilst more Chinese (3.5%) live around Edgware.

According to the indices of deprivation[12] Harrow is 31st out of the 33 London Boroughs (where 1st is the most deprived). In many cases Harrow is below the national average, but above the London average. Most income deprivation affecting both children and older people is in the south and centre of the borough. Compared

---

4 UNHCR
5 CVS Consultants 2002, p.7
6 Improving Health, Harrow PCT, 2003
7 Choosing Health, Government White Paper, 2004
8 Health Profile of England, DOH, 2006
9 Vitality Profiles, Harrow Strategic Partnership, 2006
10 Vitality Profiles, p.13, 2006
11 Vitality Profiles, p.15
12 Indices of Deprivation, ODPM, 2004

to other London boroughs, Harrow is better than average for health and disability deprivation, with only one ward (in Roxbourne) part of England's most deprived 20%. Note: health deprivation indicators include emergency admissions to hospital, mood and anxiety disorders, and suicides[13]. Wealdstone had the highest rates of people getting treatment for drugs and alcohol. Amongst the drugs detailed in the report, *quat* (a stimulant used by Somali people) was not mentioned.

The Vitality Profiles document outlines areas of the borough where many of the population are aware of the state services, claiming incapacity benefit, disability living allowance and income support, with concentrations around the council housing estates. The wards of Harrow Weald, Wealdstone and Marlborough had the lowest life expectancy rates. Marlborough had the highest rate of people placed in temporary accommodation, with Wealdstone and Queensbury next. Note: homelessness figures are derived from the people placed by the council into temporary accommodation. Roxbourne had the highest number of social rented properties.

Concerning social care, children in need in the borough vary throughout the wards: in Headstone North the rate is 8 per 1000, whereas in Marlborough it is 38 per 1000. However, these details include only those children known to Children's Services. Of the borough's adult population, 1.3% receive support from Adult Community Care Services, with more need in the central and southern parts of the borough, and in the Roxbourne and Stanmore Park areas. This includes people with mental health problems, but not those in residential or nursing care.[14] The ward of Greenhill has the highest number of older people in need, who registered that they need care. In 2005, 7.3% of the population were aged 65 and older. In 2001, 1 in 10 of all Harrow residents were carers, some 20,550 in number.

In 2005, the MORI Social Research Institute conducted a poll to research on perceptions of Harrow residents[15]. Data collected indicated that 39% of the population considered the council was successful in dealing with health and social care services, while 21% felt they were unsuccessful. Residents of South Harrow and Rayner's Lane, 48%, said they noticed successful improvements in health and social care services, compared to those with Stanmore, which was only 29%. Residents over the age of 65, more frequently said that health services had improved, rather than younger people.

1.iii Mental Health and BME populations

The World Health Organisation suggests that substance misuse and mental health problems are associated with poverty, marginalisation, and social disadvantage. They suggest that there is a need to understand the situation of people who have substance related mental health problems, and protect the human rights of people with those disorders. These disorders result in premature or mortality. Stigma towards people with mental, neurological and substance use disorders increases their vulnerability and decline. Relative poverty, low education and inequality within communities are associated with increased risk of mental health problems[16]. People in the Somali community in Harrow, who use the drug *quat* and mix it with alcohol or cannabis, fall into this category of individuals.

Migration means people with different cultures come together, which Bhugra and Minas identify as collectivist cultures and individualists cultures[17]. This difference in

[13] Vitality Profiles, p.27
[14] Vitality Profiles, p.106
[15] What residents are telling us, MORI 2005
[16] WHO, mhgap 2007, p.6
[17] Bhugra & Minas 2007

cultures leads to distress and dysfunction in some people. People develop distress, because they do not have access to their normal community of support. "F*ragmentation and erosion of identity, the loss associated with displacement from familiar context and support networks, the difficulties of settlement, and the pressures on accustomed family structures and relationships can increase vulnerability to mental illness*[18]*."* Bhugra and Minas say research conducted "s*howed the effective delivery of mental health programme to immigrants, who are in the minority have little effect on mainstream mental health services*." I have discussed the features of different cultures in section two of this report, together with their significance for approaches to mental health promotion.

The report mentioned earlier, commissioned by the Department of Health, presented some of the stressors for migrant populations[19]. These include the following: stable marriages in the country of origin, may come under pressure once the family arrives in UK. Family structures may break down and there may be specific problems with regard to women refugees. High levels of stress experienced by some refugee groups, as a result of trauma or war, might be identified as PTSD in this country[20]. However, this is not always recognized. Depression is described as a side effect of trauma.

Suicides are virtually unknown in a country like Somalia, but occur frequently in UK amongst young men. Bereavement, as a result of coming from a war situation is common, particularly when the body of the deceased is not found, the appropriate religious rituals may not have been conducted, and grieving has not taken place.

It is common for psychiatric problems, to manifest themselves in a somatic manner, physically in the body. Memory loss and anger become normal. Drug abuse occurs. There is a particular problem with the Somali people and the use of the unrestricted drug *quat*.

On arriving in this country, some refugees may have problems, acculturating themselves with the lifestyle in the new society. Lack of acculturation can lead to depression and despair, and may also lead to culture shock. People may have had good education and jobs in their country of origin, and a rich network of family and friends, but here they do not. Suicide may result from this loss of social standing, and an inability to cope with that loss[21].

However, the authors note that being a refugee does not automatically mean that one has mental health problems, and it can be an indicator of a human being's capacity to survive. This needs assessment explores whether the points raised above are relevant for the BME community in the borough of Harrow.

In UK migrants may experience instability, with regard to finance and housing, and racism due to their differences with the host community. People's attitude towards mental health is different and sometimes they do not understand how the term is used in a western situation. People have different interpretation of the term mental health, for example:

> "A *person is either 'sane' or 'mad' in Somalia, there are no degrees of gradation in between and there are no words for anxiety, psychosis, counselling etc. The concept of mental illness amongst Somalis… is limited to severe mental disorders, and does not extend to depression or stress…. Until recently the only facilities were asylums without treatment where the very seriously disturbed were incarcerated"*[22] .

[18] Bhugra & Minas 2007, p.6
[19] CVS Consultants 2002
[20] CVS Consultants 2002, p.12
[21] CVS Consultants 2002, p.17
[22] CVS Consultants 2002, p.20

This was also recorded by the Scoping Exercise conducted with BME groups in Scotland, where the authors realised that the word 'mental' was associated with mental illness, and not mental well being[23].

The report highlights some key themes to address, which this needs assessment will consider during focus group workshops and meetings. These include:

- Mental health problems are not always recognized.
- Mental health problems may be as a consequence of migration itself.
- Migrants may have different understandings of the term mental health, and different responses to it.
- They may not be clear about the pathways to access mental health services.
- They may regard practical issues, like housing as being more important than mental health.

The DOH report in 2002, offers a useful presentation of: basic symptoms of refugee mental health; the broad range of factors that may impact on a refugee's mental well being; and it points to positive and negative factors that may assist or hinder recovery. Concerning the topic of health promotion, there is the concept of resilience, the ability to survive against all odds. Also useful recommendations for well-being, are good levels of activity, and being acknowledged by others. We need to look at the cultural appropriateness of beliefs about triggers of mental ill health, diagnoses, and treatments, in order to advance mental health promotion. Charles Watters suggests that there are four issues, useful for mental health and well-being[24]:

- Contact with family members
- Good support links with the local community
- A strong religious or political ideology
- A proactive problem-solving style

1.iv Research with BME Groups in Harrow

Harrow is the fifth most ethnically diverse borough in the country, and the 2001 census says 41% of the population belong to a non white ethnic group. This is higher than the London average of 29%, and the national average of 9%.

The national branch of MIND, is currently mapping refugees and asylum seekers in UK, and exploring the needs of those communities. Their research is ongoing, and a final report not yet available[25]. Mind in Harrow is currently running several projects that address mental health needs of BME communities, one with the Somali community [26], and one which was recently completed on the Gujarati community[27]. Mind in Harrow also conducted an earlier research project, which mapped health access for Somali, Iranian and Afghan asylum seekers[28].

When the Open Up project ran a Somali community mental health workshop in Harrow, in January 2008, the meeting identified the concerns of the Somali community, and noted about their comments about discrimination and misdiagnosis[29]. They made a series of recommendations for change, one of which was to develop training and education for both mental health workers and the community to make services more accessible. The data generated by this needs assessment goes some way to offering more culturally appropriate information.

---

[23] Scoping Exercise, UCLAN & NHS Scotland, Aug 2008
[24] Watters C 1998
[25] Solle D, Aug 2008
[26] Mind in Harrow, Annual Report, 2007
[27] Gujarati Speaking Asian Elders, 2008
[28] Mapping Health Access, 2004
[29] Open Up meeting notes, January 2008

A report commissioned by Mind in Harrow in 2004, had a team who conducted research, mapping health access for refugees and asylum seekers in the borough[30]. Focus groups were run, in order to discover healthcare issues for refugees, and to identify where there were gaps in service provision. They wanted to identify the pathways that refugees and asylum seekers used to access mental health care services, and they noted how to contact vulnerable individuals and to use the most appropriate methods to inform them about the services. They also made a series of recommendations to raise awareness of the needs of refugees and improve the health care available to them.

The report found that refugees had little awareness and understanding of the kind of services that were available, had a poor understanding about the NHS system, and about mental health services available. They relied on community organisations for support[31]. Younger members of the families had a better understanding of the health services, but made less use of them. The researchers found refugees did not understand the treatments administered to them. There were frequent, missed appointments, and negative experiences of hospital care.

At that time, they noted that GPs were not providing interpreters, and when they were available, they were not aware of the different languages spoken by the Afghan community. Some were asked to bring their own interpreters. The authors noted that there was a problem with the lack of adequate material translated into the appropriate languages. They were aware of the problems of asylum seeking, together with its uncertain future, and no right to work.

With regard to awareness of service, they write: "*very limited knowledge on what mental health services are available and how to access these services for all refugees from all the communities and sectors in the focus group*". They noted that there was a problem when female patients requested female staff to deal with their ailments. They identified the need to translate health material, and noted that awareness of services and ways of accessing them is poor.

The final point in their conclusion, says "*it is clear that training and service providers about working with refugees and training communities on service and referral awareness is required. This would help bridge the gap that exists between mental health services and refugees and their communities"***.** They recommend that translated material should be available to all refugees, that it should be distributed in appropriate places. The interpreting service should be available, including female interpreters. Education needed to take place to ensure patients understood the options for Healthcare services.

They also say there needs to be a link between health care and refugees. "*This needs to be improved by increased communication and training of both refugee communities and service providers*". They hope that "*services will become more culturally aware and provide services sensitive to the needs of refugees communities*."

The Autumn Assessment of Mental Health 2004 outlines the local implementation of BME mental health review[32]. It suggests that the mental health service should be appropriate to the needs of those who use it. The authors acknowledge that BME ethnic groups tend to suffer from poorer health, have reduced life expectancy and experience of greater problems with access to health and social care than the majority white population. There was a need for advocacy, but none was available for BME users at the time of the report. They noted issues about racial harassment

[30] Mapping Health Access, Wasp et al 2004
[31] Mapping Health Access, 2004
[32] Autumn Assessment 2004

and wanting to reduce the disparity in treatment and outcome in the populations but did not make any specific suggestions as to the way this might be done.

In 2005 Harrow Council for Racial Equality undertook work to improve BME access to services, of which the largest number of clients was for mental health services.[33] They supported 300 clients in their asylum seekers and new arrivals project for 10 months. They provided advice, support and practical casework, and they noted "*the need for a one stop shop for asylum seekers, new arrivals and refugees, particularly from the Asian and black and ethnic minorities is essential*."

