Barriers to seeking help

What stops ethnic minority groups in Redbridge accessing mental health services?

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1.0 Summary

This report seeks to discover specific barriers which prevent ethnic minority groups in Redbridge from seeking help from local mental health services. It also makes recommendations about how these barriers might be addressed and overcome.

1.1 Background

In an innovative piece of partnership working, the PCT commissioned RedbridgeCVS to employ a Community Development Worker (CDW) who would be based in the voluntary sector *and* in a Mental Health Trust team, as part of the *Delivering Race Equality* agenda. This report is that CDW's first project.

The London Borough of Redbridge is an ethnically diverse region (the 9th most diverse local authority in England and Wales) whose mental health services, like most of those in the region, show a worrying over-representation of Black Caribbean, Black African and Other Black people, and an under-representation of Asian people. Both statistics point to disparities in understanding of mental health problems and knowledge of the services available in these key ethnic minority groups. There is also widespread fear of seeking help and of mental health services generally among ethnic minority communities. This report seeks to understand why many people in Black communities reach crisis points in their mental health so that large numbers of people are detained under the Mental Health Act, and why so many people in Asian communities spend their lives hiding their mental health problems and never find help – as well as learning lessons which can inform service design and delivery for all ethnic minority communities.

1.2 Approach

A range of ethnic minority voluntary sector groups and service users was consulted by the Community Development Worker. With most groups, mental health group discussions were set up and tape-recorded or notes were made. With one group that preferred not to discuss the issue in person, the same questions were used on anonymous questionnaires. Young people were shown clips of a film in which a young person experiences psychotic symptoms and they were asked about what they would think and do in that situation.

Questions focused on what individuals thought about mental health, whether they felt comfortable talking about it with their community and what they would do if they experienced symptoms.

1.3 Limitations

There was therefore no scope in this project to investigate how accurate people's perceptions about mental health services were. Furthermore, there was no scope in this work to find out how clinicians themselves would respond to the beliefs and views expressed here by the community. The document is one-sided insofar as it represents community recommendations without consulting clinicians, commissioners and other stakeholders on their own views. It is, however, important to give these views a platform because they illustrate what many community members believe to be true and therefore what holds them back from seeking help.

My lack of skill in speaking South Asian languages meant that I was not always able to capture the views of women in particular who did not speak English. The sample of participants was never expected to be fully representative of Redbridge's ethnic minority communities and as such not everyone's views will be raised here.

1.4 Key findings

1.41   Barriers to acknowledging mental health problems

The various minority ethnic communities' social, cultural and religious responses to mental health problems posed a number of key obstacles for individuals from such communities in acknowledging their mental health problems. Gossip, negative stereotypes, social rejection and lack of understanding all made it harder for people to identify symptoms as a problem. These were exacerbated by a lack of positive media portrayals of people living well with mental ill-health. Spiritual and faith leaders were identified as key figures who are currently not involved at all with statutory mental health services.

1.42   Barriers to seeking help

Although South Asian groups said a medical professional would be the first person they sought help from, many people suffer in silence. A number of people from South Asian communities felt it would be better to forget their problems than to talk to somebody else about them. Having family support was identified as critical to help seeking. Young Black African men, by contrast, saw psychotic symptoms as spiritual and identified faith leaders as the appropriate person to seek help from. They were quite suspicious of mental health services and were unconvinced that medication would be of any use. Not everyone is aware of the services and help available but those who did find services sometimes found them to be far better than they had anticipated.

1.43   Perceived causes of mental health problems

Ethnic minority groups' causal explanatory models of mental health problems jarred conspicuously with the Eurocentric bio-medical model adopted by NHS services. Rarely was any biological cause discussed, with social problems, family difficulties, isolation, life in a different culture or a new country, stress generally, substance misuse, psychological problems, spirits and indeed psychiatric medication itself cited as more likely explanations. This of course represents significant challenges for services to engage ethnic minority groups with their own model of mental ill-health.