They found the project was a very valuable service, but it ended when the funding ended. They also had a health advocacy and referral service, funded by Harrow Primary Care Trust, in order to improve BME access to health service. Their aim was to increase awareness of health services, and reduce health inequalities and social exclusion.

The project saw 53 clients, the majority of whom self referred. Many clients came from the area of Wealdstone, which had been flagged as an area of severe deprivation and need. Other wards that they noticed with high client numbers included Harrow, South Harrow, Rayner's Lane, North Harrow, and Stanmore. They suggest future health interventions should be aimed at these areas.

This needs assessment complements the one conducted by Husbands and Thomas in Harrow, which was commissioned by the Mental Health Partnership Board in 2007[34]. The authors noted that there was a direct relationship between household income and likelihood of being diagnosed with a mental disorder[35]. They said more information was needed about black and minority ethnic groups, so that appropriate services could be planned.

They considered that the BME population required targeted measures for mental health promotion, in order to address cultural and religious backgrounds of the groups. They noted "*refugees and asylum seekers have special mental health needs, in particular in relation to displacement, separation and post trauma*"[36].

1.v Reducing Isolation

In Harrow, there is twice the number of people with depression as one would expect from the national average, and nearly twice as many people with a diagnosis of psychosis, compared to the national prevalence. They suggest this is for the following reasons: "*The ethnic diversity of Harrow and its significant refugee population are probably contributing to the apparently higher than expected level of mental health need, as judged by comparisons of service use*"[37].

Husbands and Thomas address the issue of communication, and suggest that users and carers need better information about what services are available, not only from the health services, but also social services, housing, employment and the voluntary services. They recognised that employment can help people's mental health problems, and noted the 15 places of supported employment with every hundred thousand of the population.

he authors expressed concern over the level of services for young black people, and men, and highlighted that there were inequalities in areas particularly with regard to ethnic minorities and refugees.

---

[33] HCRE Annual Report, 2005/06
[34] Husbands and Thomas 2007
[35] Husbands and Thomas 2007, p.10
[36] Husbands and Thomas 2007, p.20
[37] Husbands and Thomas 2007, p.41

The point was made earlier about the beneficial effect of activity in inducing well-being and reducing isolation. During 2007 and 2008, several conferences have taken place in Harrow, looking at vocational and prevocational strategies for mental health service users. Participants at the conferences recognized that isolation was a barrier to recovery from mental health illnesses. Steps were needed at a pre-vocational level, to allow people to increase their confidence and develop life skills, as a way of beginning social inclusion. This was seen to be a necessary step before offering people vocational services, to get them back into work or education[38].

During 2008 people who attended those conferences noted that they still wanted an improved dialogue with decision-makers. There was a suggestion that both employers and front-line health care professionals should have more awareness of support available. A need was highlighted for regular evaluation in order to assess the effectiveness of the measures.

Refugees and asylum seekers in the borough come from Afghanistan, Iran and Somalia, and numbered around 500 in 2003 who had registered, although the actual number is thought to be much higher. There are fairly high levels of mental health needs in the Somali population, but it is thought that they used the service relatively infrequently[39]. However, those who were attending educational courses or working had less mental disorder than those who were not.

1.vi Needs Related to Muslim Community

An interesting comment by MI5 was recently reported by Alan Travis[40], the home affairs editor of the Guardian newspaper. MI5 had conducted research into terrorism in Britain, and discovered that the terrorists were mostly British nationals, not illegal immigrants and, far from being Islamist fundamentalists, most were religious novices. MI5 said there was evidence that a well-established religious identity actually protects against violent radicalisation.

Some years earlier, one of the project workers at Mind in Harrow had written an essay on Islam and Muslims being presented in a negative media context and wrote "*We seldom have such an exhibition of religious affiliation with peoples of other faiths, who are involved in untoward activities*." She said: "*mistrust, hostility and misunderstanding can breed between communities and social exclusion can affect people's self-esteem and mental health*.[41]"

Ishaq suggested that in order to do mental health promotion among the Muslim community, we should explore how their religious beliefs affect the perception of illness. "*The Koran states that no soul is burdened with more than it can bear, so some Muslims take comfort from this, and it strengthens their belief in themselves.*" She claimed that people of the Muslim faith may believe that they have strayed away from the teachings of Islam, if they acknowledge that they feel distressed. With treatment, it helps the people have a connection with God.

After reading her comments, I interviewed one Harrow resident, whose family originally came from Pakistan[42], on the topic of mental health promotion with Islamic communities. He had incorporated religious teachings as part of a health promotion package when he worked elsewhere in UK.

Data generated in focus groups and interviews with members of BME communities in Harrow is presented in the following part of this report.

---

38 Lawton-Smith S 2007

39 Husbands and Thomas 2007, p.16

40 Alan Travis,, 21st August 2008

41 Sameera Ishaq ND

42 Reehan Mirza, see Appendix B

Results of
Needs Assessment Workshops

2. Introduction

2.i Research technique

This project used qualitative ethnographic research techniques, to ascertain mental health promotion needs of the BME population from their own perspective.

The author has a professional background that lies within Medical Anthropology, and this report is influenced by that discipline: the author is not a medical or health care practitioner.

Participatory research with stakeholders from different BME communities generated information about:

- the key messages they wanted to promote to enhance mental well being
- the strategies they thought were the most appropriate for a mental health promotion programme among Harrow's BME communities
- their understanding of triggers for mental distress
- their suggestions regarding innovations

The research addressed the proposition that different cultural groups may have different explanatory models for mental ill health, and this meant cultural beliefs may influence perceptions about illness, and peoples' subsequent timely access and uptake of statutory and voluntary health services. The key messages encouraged suggestions for ways of reducing isolation and enhancing social inclusion.

The underlying assumption was that there were variables of age, gender, and historical background, each of which had particular mental health promotion needs. For example, some people had migrated for voluntary reasons, perhaps as economic migrants, whereas others were forced migrants, as refugees and asylum seekers from war torn countries.

As the meetings progressed it became clear that females of one community had different mental health needs from men of the same community.

2.ii. Workshops and meetings

Meetings were attended or workshops facilitated with the groups in the chart below, which presents the numbers attending (50 in total) and their ethnicity (the facilitator has been included in the count for each group meeting). Four focus groups were run, there were two more informal meetings with counseling centres, and the author also interviewed two men: one member of the Somali community, and one from the Pakistani community. The data generated during these meetings is presented below.

Organisation	Numbers attending	Ethnicity	Gender
Age Concern Harrow, POP	8	3 Asian 1 black 4 white	6 women 2 men
Harrow Women's Centre	3	1 black 1 Asian 1 white	3 female
EKTA, South Asian Mental Health Service User Group	13	12 Asian 1 white	8 female 5 male
Yakeen counselling	8	3 Muslim 4 Hindu 1 white	8 female
Somali Community Group	12	11 Somali 1 white	11 men 1 female
Somali Family Support, Muslim Women	13	Somali x 7 Ethiopian x 2, Pakistani x2 White x 2	13 female
Total includes facilitator in each group	57		

Figure no.1 Group numbers, gender and ethnicity

3. Beliefs about triggers for mental ill health

The research was originally focused on two questions: one, about the kind of message BME communities would like to see used for mental health promotion, and secondly an exploration into the most appropriate strategy for mental health promotion. However, I felt it was also appropriate to address BME theories about illness causation, as these influenced their health seeking strategies.

People attending workshops and focus groups for this health promotion project wanted their beliefs about triggers resulting in mental ill health to be acknowledged. This is in order to create an explicit understanding, so that patients, health care providers and the host community know where each other are coming from. They wanted people to understand the historical background of migrant communities in order to better understand why they get mental distress.

For example, the Somali population would like the host community to take account of several issues, which influence the causes of mental illness: i) people's life in their country of origin ii) the transition between there and Harrow, and then iii) mundane daily life in Harrow. I have given examples of each below.

3.i. Life in country of origin

The history of the country of origin is significant, and it helps to explain why people migrate to Harrow. One man said: "*In Somalia, there has been a civil war over the last 18 years. There has been a lot of trauma and anarchy, and many people have fled from the Civil War to different parts of the world. When Somali people come to Britain, they are already traumatised. Some of them have seen their families killed in front of them. Some women have been raped. Because of this, people have a lot of scars in their mind. Coming to a new country, the dynamics of the family change. Somali society is male dominant, and here they have to adapt to a new environment and a new system. The children assimilate very easily with the new society, and many men become redundant, and this creates a lot of anxiety and depression. People don't know about their future, and this creates further trauma*[43]".

[43] Abdi Gure

3.ii. Transition between country of origin and Harrow

One young man, who attended the Somali Workshop, and had remained silent for most of it, explained his situation**:**

"I am the youngest here. There are many people older than me. I want to express myself through my mother language.

One of the causes of mental illness is the stress that a person suffers. One of the major stresses is unemployment. Another stress is that when we come here, we have to take status from the Home Office. Back home, we don't need it, we never think of having any status. So here, if the Home Office rejects us, we might get mad. It is stressful. We might be deported. We can't prepare for or predict our future. We are trapped in an unforeseen future. This causes a lot of stress, and a lot of mental illness. It is important to understand this about Somali refugee status. This is one of the key factors of our time, am I going to be deported or not? Where should I flee? How can I survive here? How can I work? I cannot get any benefits. I am not entitled to anything. This is madness itself. It is a vicious cycle with no exit.

Most of the people who get sick, they are younger, and employment is the biggest issue. One of the reasons, we may get mentally ill, is that we live in the wider community, where many people are entitled to work, but we are not. Many people have access to employment, but we sit there idle. I look at others, and I feel powerless. Even within the community, no one can help. Like this, even a person might commit suicide. That is what happened a few years ago amongst the young Somali, they had the highest suicide rate in London.

My suggestion to create change, is to lift the pressure from the person, when he applies for asylum, so he can look forward to a future, and access to education and employment. So he can build his future, on the basis that other people built theirs. By granting asylum when a person applies. If we leave from a civil war situation, through hell, through a difficult situation to arrive here in Harrow, we already arrive here with heartache. The solution is to educate the people and to create an employment environment, where people can get work."

3.iii Daily Life in Harrow.

General stressors. There are various stressors, which in combination, may be triggers leading to mental ill health. Those given in the workshops include accommodation issues, such as poor quality housing, large families, and no security of residence. Recent migrants may also have the following problems inhibiting their well-being: language barriers and literacy problems, cash shortage, drug abuse, and isolation.

Other factors influence peoples' coping strategies including having no extended family in UK due to migration, and therefore less support in Harrow. In certain countries of origin, the community (Arabic: *ummah*) and the extended family is the norm, rather than the nuclear family as in the west.

Peoples' religious faith helps them to cope, but they want other support as well. Migrants bring their beliefs about religion and spirituality into the UK, and into Harrow. Another stressor might be the religious prescription which is placed on stress: resulting in problems about guilt, and lack of ability to have the esteemed quality of self-reliance. There may also be traditional beliefs about religion and ritual which people prefer to adhere to[44].

[44] Gujarati Speaking Asian Elders 2008

There are other issues which influence migrant person's well being. Sometimes people experience culture shock, especially when they don't have the support of the extended family.

- *Peoples understanding of time is different. Here, time is very specific whereas in Somalia it is expandable, infinite. This is a problem, with regard to appointments.*
- Letters arriving in the home come from various agencies, from immigration, from the home office, from car insurance, from the mortgage, utilities bills, TV licence. There are so many letters that people cannot handle this. Sometimes people don't pay their bills for six months because they don't open their letters.
- *In Somalia, the drug quat was not a problem, it was taken in ceremonial or social circumstances. People would only take it for an hour or two. Now everybody is using it for mass consumption, even females and young people. It is legal in UK, and we know that it causes psychosis.*

Women's stressors. For women there may be additional stressors concerning childbearing and contraception. People want larger numbers in their families, as was normal in their country of origin. Some believe that contraception is wrong, against the will of god, and may only be used if a woman's health is in danger. Repeated births are normal in some societies, but in Harrow, they may become a problem, when there is little or no extended family support.

There may also be mental health problems if a woman gives birth to a girl child, as this can create depression, or rejection by her husband and his family, or a woman may have postnatal depression. There is also a problem if a woman has a late child or no child, and then there may be a risk of divorce.

Women also feel that hospital staff are critical of repeated births, and they seem to fear foreign women, and they can be rude. They feel there may be racism, that white people are treated differently from other races. They feel staff at the hospital maternity unit in particular, do not listen to patients.

FGM (female genital mutilation) is seen as a trigger for mental health problems for women of African origin. Some women in Harrow develop ill health as a result, with fistula, have problems with their period, and have problems urinating. There is a fear that they won't satisfy their husbands sexually, if they don't have it. Repeated births mean that they are repeatedly cut and re-stitched. The women in the group felt differently about it: one said that pharonic circumcision was not very much and was okay, while others said it was not part of the religion, it was part of east African culture[45].

One participant said she campaigned a lot about circumcision, but found people did not want to hear about it. *"They take the children to the airport, to take them abroad to do the circumcision. This is done to children of five years old, and it is haram. It is not part of the religion of Islam."* Another said she would not circumcise her daughters: *"I will never, never touch my daughters".* However her family were putting pressure on her asking whether her daughters had been circumcised, wanting to know how they could get married, and be seen to be a virgin, if they hadn't been circumcised.

One woman explained: *"In Somalia and Sudan it is type 3. On the wedding night the parents and the in-laws check that the girl is intact. If the girl is not a virgin, some men with a bad mentality, will divorce her straight away."*

One of the women in the group was from Pakistan, and she said: *"I am very shocked. I cannot believe I am hearing something like this."* Another, who was

[45] Reehan Mirza, Appendix B

a school teacher of Pakistani origin said: "*I wanted to bring this issue up because in schools, this is my job as a Moslem woman and teacher, to know about these things. But this is not my culture, I am from Pakistan. We have plenty of Somali girls in the school, and we can't understand why girls of between five and six years old, are taken on holiday during term time. When they come back, small girls, they can't do PE, they have problems doing physical exercises, and they can't control their urine. I had no knowledge about this. This is in reception class.*"

"FGM is internationally recognized as a violation of the human rights of girls and women." More details are available from the fact sheets of the World Health Organisation, and can be found in the **Appendix A** of this report.

Summary of Key Points: Triggers for mental illness

Respondents consider the following factors influence their well being

- Psycho-social, economic and political factors trigger stress
- A person's historical background
- Being in transition as a migrant
- Being treated differently from the host population
- Culture shock, and mundane daily life activities
- Reduced support networks
- FGM practices

People wanted their beliefs about triggers resulting in mental ill health to be acknowledged, in order to create enhanced understanding between patients and health care providers. They wanted their narrative to be heard.

4. Messages to promote well being

The kind of messages that BME groups suggested during the workshops and meetings fall into five categories. These were:

1. Positive Ways Forward
2. Negative Aspects of Beliefs
3. Recognizing cultural presentations of mental ill health
4. Services and ways of access them
5. Support available: statutory services and voluntary sector

In the following passages, I have set out the main points, which illustrate the complexity of the issues raised.

4.i. Positive Ways Forward

Being Normal

- Respondents wanted to normalise experiences of mental ill health, to challenge the stigma, to remove the taboo, and to promote acceptance of those who were suffering.
- Mental ill health is normal, we may all get it at some point in our lives
- People want to reassure the public that there is nothing wrong with having a mental illness.
- Anybody can get it. Everyone might suffer
- Normalise mental illness, and compare it to heart disease, or other physical ailments. Learning disabilities need to be included

- Promote acceptance of mental health by using celebrities like Stephen Fry or Frank Bruno, to illustrate the point.

Episodic Nature

- Respondents wanted to make it more explicit, that mental health is episodic in nature. It comes and goes.
- They note the assumptions in the West and in some African countries, that if you have a mental health problem, you have it for life. The Somali community believe that a mental illness is for life. If people have a mental illness, there is a risk of being rejected by the family. The assumption is that a person will never recover.
- By contrast, in India, there is an assumption that one day you are bad the next day you good: your mental illness is an episode, not for life, and it is treatable using both medication and religious rituals.

Recovery Model

- We need to define that there is a recovery model and an illness model, and that recovery from mental illness is possible.
- With a recovery model, we can promote quality of life.

Behaviour

- We need to inform patients that there are ways of behaving in a hospital. For example if someone is angry, that may be taken as an indicator of mental illness, and they may be detained for longer.
- We must talk to people and identify their coping strategies and promote these.
- We need to give community health seminars and make presentations there, to offer stress management and other skills, life skills, and exercises for the patient's well-being

Women in Health

- Women considered that they had specific needs to address regarding positive messages, and the mental health of Muslim women from different countries of origin, were influenced by different factors.

- The women I spoke to wanted other women to be aware that: they must speak out, to address stigma and society's taboos; to know their rights, and stand up for themselves; to know they are valued, and no one need take advantage of them, both within the family, and within a health care setting.

- They felt that Muslim women could learn their rights through the Islamic way, and that would help to empower them, and offer them support and protection.

- Some women felt that it was *haram*, forbidden for them to talk.

- Another said "*With regard to personal issues, and mental health, whether you are married or unmarried, you have feelings. You need to use the proper resources that, and to know that when you speak out, it will be according to the Islamic law. God has given us the right as women to talk about such things. We should be assertive, and know our rights"*

- Muslim women wanted to use the Koran to present issues which had been discussed in it, to pass the correct information to people, in a clear manner. One said "*the pure Islam is perfect. It gives guidance in every aspect, of health and social behaviour. It was the first declaration of human rights. Once women know the rules, then the society will blossom as their children are taught the correct ways. Every right for a woman is written there. The*

perfect man is said to be one who will give the woman, all her rights, but not demand all of his from her."

- Misuse of the Koran: Women were aware that problems came when a person selected in isolation, an element of the Koran to make a particular point.

4.ii. Negative Aspects of Beliefs about Mental Health

Respondents felt that any messages put forward should also be explicit about the negative beliefs about mental health, so that they could be used in discussion. The following topics were put forward:

Invisible
- Mental health is invisible, anxiety is invisible, stress is invisible.
- *The symptoms of mental illness are hidden, not like physical illnesses. When they are hidden, and we keep them hidden, we cannot access treatments, and cannot be helped efficiently. Now we want to make mental health issues open and less hidden.*

Denial and Isolation
- *We want to address issues of denial, isolation, and non-acceptance of illness*.
- Within the family there is a lot of self-denial, people are scared.
- One man said: *"In this room that we are lucky, because we all access services, but there are people out there, in Harrow, hundreds of them, who do not want or do not know about the services. There are people who insist there is nothing wrong, they deny any illness, and they will not go for any help. They will not accept any services."*
- *We should not feel isolated, if we have mental distress, we should communicate with others*

Stigma and Taboos
- We need to address issues of stigma
- We need to discuss how to get rid of stigma, within family and community.
- Among the Somali community, there is a stigma related to mental illness. Nobody wants to claim that they are mentally ill.
- Associated with stigma, is the fear of gossiping, people have when accessing services for mental health issues.
- We need to question the taboo, and talk about it.

4.iii Recognising cultural presentations of mental ill health

This topic came up and again and again in the workshops and discussion groups. Respondents wanted to bridge the gap between the different kinds of knowledge. They wanted to work with mental health care professionals to prepare of list of definitions of mental illness, the symptoms prevalent for this, and the strategies to address them, both here and in their own country of origin. Then they wanted this list translated into the appropriate languages.

People want a list of the mental illnesses, because they are not familiar with the symptoms, or the terminology, or the treatments, as used by the healthcare professionals in Harrow. Such a list could be made available as a leaflet. They want a working party to be arranged in order to create such a list with each of the major BME groups in the borough.

I've put a selection of comments from the groups below.

Eurocentric and Culture Specific

- *"What do people do, when they arrive here with this Eurocentric concept of mental illness and treatment? How can we bridge between the system here, and the system back home. We need to bridge the gap. This is very important. This will help people access the service. Somali people need to understand what mental illness means here in UK. We need a continuing educational process".*

- *"We want the professionals to understand the mindset of the Somali person. What is the definition of mental illness back home? What we understand is that someone is mentally ill, when they act bizarrely. When someone talks to themselves, and here they say they are hearing voices, and have schizophrenia. But before that happens, there are symptoms of depression and withdrawal. We don't define those in our culture".*

Terminology and Symptoms

People want to know the cultural expressions of mental health symptoms, and they feel strategies are needed to recognise cultural presentations. They want a list of correlations between cultural manifestations and psychiatry terminology. They want to explore culturally appropriate ways of addressing those symptoms. They want a greater understanding of depression.

Anger was expressed against the use of the term schizophrenic, being the diagnosis of all Somali men being seen by the advocate at Mind in Harrow. People felt it was used by default. They raised the issue of institutional racism (see Fernando[46]).

- *"In Somali language, there is no such concept as depression. When people are mentally ill, we say they are crazy, and there is stigma. We need to know the symptoms of depression, withdrawal, and anxiety. We need to expand on the differences between different types of mental illness. The whole concept is about understanding mental health from a Somali perspective. We lack the right words, and the right language about this."*

- "*We need a series of questions, using symptoms that people from different ethnic groups may recognize for example: do you have _ _ _ _ _ then contact _ _ _ _ _ _ _ . Using appropriate language, for all from the communities, and cultures. For example, Chinese have heartache, and the Indian community have different words for depression.*

- *"For example we don't have the word depression in our vocabulary. We need to have the exact word. We don't have a word for paranoid schizophrenic, and so we need to know what this means. Perhaps we can discuss this in community meetings and use them to disseminate information."*

- *"We need training and education, so more people can understand the terminology. In our language, we don't have terms like depression and schizophrenia. We need to know what they mean. In order to simplify peoples understanding, we can translate these terms into the Somali. We can work with the psychiatrist to translate the terms in a way that we can understand."*

- *There is now a difference between the generations of Pakistani people in the UK. In the older generations in Pakistan, you will not find the concept of*

[46] Fernando, S. 2002

depression, though they may say they are feeling sad. My generation that were born and bred in UK are more aware of depression and schizophrenia. You will hardly find this awareness in Pakistan and India. The only thing they recognize as mental illness is bizarre psychotic behaviour, behaviour that is totally abnormal. Concepts like depression are a modern illness. My parents would not believe in the word depression, nor take any drug treatment for it. It is an alien concept. I had never heard of anybody in Pakistan, of the older generation who would use this. With the younger generation, this is different, and they take Seroxat or Prozac.