1.44   Barriers to using primary care

A number of concerns deterred people from ethnic minority groups from seeking help at the primary care level, and they often waited until their symptoms become severe before seeking primary care support. People said they expected primary care practitioners not to have enough time to listen to them, to prescribe anti-depressants as a default solution, to be dismissive or tell them 'there is nothing wrong with you'. Many people felt their problems to be social rather than medical while others did not feel primary care workers had any expertise in mental health. Some people really struggled with a new clinician because they felt they would not know about their previous history and others felt any waiting list they would be put on would be so long that it would not be worth seeking help. People asked for talking therapies delivered by someone based at the general practice of the type supported by the Improving Access to Psychological Therapies agenda.

1.45   Barriers to accessing services

Ethnic minority groups wanted services to be delivered more holistically. Some people wanted complementary and alternative therapies to be available. Although this is a somewhat contentious issue, the NHS does currently provide some of these therapies and they may be a crucial way of engaging ethnic minority groups by illustrating that services go beyond the Eurocentric medical model. Many service users struggled to get their physical health needs taken seriously and ethnic minorities with multiple needs felt they were always being referred from one agency to another. The heritage of relations between White communities and ethnic minorities mean there are profound reasons why some people will be suspicious of what is seen to be a White-dominated service. Ethnic minority groups felt medication needs to be complemented by a range of talking therapies. Those not using services wanted more information in their own languages

about the help available; those using services wanted more information available translated about their medication and treatment. Ethnic minority service users felt their views were rarely consulted and wanted more support during the discharge process from inpatient units.

1.46   Service user views
Service users from ethnic minority groups emphasised the importance of statutory *and* voluntary sector community support services in their recovery. Some were very enthusiastic about being involved mental health promotion. They wanted services to take a more holistic approach to their overall health and wanted the ward environment to have a more therapeutic atmosphere. Carers also discussed their needs, particularly how they feel isolated with no help available during the night and at weekends. Ethnic minority service users struggled with the inconsistent employment support service that has been delivered in the past but overall many people were extremely happy with mental health services. Few people knew how they could complain about their care if dissatisfied and wanted something convenient which they could be confident would take their comments seriously.

1.47   The role of the community sector
Ethnic minority service users highlighted how valuable voluntary sector mental health support services are for their recovery and wanted their capacity to be strengthened so that they could expand their provision. The groups themselves struggle with the competitive nature of the funding market, leading to rivalry between groups which provide similar services and distrust about groups which do not appear to deliver what they are funded to. Voluntary sector groups wanted to work in partnership with the statutory sector but some felt they had been ignored. They highlighted the importance of working with faith leaders to engage community members with mental health services.

1.5   Recommendations

A range of important and achievable recommendations are implicated by the views expressed by the ethnic minority communities spoken to during the research for this report; a summary of all of these can be seen on the first page of the Recommendations section and in the two work plans at the end of this report.

The following actions have the potential to make the most significant impact on ethnic minority communities' perceptions of mental health and services and, therefore, their likelihood of seeking help as early on in their illness as possible.

1.51 Education and Promotion
1. Long-term programmes of both formal and informal community mental health education with a focus on myth-busting and raising the profile and accessibility of primary care, reaching out to individuals as well as key figures such as faith leaders.

2. Mental health awareness outreach education to children and young people using creative media such as film, drama and music to communicate information about where to seek help and what is available.

3. CDWs to work with a range of local media on more positive reporting of mental health and suicide stories. This could include developing a "speakers' bureau" through RUN-UP so that local service users from diverse ethnicities can be consulted by local media on mental health issues.

1.52 Within the Voluntary Sector
1. Genuine commitment by the statutory sector to acknowledge the important role of the voluntary sector, to financially invest in it through tendering long-term contracts and to undertake meaningful partnership work to build its capacity.

2. CDWs to develop a network of ethnic minority groups involved with mental health who wish to work together and explore partnership bids for funding and to collaborate.

3. Develop communication channels between statutory and voluntary sectors to enable better signposting and referral as well as partnership working and greater involvement of the community sector in the planning and design of services. This will include meaningful working relationships between the highest management in mental health services and community and faith leaders.