4.iv Services and ways to access them

People want to know what the key factors are for influencing mental health and well being. They want to better understand the causes, the symptoms, and the treatments. They want to understand what mental health is: what does it mean? Respondents considered mental health promotion in two parts: one is the BME population, the other is the mental health service providers. The over-riding belief was that if professionals were not aware of how specific BME groups understood mental health, they would not be able to help them. They see this as the first step, and then the following step, is to inform people where they can access help, that is, the pathways to service provision. People wanted to have more detailed information on the following topics:

a) Sign-posting

- Good signposting and information on pathways to access services
- The support available to patients and carers, and how to access it
- Where to access both immediate support, and on-going support
- Counselling services available, for individuals and families
- Places where they could access a rigorous assessment of the needs of patients, carers, and their families.
- Information about the role of the PCT

b) Statutory services and voluntary sector

- Sign post what help and support is available, and where
- Explain that help and support is available, invite people to ask
- Confidentiality: make it clear which services are confidential
- Identify user rights, for example, access to the Freedom pass
- Explain the reasons people attend counselling services: anxiety, panic attacks, depression, low self esteem, domestic violence

c) Training and education

- Where would carers access psychological skills training?
- Ways for carers to address the symptoms of their relatives
- Training in counselling skills

d) Access to female practitioners

- Women of different ethnicities and religions said they wanted to have access to female practitioners, to discuss intimate topics.
- They consider it as an issue of discrimination, if only male practitioners are available to consult.
- They feel women would understand them better
- They feel safer and more secure discussing their health with female medical and health care practitioners
- They consider it is an equal opportunities issue

e) What kind of information?

Respondents said

- We need to know where to get the information from.
- We need to indicate the pathways towards the services.
- We need good signposting to know the pathways towards mental health and treatment, in different languages.
- There should be posters, not only in English, but in any other main languages spoken in the borough.

Summary of Key Points: Messages to promote well being

Positive Ways Forward

- People want to normalise the experience, and reduce stigma and taboos around mental ill health
- They want to explain the episodic nature of some mental illness, and promote the recovery model, compared to the illness model.
- Identify behaviour likely to result in increased detention
- Identify coping strategies
- Muslim women from different countries of origin have different health needs.
- Muslim men and women want to use the Koran to promote mental well being.

Negative Aspects of beliefs

- Mental illnesses are often invisible, and hidden
- People may be in denial that they have a problem
- They may live in isolation.
- Stigma and taboos need to be tackled

Recognising cultural presentations of mental health

- Respondents consider that mental health services in the borough are Eurocentric and not Culture Specific
- They want a list of correlations between cultural manifestations and psychiatry terminology.
- They want to work with professionals to create a list of the definitions of mental health terminology and symptoms in different languages and cultures
- Different generations of the same ethnic background have different ways of understanding symptoms of mental health

Services and ways to access them

- People want:
  - better signposting to access care pathways
  - more understanding of roles of statutory services and voluntary sector
  - Training and education
  - Access to female practitioners

5. Dissemination of Oral information

5.i Oral v. Written Dissemination of Information

The data collected from focus groups and interviews suggests that BME groups and mental health service promotion providers have different strategies for disseminating information about mental health: one is oral, the other written.

For example, BME groups disseminate information using oral information passing through word of mouth. They disseminate information using culturally normal strategies like personal contact, via elders, community leaders, religious leaders, extended family members, barbers, grocers, and they hold large group meetings at temples, mosques, churches.

In contrast, the underlying assumption, with the host community and mental health care providers is that clear written information, signposting pathways to access help is more useful. The underlying assumption is that an individual will pick up the literature, read it, know what it means, and act upon it.

This section of the report on information dissemination is divided into two parts:

- those with a preferred oral tradition
- those with a preference for written traditions

5.ii Societies where Oral communication is valued

In a western context, the written word is valued and respected, as means of information dissemination. BME communities may respect other means of information dissemination and health promotion strategies.

Among BME communities, oral communication is a useful strategy for dissemination of mental health promotion information. This may be done in the following ways:

Personal contact.
Personal contact and networking is very important as a means of health promotion. People respond to verbal personal contact, to attend meetings, or receive information.

Contact via Elders and Community leaders.
People respect their religious and community leaders, the mullahs, and the sheikhs.

- The Somali community felt that they could work with their leaders to explain exactly what mental health is, and the kind of medication available. They could ask both secular elders in the town, and religious leaders in the mosque, to arrange big meetings, and have speakers, who are knowledgeable on the topic. They could get around 500 people together, perhaps every three months.
- *Dialogue one-to-1, to build a relationship to encourage participation in mental health services. Have one-to-one meetings with community leaders to develop a strategy to reach their community.*
- They would invite different age groups, all within the families. They wanted a series of meetings, so that they can present the information, bit by bit, repeatedly, over time.
- Meetings can be arranged with the professionals, with GP practices, nurses, policy makers and managers, in order to raise awareness of cultural issues.

Contact via Ground roots networks.
People also wanted the promotion project to be both top down from community elders and leaders, and bottom up, through the grass roots networks. People considered that these groups underpinned the community. One person in the Somali group commented:

- "*In order to promote information about mental health, it is my personal opinion that this project needs to be community led, where support will be given from the PCT to the community. This campaign of mental health promotion should be community led, and community-based. In this way, the community engages with the majority of its members, through their own organisational skills. This promotion exercise should be done through the community, by the community. They know what the needs are and how to reach the population*".

- *If we go through community leaders, we can raise public awareness about mental health issues. We can arrange a meeting, and invite people from MIND to speak, and start a discussion. We can get a huge number of people together, to talk about this issue, which is hidden in our society.*

In the Asian Networks in Harrow, it was noted that some people were not comfortable reading or writing in English. They wanted the community itself to develop a training structure, according to the perceived needs of that population. They would then conduct outreach work with their members and the population. Respondents felt that:

- *"Our members should be contacted through informal groups and meetings. There are lots of groups on the Asian network, who could give out messages to members about access to services in mental health. These groups could disseminate information to others, for example about the freedom pass. We can tell people where to get the forms in different networking opportunities."*

5.iii Audio visual mental health promotion

Television & Radio
Respondents felt that any mental health promotion package should include discussion and documentaries on culture specific TV programmes and on radio. This strategy would reach people who were secluded in their home. In some homes we were told they had the Asian television on in the background the whole day. Promotional programmes or advertising could be developed and then run on existing channels. Respondents wanted to use TV and radio to inform people. The following comments were made:

- *"On the Islamic television channel, they already discuss personal health problems, and we could ask them to discuss mental health problems. We need a female people to talk about this either Muslim, or non-Muslim. In the past, they had male academics, who simply didn't understand things from a female perspective. It is possible to discuss intimate things within the rules of Islam".*

- *"Information should be distributed by radio for example, Sunrise radio, and on the Asian TV channels. Asian radio and TV channels are so powerful at the moment. Every household has Asian TV channels, and one of the biggest pastimes is to watch these channels. We could publicise on the talk show, on a documentary, or a play or a drama. It would be better for mental health, if it was discussed as topics on these programmes".*

    - Television: Use the channels which already exist
        - There are 12 TV channels, E.g. ASTHA, Zee TV
        - Islamic Channel 813
        - Asian News TV channels
    - Asian radio channels

    - Sunrise Radio
    - Punjabi station
- Choice FM Radio for black people
- Northwick Park Hospital radio for people in hospital.

Films and Cinema:

- *"It would be good to have information in the local cinemas, as advertisements before the film, the services that are available for public mental health in Harrow, could be mentioned before, the film. It could be done delicately, in the form of animation, perhaps. The message could be humorous, to engage the person."*

- We could show films that already have a mental health content, then run a discussion group after.

Plays, Drama and Documentary.

Respondents wanted to work with the PCT, to create a movie or a documentary to get the message across. They felt this would be a powerful way to create health promotion with large numbers of people watching the TV or film adverts. They wanted to develop play and drama specific storylines and offer these at community centres, followed by a discussion session.

- *"We could create plays illustrating stories about people who are not well to show ways of it understanding symptoms of mental health problems, and ways of accessing treatment."*

Summary of Key Points:
Dissemination of Oral Information

- BME groups and the host population have different strategies for disseminating information: one is oral, the other written.
- In societies where oral communication is valued, people use personal contact through community elders and religious leaders
- Religious institutions are considered a good place to disseminate and discuss information about mental health
- Cinema and television were considered an excellent potential strategy to use for mental health promotion programmes.
- People wanted to work with the PCT to create plays and drama on the theme of mental health promotion, and then use these to initiate discussion with attendees.
- A formula of presentation and discussion, in specific places, with culturally appropriate food, is preferred strategy to use for mental health promotion.

6. Dissemination of written information

6.i Validity and effectiveness

There was considerable discussion at one of the meetings about the validity of written information. People in the group addressing mental health promotion for the more elderly BME populations in Harrow questioned the effectiveness of mass mail-outs.

- *"We need to question the validity of mass mail outs, and their effectiveness in reaching the required groups, and influencing people's well-being and mental health. We need to question the numbers game."*

- *"We know that with quantitative schemes, we can reach numerical targets, but is this the most effective way of creating change? Or is it more effective to talk to one member, one community leader who could then transform the lives of hundreds?"*

- "*If we use the newspapers to present material about mental well-being and to promote mental health, although this newspaper may have an audience in the hundreds of thousands, what effect will this have been changing someone's attitude? Is it not more important and of more value to talk to one community leader and invites them to talk with their people?"*

However, when I visited the Women's Centre and spoke to staff there, they found leaflets were a good way to disseminate information about their services

- Leaflets can be used for promotion, and these can be put in the temples, in the mosques, in the Gurdwara, and the GP surgeries. They can even be put in barber's shops, and in restaurants.

- Posters and leaflets should be put as notices in the main languages used in Harrow in hospitals and public places.

6.ii Leaflets and posters

Respondents felt there were problems associated with leaflets and posters: across the cultural groups they said leaflets "*do not work*" for mental health promotion.

- If there are leaflets, people want them to be language specific, simple, brief and written in a non-technical manner.

- Leaflets need to be translated into a selection of specific BME languages, to create understanding of mental health issues, and not to scare anyone.

- They need to be written in a style that is easily accessible, including those that are translated.

- In the past leaflets that were translated, had been written in a high academic style. People want them written in popular language. They do not want them written in the Gujarati or Arabic equivalent of medieval Shakespearean texts.

- Research needs to be conducted into the content of the leaflets, so that it fits its educational purpose.

- The Somalis suggest we may need some leaflets to identify how different cultures define their conditions, for example, physical ailments, sleeplessness, and headaches. They consider mental health professionals

would also find these leaflets useful, so that they can understand their cultural background.

6.iii Local newspaper

- People wanted messages about mental health promotion in the Harrow Observer, and the Harrow Times, and in Asian voice, and in other Asian specific newspapers. Asian voice is the most popular magazine that comes out quarterly in the UK, and it covers health issues. People felt that there could be one issue addressing mental health in it. This would be at the same time as addressing cardiovascular problems, or diet.

- They hoped that topic of mental health could become one of the mainstays in these journals. Negotiation is needed with the editors.

- They felt it was appropriate to advertise in local newspapers, like the local Recorder, the Leader, the Asian newspapers: Urdu Jung, Ausaf, Gujarat Samarchar, and Asian Voice, one of the oldest newspapers in UK.

6.iv The Internet

People considered that the internet was a useful way of disseminating information about mental health.

- People who are computer literate can go surfing to find out more information.
- *"If we find groups that have newsletters, we could incorporate a story so that when it goes out to members there will be a story about mental health".*

- On the Internet, we could open a chat line about mental health issues, to exchange information, or a Yahoo discussion group

- Respondents noted that Northwick Park Hospital had run a talk on depression and anxiety, but hardly anybody heard about it. It was offered free of charge, but only people who could access the information by e-mail heard about it.