1.53 Holistic Healthcare

1. Low-intensity talking therapies (such as those provided under IAPT) delivered by ethnically diverse therapists (some of whom should be trained community members), not just in primary care settings but also other ethnic minority community centres to reach out to individuals who will not seek help themselves, to prevent problems escalating into more serious illness and improve early detection.

2. Future healthcare developments such as polyclinics and relocations of community mental health services to take on the suggestions of service users for a more holistic approach to mental health and wellbeing, incorporating faith, physical and mental health services, exercise, nutrition and voluntary sector services under one roof.

3. Statutory services to publicly acknowledge approaches to mental health outside of the Eurocentric medical model, for example through events to showcase its best practice initiatives under the banner of 'Holistic Healthcare'.

1.54 Accessibility

1. High quality publicity campaigns aimed at different ethnic groups in prominent community locations to dispel misconceptions about the nature of mental health services and raise positive awareness of the services available and how to seek help.

2. CDWs to work to raise the profile of primary care as an approachable first port of call for mental health services and support, ensuring it is perceived as welcoming to all ethnicities.

3. Greater involvement of ethnic minority service users in RUN-UP and NELFT service user committees as well as one-off events to consult service users and carers from specific ethnic minority communities in service planning and design.

1.55 Improvements for service users

1. CDWs to work with local carers' groups to investigate ethnic minority carers' needs and determine gaps in the service; work on an information pack in key languages to make carers aware of all of the respite and support networks available to them.

2. Cultural competence training to be delivered to a group of ethnically diverse service users. Developments to be made to expand the training into a more extensive programme for clinicians and for evaluation of training impact to be part of staff personal development plans.

3. Chaplaincy provision in NELFT to be appropriate to the ethnic diversity and breadth of faiths as well as the population size of the region covered by the four boroughs served.

This report has been an important step in attempting to understand and address the mental health needs of ethnic minority communities in Redbridge and the significant barriers they face to seeking help. The next step is taking seriously the recommendations implicated by these communities' views and engaging in meaningful work from the

lowest to the highest levels of mental health services. This report sets out what needs to be done in terms of practical, achievable actions which can, over the next two years, work towards ensuring that by the end of 2010, Redbridge mental health services can realistically aspire to *Delivering Race Equality*.

2.0   Introduction

2.1   What is an ethnic minority?

Black and Minority Ethnic (BME) groups are defined by the Department of Health in *Delivering Race Equality in Mental Healthcare* as "including those of Irish or Mediterranean origin and east European migrants"; for simplicity I will use 'ethnic minority groups' in this report.

2.2   Ethnic minority groups are over-represented in mental health services

This sector of society has long been found to be over-represented in mental health services in the United Kingdom, given its relative presence in the general population (e.g. Littlewood & Lipsedge, 1982). No-one knows why this is, although hypotheses have ranged from "migration causes mental health problems" to "more people who migrate have mental health problems" to "certain ethnicities are more vulnerable to mental health problems" to "psychiatry is institutionally racist" and beyond. While some have been clearly discredited, it is likely that many factors implicated by these hypotheses play a role in the mental health of ethnic minority groups. Some people (psychiatrists among them) strongly believe that the disproportionate numbers of Black African and Black Caribbean people on inpatient units can be attributed to institutional racism in psychiatry. This point is complex and has degrees from the view that services are less equipped to support ethnic minorities and so can provide those groups with inferior care to White groups, which is obviously correct, to the view that psychiatrists simply do not understand ethnic minority groups and mistake cultural behaviours and practices for symptoms, which is harder to substantiate. However, I will take the view in this report that the vast majority of people from ethnic minorities using mental health services in Redbridge genuinely have diagnosable mental health problems.