- Mind in Harrow, has a web directory of services and mental health, which is currently being updated at the moment. For those people who are computer literate, they can go on to Google and search on it. It has all the services related to mental health in Harrow on it. It shows counselling and psychotherapy services.

- People wanted a mental health directory, with culturally appropriate information, with an up-to-date directory of support systems, with multiple links and ways of providing up-to-date information.

6.v Language Barriers and translations

Respondents wanted more people to be trained as advocates, who can be cultural brokers between patients and practitioners, explaining the cultural background. Patients would feel more confident that their case will be appropriately considered if they had a cultural mental health broker.

- Respondents wanted English language classes to be considered as an important part of mental health promotion

- Language is seen as one of the main issues. *"One of the main things hindering integration, whether its unemployment or mental health, is the language problem. If people do not understand the language, how can they understand the services that are provided?"*

- *"There is assumption that everybody understands English, and this isn't true. Those people who can't read or write English can ask for translation of these leaflets into their language. We should advertise that this translation service is available".*

Summary of Key Points
Dissemination of written information

- Respondents question the validity and effectiveness of using written information for mental health promotion
- When leaflets are used, people would like them translated into the appropriate language, using an accessible popular style of writing.
- Selected Asian, Islamic and Black newspapers should be used for advertising mental health promotion
- The internet can be used for chat rooms, on-line directories, for those who can access it
- People do consider that language is a barrier, and want translated material

7. Places to Disseminate Information

7.i Religious institutions

Respondents wanted mental health promotion to be conducted through the medium of presentations made at religious places: the temples, mosques, Gurdwara, churches and the khalsa college. They wanted to conduct health education for the community. They want to make contact with people of the faith, and the traditional elders. They wanted culturally appropriate food available at presentations.

People in Harrow go to two mosques, the central one, and the Sri Lankan one. After Friday prayers and lunch, respondents suggested that the promotion team would make a booking with the imam, and ask to give a mental health talk, as has already been done with an anti-smoking campaign, and a heart disease awareness project.

On Sundays, young and old go together to Hindu temples to pray. Respondents suggest talks on mental health promotion might take place after normal prayers. At these times it is normal to have health talks, and these can be arranged with the priest beforehand.

- People felt we should have an awareness of the dates of religious festivals, holidays, and prayer days, and use these to promote mental well-being.
- Respondents wanted to raise awareness about mental health, so that their populations would engage with services and access them in good time.
- They wanted support for both patient groups and prayer groups, in order to engage with mental health users and carers.
- There is a woman's Chair at the Harrow Sri Lanka mosque. There the committee is active in many ways. She can be approached and asked to offer space for presentations about women's mental health. Then a programme can be sorted out with her.

- Presentations can include information about the statutory and voluntary services available; the vocational and pre-vocational support available.
    - They would explain that there are different names, different illnesses, and different ways of treatment. They would make a note of the different causes, the different illnesses, the names of the illnesses, and the different treatments. They would address the issue of taboo, and stigma, and acknowledge that talking about mental health is quite difficult.

- They would like funding from the PCT to do this, after religious services, in order to make a difference to people's health.

7.ii. Secular Places

Health Fairs:

Health fairs are organised regularly, with speakers on different aspects of health. Respondents felt that a health fair could be an occasion to speak about mental health issues, as well as physical problems, such as breast cancer or giving up smoking. These health fairs could be more widely promoted, so people from different communities can attend and learn about mental health.

- Present a piece for Harrow's World Mental Health day
- Use Black history month

Schools

People wanted education about mental health issues to be available much earlier in the educational system. They wanted to address denial, and involve the wider society in the discussions. One woman said:

- *"We need to question, why is there denial? We should not be concerned just with the service user, but with the society around them, the family, wider relatives, the religious community, and the social community."*

- *"Education in schools and colleges is of critical importance. The root of the problem is that people need to hear about this when they are younger, to alleviate fear about mental illness. We should start mental health, education, at the same time as we start sex education in schools. This would change attitudes."*

Further and Higher Education

- Contact can be made with student welfare offices at the Further and Higher Educational establishments in the borough.
- Training programmes can be arranged in association with Mind in Harrow, to run workshops on mental health promotion

Shopping Centres:

- There could be a stall to promote mental health at St Georges and St Anne's shopping centre in central Harrow, where people could stop and have an informal chat.
- Leaflets could be provided at day centres, community centres, barbers, grocer shops, and restaurants.

Medical Centres

- People would like to have an advisor at their GP surgery, who gives out advice and information
- They would like more counsellors available at the GP's
- They wanted information notices in other languages in public places, GP surgeries, hospitals, and day centres.

For elderly people

- Take a stand at Northwick Park Hospital, near to the elderly wards.
- Use Older People and Pensioners Forum, to attract older carers patients
- Visit day centres, and residential homes, and hold talks.

Sources for leaflet drops

- GP surgeries
- Police
- Women's Aid
- Harrow Council Hate Crimes
- Grocer shops which are culture specific
- Barber's shops which specialise in BME customers

Sources for Children's leaflet drops

- Kids Can Achieve, Pinner Green
- ADHD Centre, Pinner Green
- Hillview Nursery: Special Needs
- Under 5's Centre
- Mother & baby groups

Summary of Key Points
Places to Disseminate information

- People want mental health promotion presentations and discussions to take place in their religious institutions
- Note should be taken of relevant prayer days, festivals and holidays, for maximum population catchments
- Secular places to run promotion include: health fairs, at schools, further and higher educational establishments, and at community centres, medical centres and day centres.

8. BME Communities Suggestions for Change Re. Innovations to current mental health care system

Participants at workshops held brainstorming sessions, and came up with several recommendations for change, to support BME mental health promotion and well being. These come into the following categories:

- Places of change (8.i)
  - Pathways to access
  - One Stop Shop
  - Drop in Centre
  - GPs Surgery & PCT
- Treatments (8.ii)
- Education & training (8.iii)
  - Cultural brokers
  - Cultural Diversity

8.i Places of change

Pathways to access
According to the current pathway, the GP is the first step to referral to the health services. Patients want direct access to CMHT. They want a one-stop-shop.

Respondents note that they face problems due to the gap in time, after a GP has seen a patient, to referral with an appropriate specialist. During this time gap a person with mental ill-health can go into crisis, and then subsequently require more severe or more extreme medical treatment, than if they were seen sooner.

Respondents want change the method of referral and the creation of a one-stop shop for patients. This would hold more information about culturally sensitive services, which would be available in the one-stop shop.

One stop shop
Respondents were concerned that when they went to the GP, a letter was written, and then it took weeks or months to get an appointment with an appropriate consultant. People wanted a fast track service to give correct information and access to the specialists. They wanted referral times to be shorter, and to be given advice about counselling services.

"We need this so that people can access services. For example we go to the GP, and then we have to wait a long time to see the consultant. People are concerned that they have to wait so long for an appointment. What they want is a one-stop shop like that Rayner's Lane, with CNWL. People suffering from mental illness can get help directly, without the long wait".

"You go to a one-stop shop, where people are specialised in mental health problems, and they can direct you immediately to the right service.

We are sympathetic to the GPs, as they deal with almost everything, so we cannot expect them to be an expert in everything. But in a one shop stop, there could be specialists, who could refer people immediately to the correct service for example to the Atkins house, or Honeypot Lane clinics.

Also, they'll be able to refer people to voluntary sector support services. They can be told that they would be benefiting by attending Mind in Harrow, their workshops by the Stepping Stones project.

These one shop stops should have access to information about all statutory and voluntary services. These places should have an open door policy".

Drop in Centre for women.
The female participants in this study said they would like to see a drop in centre for women available in the borough. They wanted it for both entry level mental health care access, and for follow up support. Although they preferred to be seen by female practitioners, they were aware that in an emergency, it was OK to be seen by men.

- *"Once women have a place to feel secure, where there is knowledge and education, they are able to discuss problems, in places like this".*

- *"We need to have a safe and secure centre in the local area, so that women know where to go to a drop in, and discuss issues, and receive reassurance from others. A safe place".*

- *"What we need is support, when there is a mental health problem, and follow-up care. This is most important"*

- *"In the case of an emergency, it doesn't matter whether or not a person is dealt with by a male or female practitioner, but when there is not an emergency, then our preference would be for a female practitioner".*

Women wanted to use Islamic and Koranic traditions to address any problems, but recognised that their may be problems with their spouses, if they used any such knowledge to question their husband's activities.

- *"I'm learning today from my sisters here that there is a way through using understanding of Islamic laws, to solve mental health problems. The law is there to support us."*

- *"Problems can arise, when a woman knows her rights, and there is a risk that she may go back to her husband, and inform him. She may come out of a mental prison, but there is a risk her husband may send her away or divorce her. She may then find herself with turmoil while within the family situation, her husband may threaten to kick her out, and that this reason, we need follow up support."*

- *"Some women are frightened, and they may say: well I'm not going to go home and start demanding my rights".*

Women wanted a drop-in place where they could access advice, and have their own food and cooking. They thought about asking the Mosque committee about help to organise this at grass roots community level. They also wanted a female representative to advocate for them in the hospital.

- *"We need a place where we can sit and discuss things, within a community of Muslim sisterhood. There any one with a problem can just drop in. This is a place where we can cook our own food, and make tea. In such a place we can talk about intimate things, like FGM (female genital mutilation)".*

- *"We also want a Muslim woman representative and advocate at the hospital in the maternity department".*

Concerns with the GP and PCT
Respondents had other concerns about the services that the GP offered, and they made suggestions for ways forward to address these. They brought up the issues of different understandings of the term confidentiality, which has been dealt with in more detail in the following section. There are also different ways of understanding the concepts of 'individual' and 'family'.

Women wanted the GP to listen to them, to hear what they were saying, both when they were patients, and when they were family surrounding a patient who was ill. They felt that they had direct experience, and one commented that her doctor seemed to take offence if she spoke about her relative who was the patient.

- *"Doctors need to listen, to the patients and their genuine concerns. We want the doctors to listen, and give us more time, and take us seriously."*

Members of one focus group wanted the PCT to raise awareness of GPs and other front-line practitioners with regard to cultural aspects of well-being. They said each practice manager needs to be targeted, to find the best ways to access their practice.

Community organisations said they felt frustration that plans for promoting well being took a long time, and they wanted the PCT to link to all relevant community groups with regard to mental health is promotion. This was happening with World Mental Health Day.

8.ii. Treatments

Respondents wanted to tackle the issue of different kinds of treatment for mental health problems. Some were familiar with alternative remedies for healing, others with religious and spiritual treatments for mental illness. They felt talking therapies and family counselling would be helpful, and a counselling helpline for Muslim women.

- *"For example in family counselling, a person's wife would be there, their daughter, and son. If we tell people that the condition may be hereditary, then straight away, they take responsibility for their relatives. Anyone can get it. It may be you. This will help them to accept their relatives who have mental illness, and to support them."*

People wanted their religious and spiritual leaders to have more access to the hospitals to visit and support in-patients who had mental illness. And they wanted to use more culturally appropriate therapeutic and counselling sessions.

For example, within the Somali community, there are particular people who are not imams in the mosque, but who are trained and dedicated to reading prayers. These sheikhs are known within the community for their skills in reading the Koran. They know which specific verses of the Koran to read when somebody is mentally ill.

- *"We need to develop counselling sessions, with both religious Sheikhs and elders. The spiritual needs of mentally ill people need to be considered. They need to be allowed access to the spiritual leaders in the hospital so that they can conduct prayers. At the moment there is no provision."*

- *"Some people get healed by reading the Koran, and religious leaders can play a big part in this. The sheikh may tell them, that this world is nothing, and you need to work, in preparation for the next world. There are those who use herbal medicine, while others use the traditional folk dance."*

Respondents wanted more information about alternative approaches to medication. They were concerned that in UK, the doctors automatically used pharmacological treatment, and did not look at alternative approaches to well-being.

People valued the PCT's interest in looking at different communities in the borough of Harrow, and looking at different strategies for mental health promotion.

- *"We need to acknowledge that there may be other strategies for addressing mental illness, apart from pharmacology and medicine, in different communities. With regard to alternative medication, we continue to accepted it and recognize its value."*

- *"We value the PCT's intention to engage with different communities, and hear our perspective. There is now a will to look at different cultural ways of addressing mental health. There is a change now."*

8.iv. Education & training

Respondents in the focus groups identified the following areas where they thought training would be beneficial:

- cultural brokerage for members of community groups
- cultural diversity for front line mental health care providers

Cultural Brokerage Training
Advocate, Translator, Interpreter. Among the Somali community, members have heard about the broad remit of the advocacy project with Mind in Harrow, and they felt it would be useful to have more advocates, as cultural brokers, to actively promote well being in practical ways. They felt it would help more members of the community, if people were trained to work as intermediaries. They wanted to develop skills, and undertake capacity building in the community. However, there were members of other groups, who were fed up with capacity building, and wanted to support active change. Others wanted training in counselling themselves.

- *"Sometimes health practitioners call an interpreter in to help with understanding, or to do translations. We think that this is not enough: we need a cultural broker as well with a Somali background. The cultural broker would explain things more easily, rather than just do direct translation."*

- *"We need to train volunteers in the community as advocates, and as befrienders. The first step is educating the community, saying about the history and background of the people. It has to be reciprocal education of both the community and the healthcare practitioners."*

- *"We need a strategy for prevention as well, to address immigration and housing issues. Medication on its own doesn't work, it doesn't address the issues".*

- Regarding capacity building, one woman was exasperated: *"We don't need capacity building ourselves: we need to train the front line practitioners in health care in capacity building. They are the ones who need capacity building, so that they can understand the communities that they work for. We should do the training. We need capacity building in both directions, with the community, and the front-line health care practitioners."*

Cultural Diversity Training
Participants felt that there was a gap in service providers knowledge that there were different models of mental health. They also felt there was a gap between state run services and voluntary services, some of whom had a different ethos. They also considered that there was a gap in training school teachers in FGM

practices, which needed to be addressed through discussions, film and TV programmes.

- *"The education and training should be from both sides, in parallel, at the same time. We need to train front-line health service practitioners so that they understand the culture and religion in the community".*

- *We need to train GPs and front-line health care practitioners in recognizing cultural expressions of ill-health. We need to be explicit that there are different models of health, there is a medical model, and a social model.*

- *There needs to be a programme of education, of the School teachers, so that they can understand about FGM. We need to get people educated, according to the proper traditions of Islam, so that they can understand this. We need to be pro-active to help people.*

- *We want to train front-line staff, so that they understand the culture and religion in the community that they serve.*

I asked one man, who had previously run mental health promotion programmes in East Lancashire for Muslim audiences, how we might go about it. He said: "*If you're targeting Islamic audiences, you could invite them to use concepts from Islam, when inviting them to workshops and focus groups on mental health promotion. This would have a bigger impact, and would bridge the gap in understanding. This would work with their own taught way of thinking in that society.*

If you want to talk about mental health awareness, then it is better for you to understand concepts of psychology within Islam itself. You could find verses from the Koran that are appropriate in order to promote mental health awareness. That would be one of the better ways of approaching this sector of society[47]*."*

He continued: "*When I included aspects of Islam in the leaflets of the health promotion I did in the north of England, I found that people look at them a lot longer. They were much more interested in the topic. For example, with regard to domestic violence, there is a verse from the Koran which says: "the best amongst you is the one who is best to his women". There are many other things that speak of the rights of women. This marketed the issue of domestic violence very well."*

Summary of Key Points
BME Communities Wish List

- Participants would like to see change to the provided services, in the form of a one-stop-shop
- They want to reduce the time gap between GP and consultants, so that referrals could take place more quickly.
- Women want a drop in centre for women only. Muslim women want to use the Koran for mental health promotion according to Islamic doctrine
- People want family carers to be acknowledged as 'experts'
- They want the range of complementary and alternative therapies to be discussed with them
- Training needs to take place, both within the community groups, for cultural brokerage and counselling skills, and with front line practitioners for cultural diversity.

[47] Reehan Mirza, Appendix B

9. What does the data mean?

9.i Plural Ways of Understanding Knowledge About Mental Health

Research was conducted using a participative ethnographic methodology, exploring the issues from the perspectives of members of the BME communities.

The data suggests that members of BME groups, the host community and the health service providers have a multiplicity of different ways of understanding knowledge and beliefs about mental health.

Because BME communities and health service providers have different ways of understanding mental health, this in turn influences the way in which any health promotion campaign is conducted.

These differences are summarised in **Appendix C, Chart no.1,** which presents an overview at a glance, illustrating the complexity of people's concerns. The following topics are presented in the central column of that chart:

- Theories of illness causation and triggers of ill health
- Therapeutic approaches
- Issues concerning privacy and confidentiality
- Models of mental health and well being
- Dissemination of information, and ways of accessing services

I have emphasised the differences, in order to make them more explicit, although in practice, there are more subtle levels of understanding in actual health care, between practitioners and clients.

9.ii Theories of Causation.

Ways of understanding mental health influences the theories people hold about illness causation, the beliefs they consider trigger ill health, and their health seeking strategies.

A person's beliefs about illness causation, privacy and confidentiality, and their models of mental health, all influence the strategies which might be used for mental health promotion, and the subsequent dissemination of information about pathways and access to services.

Thus, there are different assumptions about triggers for mental illness, and different beliefs about causation. Also different symptoms manifest in response to those triggers, in different cultures.

This awareness influences the way we promote mental well-being in the community, the key messages we offer, and the culturally appropriate strategies we use.

9.iii Therapeutic Approaches.

Different therapeutic approaches are set out more clearly in **Appendix D, Chart no. 2.** For example, BME groups use a psycho-social, economic-political and environmental approach to explain the triggers of mental ill health. As a consequence of this, their therapeutic approach focuses on group dynamics and a need to understand their historical context and address issues of concern in their mundane environment.

In contrast, the biomedical and clinical approach of mental healthcare providers focuses on the individual, and their therapeutic approach is concerned with addressing individual symptoms and behaviours. Then health promotion is concerned with indicating clear pathways to access well defined services.

9.iv. Confidentiality and Privacy

There are also variable beliefs which influence practice concerning privacy and confidentiality. For example, in BME communities, people believe that an individual cannot be separated from the context of his or her family. In this way, one to one privacy and confidentiality, which may be a normal value in a Eurocentric environment, may not feel appropriate to a person of a different ethnic background.

Workshop participants felt that the western model of confidentiality did not work. They expected the GP and mental health consultants to work more closely with the family. They thought that patients needed more family help and support to get them out of mental health problems. Some suggested the treatment, the isolation, and the frustration, made patients more dangerous.

One woman said: "*The one-to-one model of meeting a patient is not an appropriate cultural service. The family is essential to a person's well being. Patients get even more sick when they have reduced access to their family".*

There were problems with peoples of the same culture, coming from different generations, for example, children born and bred in UK may put a high value on privacy, whereas older adults value the presence of family members.

Due to the stigma associated with mental health problems, people were worried about how to address the fear of gossip, with other community members hearing about personal problems.

Concerns with counselling were complex: on the one hand, there is an assumption that people want to see someone of the same culture, who speaks the same language: *"you want to see someone of the same race, religion & culture, so that you feel you can be better understood"*

However, counselling services in Harrow said their clients deliberately asked to see someone from a different culture, who was not of the same ethnic group. This was due to the fear of discrimination and stigma.

> *"If you see someone of a different race, it is better, and then no gossip gets back to your family. Sometimes women in particular ask for this".*

Even in the befriending scheme run by Mind in Harrow, people ask that they are not matched with somebody of the same community. And yet there are others who ask for someone of the same community.

Ill health was seen as something you kept to yourself, and people didn't talk about receiving counselling, due to stigma. One woman said: "*You don't want everybody to know, but you do want someone to help*".

At the Women's Centre in Harrow, when it first opened, Asian women phoned very little for advice & counselling, now they phone and attend much more. Women attend because the women's centre is private, safe, with proven confidentiality. No men go. At the time of writing, there was no record of Somali women attending.

The issue is complex. People of the same ethnic origins may have different needs about privacy, depending on their age and gender.

9.v Models of mental health.

Fundamental to health promotion strategies is the understanding of different models of mental health and well being which exist in Harrow.

For example, the medical model may be exemplified by information on the pathways to access health services, by the established care routines and practices used in health care settings, and the evidence based strategies which practitioners use to diagnose and treat specific conditions, which are identified by common terminology and published literature.

In contrast people using the social model may address issues concerning: "*what does the condition mean to me, to my family, to my marriage prospects, and my work colleagues, to my future? Why me? Why now*?"

The illness model suggests that any condition is an illness for life, and for certain BME communities, this means the individual may be stigmatised and excluded by the family. They may have reduced marriage prospects, and the family may be stigmatised and gossiped about by people in the same ethnic group. The word 'mental' is assumed to mean 'mad'.

In contrast, the recovery model suggests that any illness is episodic, and with correct treatment and attention may be cured or stabilised, so that the person who was originally considered 'sick' can recover and lead a normal life. In the recovery model, mental ill health is considered a 'normal' condition, which anybody can get.

The terms different communities use for mental well being, are often established within their religious or philosophical traditions, and this was noted during a recent research exercise in Scotland.[48] The Department of Health is also conducting research into cultural manifestations of BME mental health.[49]

9.vi Different Approaches to Mental Health Promotion

BME communities and the host population tend to use different strategies for presenting and disseminating information as part of mental health promotion. A selection of these strategies is outlined in **Appendix, E, Chart no.3.** As before, I have emphasised the differences.

People's ways of accessing information and services can be quite different. The chart presents generalised information from two perspectives: the column on the left from BME groups and secondly, the column on the right from the host population and mental health service provider's perspective.

BME communities tend to use oral traditions, with personal contact, and group meetings organised by religious or community elders. They prefer audio visual approaches to mental health promotion, through TV, radio and television.

In contrast the host community and mental health providers in it, tend to use written material, and assume if it is disseminated widely enough, then an individual will read it, understand it, and act upon it.

Once these different ways of understanding peoples' beliefs and knowledge are acknowledged, appropriate health promotion strategies can be used.

The need to create a bridge between the different approaches is set out by Mirza who makes the following reflections regarding mental health promotion**:** "*There is*

[48] Scoping Exercise, UCLAN & NHS Scotland, Aug 2008
[49] DOH, Reference being sought

no point in addressing the black and ethnic minority populations, and not working with the front-line mental health providers at the same time. There needs to be a bridge at both ends.

The more you understand their way of thinking, and the more you spend time with them, you will build up an accurate model, of ways forward, of bridging between different ways of thinking, for mental health compliance.

There will not be much enthusiasm from the ethnic minority communities if mental health promotion and awareness does not bridge between their ways of thinking and yours. It is fundamental to engage both with the communities and with the front line practitioners. They are sides of the same coin[50]".

Following the suggestions in the 2002 DOH report, on what the authors call 'positioning'[51], which suggests that a participatory approach to mental health promotion is more appropriate with black and minority ethnic groups, rather than members of the host community, taking the position of experts, and informing the BME population, of how things are done.

In this way we learn from the communities what health promotion strategies they consider are relevant for them. Then the way forward is placed on empowerment, cultural appropriateness, and working together on the education and training of all parties concerned.

Any mental health promotion programme which acknowledges different cultural strategies for addressing and understanding illness would be more clearly heard by the target populations, and therefore more successful.

[50] Reehan Mirza, Appendix B
[51] CVS Consultants 2002, p.33

10. Recommendations

Recommendations can be found throughout the report, in the boxed summary of key issues, at the end of each section.

10.i. Working Together

1. If the forthcoming project on mental health promotion employs the same strategies, which have previously been used for mental health promotion, then the project may meet its numerical targets and indicators of success. However, it is doubtful whether this alone will transform well being, or create beneficial changes in BME mental health at a societal level.

2. Once the different models for understanding and disseminating information are acknowledged, we need to consider advancing mental health promotion using a variety of participatory techniques. These are preferable to the old educational style of didactic methods alone, where the recipient is the passive acquirer of presented information.

3. Teaching and learning needs to take place at the same time, serving the educational needs of both BME groups and service providers.

10.ii. Cultural Knowledge and Mental Health Promotion

4. Use the cultural knowledge base of the different communities to determine the content of any promotional literature or audio visual material. For action research projects, see recommendations in point 10.vii, with suggestions of workshop structure.

5. Religion and philosophy are often important to BME groups, and in order to bridge the thinking between different communities:
    a. Create working groups with Muslims, to select and discuss appropriate texts from the Koran, and include key concepts, like: peace, patience, personal reasoning, and resilience.
    b. Do the same with Hindu communities: it may be effective to use sacred texts from the ancient scriptures
    c. Explore whether other ethnic groups such as Afro Caribbean or Chinese would find a similar strategy regarding Christianity useful. If so, conduct an action research workshop.

6. In meetings, explore what participants understand by the term 'cultural awareness', and ways it is addressed in a mental health care setting.

10.iii. Culture, Symptoms, and Terminology

7. We know people understand mental health and symptoms in different ways. Set up a working party to develop a list of terms, symptoms, and diagnoses, made up of BME members, psychiatrists and allied health care practitioners
    a. Set up a sub-group for each faith or community group
    b. Check whether DOH Information Group is already doing this. If so, use it to discuss their findings.
    c. Address drug and alcohol related issues

8. Aim: to correlate Cultural and Medical Definitions of symptoms
    a. define service providers terminology for clinical symptoms
    b. define cultural manifestations for mental health symptoms

10.iv. Service Providers, Signpost Pathways and Access

9. Signpost pathways to access services in a simple manner
    a. Although there is a document on care pathways, which give an overview of Harrow mental health services for adults, for front-line providers, it is complex. It lists the services that are available in the borough, and it sets out the referral process. There are complex diagrams which provide information about the initial contact care pathway, and the care pathway to access services for GPs[52].

    b. Prepare a clear document, written in an easily accessible style
    c. Translate it into appropriate languages, using popular terms
    d. Use written, oral, and audiovisual dissemination strategies

10. One stop shops
    a. Set up a working party to discuss the funding streams, staff resources, and policy requirements to meet BME community needs, as defined in section 8.i above, for a one-stop-shop, and a drop in centre for women.
    b. Address the needs of female BME population, and their requirement to have access to female staff.

10.v. Therapeutic Approaches

11. We acknowledge that people use different models of health.
12. The WHO definition of mental health, given earlier is: *"a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity[53]"*. Any health promotion project needs to address this factor of social well being, as well as mental well being.

13. We need to support people in a holistic manner, and be concerned with the external factors, which trigger distress, and address them practically.

14. We know that when people are active, there is less mental illness
    To this end, set up a working party to address and manifest:
    a. A pre-vocational strategy for mental health service users, creating activities, work experience, educational courses, like Mind in Harrow Stepping Stones project, like the Confidence for Life course.

    b. A vocational strategy to train supporters, counsellors, community champions, carers, and advocates. Advocacy is recognised as having a positive impact in helping people with life situation problems.

    c. Address communication difficulties with the offer of EFL classes

15. Some consider mental ill health as a normal consequence of migration (see section 3). Mundane daily life issues may be considered more important for well being, than any treatments for mental illness.

16. Establish regular meetings, where members of BME communities can explain their story, their narrative, about their history and cultural practices. This may go some way to heal understandings between BME groups, service providers, and host community.
    a. The Expert Trainers model used by MIND in Harrow can be used to address this, with meetings held in schools, further and higher educational institutes in the borough.

[52] Harrow Adult Mental Health Services, 2007
[53] WHO, mhgap 2007

10.vi. Dissemination Strategies

17. We know people use a range of learning styles including oral and written. Use written, oral and audiovisual health promotion dissemination strategies

18. Arrange meetings with religious and community leaders to discuss mental health promotion, and book dates for presentations, action research, and presenting leaflets or posters.
    - **a.** Gather a list of elders, religious and community leaders, and religious institutions throughout the borough of Harrow, with whom to liaise over mental health promotion activities. List their contact details.
    - b. Gather a list of dates of religious festivals for maximum effect, to reach high numbers of BME populations on mental health promotion.
    - c. Service providers give presentations at meetings asking BME leaders and elders to disseminate information about pathways and access to services. Explain available medical and other therapeutic treatments
    - d. Work with BME service users to create a play, incorporating key messages in section 4.i. This play can be performed at meetings, to trigger facilitated discussion on specific topics after performance.

19. Advertise in Asian, Black, and Muslim press, TV, Radio, Cinema
    - a. Use information from BME groups to inform the leaflets, and adverts
    - b. Prepare a press release for radio and local cinema

20. Translate leaflets and posters into appropriate languages in a simple manner, in an accessible popular style of writing.
    - a. See section 7, for religious & secular places to disseminate info.

21. Update and maintain internet Mental Health Directory at Mind in Harrow, with material relevant to BME groups on statutory and voluntary services.

10.vii. Structure of Meetings

22. Information generated from this needs assessment suggests we consider using a participatory action research approach to mental health promotion.

23. Conduct a series of meetings with members of BME communities and front line mental health care providers, to discuss the following topics:
    - a. the meaning of cultural awareness, in practice
    - b. sacred, religious and philosophical texts on mental well being
    - c. cultural theories of illness causation
    - d. cultural symptoms and clinical diagnoses
    - e. ways of addressing triggers of distress
    - f. pre-vocational activities and vocational training
    - g. content of promotional material

24. Create a structure for an action research brainstorming workshop
    Potential meeting structure:
    - a. Introductions
    - b. Agree session's focus
    - c. Listen to a presentation on each stakeholder perspective
    - d. Define a real question to explore in small group work
    - e. Open plenary session to discuss issues raised
    - f. Feedback results to mental health promotion team

10.viii. Evaluation

25. Define and manage a schedule and built-in strategy for evaluation, to keep track of the progress and manifestation of the above recommendations.

References

Autumn Assessment Of Mental Health 2004,
A paper outlining the local implementation of BME mental health review..

Bhugra D, Bhui K, 2007,
Textbook of cultural psychiatry, Cambridge University press

Bhugra D, Minas I, Sept 2007
Mental health & global movement of people, in The Lancet: Global Mental Health

Census 2001
http://www.statistics.gov.uk/census2001/census2001.asp

Choosing Health, Government White Paper, 2004

Care Pathways, Dec 2007
Harrow Adult Mental Health Services, CNWL NHS Trust,

Craig D & Ellis R (Eds.) 2005
What residents are telling us, MORI Social Research Institute.

CVS Consultants & Migrant & Refugee Communities Forum 2002
A Shattered World: The Mental Health Needs Of Refugees And Newly Arrived Communities. http://www.harpweb.org.uk/downloads/pdf/rep1(ref).pdf

Fernando, S. 2002
Mental Health, Race and Culture, Second Edition, Basingstoke: Palgrave.

Fernando S, 2005
Multicultural mental health services: projects for minority ethnic communities in England. Transcultural psychiatry, 42, 420 – 36.

Griffiths D 2002
Somali & Kurdish Refugees in London, Ashgate Publishers

Harrow Council Study 2004
What Harrow Community Groups Think, MORI Social Research Institute.

Husbands S and Thomas J, 2007
Health Needs Assessment for Adults in Harrow with Mental Illness, Harrow PCT

Harrow Adult Mental Health Services, December 2007
Care Pathways phase 1,

Harrow's Diverse Communities, June 2006

Harrow Strategic Partnership, 2006
Harrow Vitality Profiles, a portrait of Harrow and its people in statistics

HCRE Annual Report, 2005/06

Health Profile of England, DOH, 2006

Improving Health, Harrow Primary Care Trust, 2003

Ishaq, Sameera No date?
Unpublished essay, project worker at Mind in Harrow

Joshi A, Parmer D & Smith J, 2008
Gujarati Speaking Asian Elders, Mind in Harrow.

Lawton-Smith S 2007
Isolation: a barrier to Recovery, points raised from conference (unpubl.)

Mind in Harrow, Annual Report, 2007

Rai-Atkins A et al 2002
Best Practice in Mental Health, Social Care, Race & Ethnicity Series, the Policy Press

Saxena S, Thornicroft G, Knapp M, Whiteford H 2007
Resources for Mental Health: scarcity, iniquity, and inefficiency, in The Lancet: Global Mental Health, Sept 2007

Travis A
MI5 report on terrorism, The Guardian, Thursday August 21 2008
http://www.guardian.co.uk/uk/2008/aug/20/uksecurity.terrorism1

UCLAN & NHS Scotland, August 2008
Scoping exercise with Black and minority ethnic groups on perceptions of mental wellbeing in Scotland: http://www.healthscotland.com/documents/2803.aspx

UNHCR Definitions and Obligations
http://www.unhcr.org.au/basicoblig.shtml
http://www.unhchr.ch/html/menu3/b/o_c_ref.htm

Wasp D, Noel A, Farah I, Habib DM, 2004
Mapping Health Access, for Afghan, Iranian and Somali refugees and asylum seekers in Harrow, Mind in Harrow.

Watters C 1998
The mental health needs of refugees and asylum seekers: Key issues in research and service development. In F. Nicholson (Ed.), Current Issues of UK Asylum Law and Policy (pp. 270-285): Avebury.

Woodbridge B 2004
Whose Values? Sainsbury Centre for Mental Health, Warwick Medical School

World Health Organisation 2008
Scaling up care for mental, neurological and substance use disorders, Mental Health Gap Action Programme, WHO Press, ISBN 978 92 4 159620 6

APPENDICES

Appendix A
Notes on FGM

World Health Organisation

http://www.who.int/mediacentre/factsheets/fs241/en/

- Female genital mutilation (FGM) includes procedures that intentionally alter or injure female genital organs for non-medical reasons.
- An estimated 100 to 140 million girls and women worldwide are currently living with the consequences of FGM.
- In Africa, about three million girls are at risk for FGM annually.
- The procedure has no health benefits for girls and women.
- Procedures can cause severe bleeding and problems urinating, and later, potential childbirth complications and newborn deaths.
- It is mostly carried out on young girls sometime between infancy and age 15 years.
- FGM is internationally recognized as a violation of the human rights of girls and women.

http://www.who.int/reproductive-health/fgm/terminology.htm

- **Type I** — Partial or total removal of the clitoris and/or the prepuce (clitoridectomy).
- **Type II** — Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision).
- **Type III** — Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).

Appendix B

Selected notes from interview with Reehan Mirza, 21st August 2008 Re. mental health promotion programme for Muslim audiences

Would you tell me about concept of patience?
The concept of patience (*sabr*) is one of the most vital for people of the Islamic faith. Patience is considered to be an attribute of God. It is used commonly throughout people's lives, especially in times of stress, anxiety, grief, and bereavement. In their homes, people have gilded frames with verses of the Koran written, and one of the most popular is: "*in alahu ma sabari*, *God is with those who have patience*". Patience is considered an absolute virtue in the Moslem mental makeup.

Is there any way the concept of patience might inhibit someone from seeking help from mental health services here?
People may think that if they are not feeling right, they must exercise patience (*sabr*) and they would not think of going into the outside world for help, or assistance. This would be like an admission of weakness, or even a lack of faith. We put all our trust in God, however, there is a famous saying: "*Trust in God, but tie your cam*el." This means trust in God, but you have obligations as well. You can pray to God, but make sure you take care of your camel as well, tie it up so that it doesn't wander off and get lost.

Can you tell me about the concept of resilience?
There are five prayers that Muslims do in the day, and after the prayers, there is one that always mentions patience and resilience, and steadfastness in times of trial and being tested, in times of illness, for any thing that disturbs a person's well-being or peace of mind.

Is there anything you can say about peace and mental health?
The concepts of inner peace and personal peace are very important: "*sukoon*" is one word that is used commonly. It is an important thing and according to Islamic thinking, you will find this peace through prayer, and communion with God. Doing good deeds selflessly. Peace is the be all and end all of a Muslim's existence, together with the concept of patience and resilience, in times of difficulty. We want to stay in peace, whatever happens in our life, instead of reacting in a stressed manner. That is the ideal model of existence.

Personal reasoning, contraception and abortion.
The Koran actually speaks about not killing children: "*Do not kill them, as we will provide sustenance for them*". A lot of Muslims may interpret this as not to use contraceptives or do abortions. Regarding abortion, *"ij tihaad"* is a concept of Islam about personal reasoning: if a birth is going to harm the mother, then it makes sense to use our personal reasoning, and undertake abortion. This does not clash with the concept of personal reasoning, and one can choose contraceptives, if they are appropriate. In Islam, it is an obligation to preserve life and health. Nobody's life should be put at risk. Islam has left it to the choice of the individual to use contraception or not. Contraception is a choice or an option.

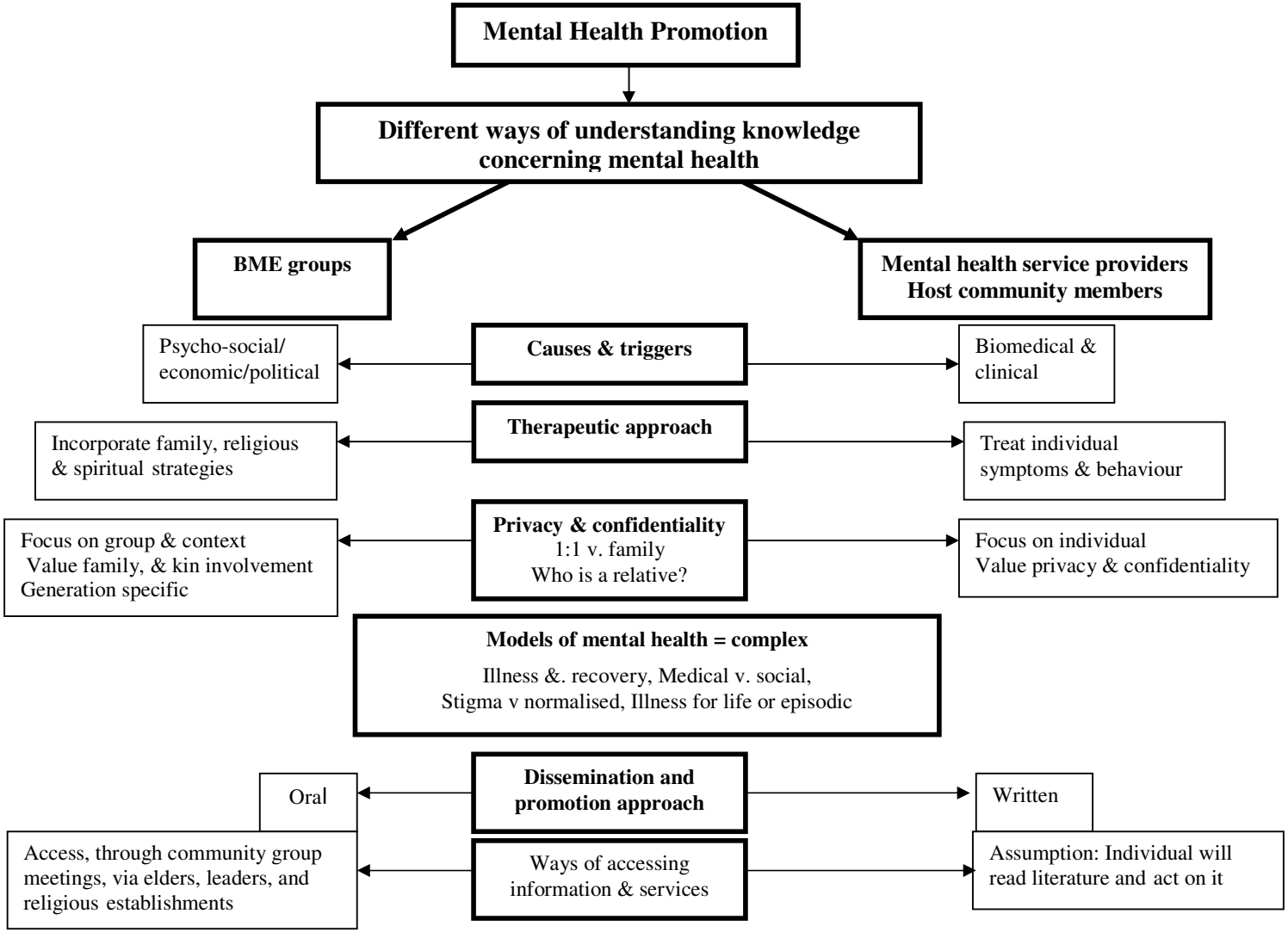
How does the practice of female genital mutilation fit within Koranic scriptures?
This is a completely anti-Islamic practice. We need to remember that the Koran is a guideline, and does not have specific laws for society. After the Koran, the secondary source of guidelines for people, are the sayings of the Prophet, peace be upon him. This practice of FGM does not crop up in any Islamic context whatsoever. It does not exist outside of Africa, not in the subcontinent, not in India or Pakistan. The practice of doing it is mutilation, and mutilation is forbidden in any circumstances. It is not related to Islam at all.

On Working together. Those who develop the policies are a distant entity, and they don't have the understanding, of how to address the older generations and the younger generations. In the documents that are written, people know that they must access these ethnic minority communities, but they do not know how to do it. The policy developers have no understanding of the community they serve, because they come from a different environment, and they don't know how people think. So it is engaging people, to look at issues from their own perspective.

It is not enough to inform people about the ways of accessing mental health services from a one-sided perspective. Working together is the only way forward.

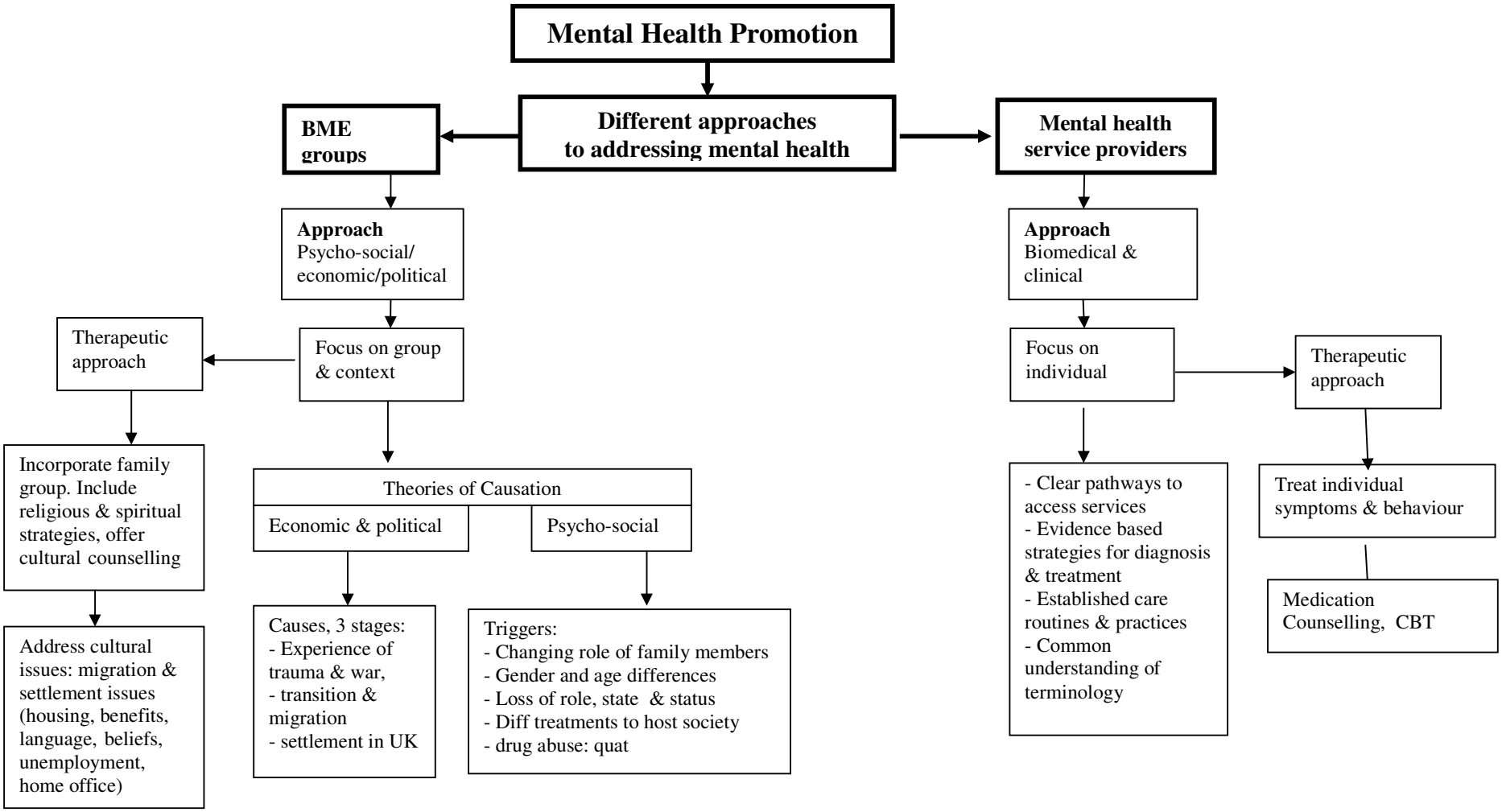
Appendix C, Chart no.1

Differences in models of understanding and approaches
Between Harrow's Black and Minority Ethnic communities and mental health care providers



Appendix D, Chart no.2

Key issues in presenting a mental health promotion message



Appendix E, Chart no. 3

Different ways of presenting a mental health promotion message