2.3   This finding is not exclusive to the United Kingdom

African-Caribbean, Black African and minority ethnic groups in general have been found to have a greater incidence of schizophrenia and other psychoses than White populations in the UK (Cantor-Graae & Selten, 2005). In African-Caribbean people it has been thought to be as much as a nine-fold increase. However, this trend is not specific to Black people in the UK. In 1932 it was noted that Norwegian migrants to the United States showed a two-fold increase in rates of schizophrenia compared to the White American population (Ødegaard, 1932). These findings were repeated for migrants to the Netherlands from Suriname, the Dutch Antilles and Morocco (Selten et al., 1997). These findings suggest that there may be something inherently stressful about being an ethnic minority in society which enhances people's vulnerability to developing a serious mental illness.

2.4   It is unclear why this is

Only longitudinal studies which follow the same people over time (rather than comparing different people at the same time) can show scientific evidence of causation at work. It will therefore be interesting to see the results of the Aetiology and Ethnicity of Schizophrenia and Other Psychoses (AESOP) project, which has been studying people for ten years since their first episode of psychosis. So far, many important findings have been published which indicate higher levels of mental health problems among ethnic minorities. The Institute of Psychiatry has not yet published anything to suggest why this might be. One likely explanation is that there is no one reason but the development of psychotic illness occurs through a complex combination of biological and environmental

factors which include genetic predisposition and environmental stressors such as social deprivation and experience of racism.

2.5 Ethnic minority groups are more likely to wait until crisis to seek help

An additional stressor placed on ethnic minority groups in the UK is that African-Caribbean and Black African people are significantly less likely to access mental health care through a GP than are White British people with the same needs (Morgan et al. 2005), and are significantly more likely to be referred by a criminal justice agency. There is evidence, therefore, that more Black people wait until their symptoms reach a point of crisis to seek help or be forced to seek help than do White people. Evidence in favour of Early Intervention services shows that the longer a person's Duration of Untreated Psychosis (DUP), the worse his or her outcome is likely to be (Birchwood et al. 1998). This supports the idea that if some ethnic minority groups wait longer to seek help, those groups are likely to exhibit more serious levels of mental ill-health. This could explain some but not all of the over-representation of ethnic minority groups. Nonetheless, it is clear that there are additional barriers which people from ethnic minority groups face to seeking and gaining help with mental health problems which most White British people do not.

Scientific debate aside, mental health problems are very common, and seem to be even more common among ethnic minority groups:

> At any one time one adult in six suffers from one or other form of mental illness. In other words mental illnesses are as common as asthma. They range from more common conditions such as deep depression to schizophrenia, which affects fewer than one person in a hundred. Mental illness is not well understood, it frightens people and all too often it carries a stigma.

> Right Honourable Frank Dobson, NHS National Service Framework (1999)

2.6 Delivering Race Equality in Mental Healthcare

A landmark case in ethnic minority mental health was that of David Bennett, a 38-year-old African-Caribbean man who died on 30 October 1998 in a medium secure psychiatric unit after being restrained by staff. It highlighted many issues that needed resolving in the NHS surrounding cultural and racial equality in mental healthcare. The government responded in 2005 with a plan for *Delivering Race Equality in Mental Healthcare* (DRE), aiming at:

- More appropriate and responsive services
- Community engagement
- Better information

2.7   Community Development Workers

To facilitate the goal of community engagement, DRE made funding available for 500 Community Development Workers (CDWs) to be recruited by Primary Care Trusts across England and Wales:

> *The aim of introducing CDWs is to enable greater understanding and ownership of the issues facing people from BME communities so that real improvement takes place in the commissioning and provision of mental health services across the full age range. CDWs will work to ensure full participation and greater ownership in the development of effective health and social care with BME communities themselves recognising their experiences and reflecting their aspirations.*

> *The role of the CDW may well vary according to local community needs but there are likely to be four key functions defining any CDW role. These are:*
> - *• Change Agent, e.g. by identifying gaps; developing innovative practice.*
> - *• Service Developer, e.g. promoting joint working, education and training.*
> - *• Capacity Builder in BME communities.*
> - *• Access Facilitator to services; community resources; overcoming language and cultural barriers.*

> Community Development: Workers for Black and
> Minority Ethnic Communities: Interim guidance (2004)

Redbridge currently has two fully funded CDWs. One is based half in the voluntary sector at RedbridgeCVS and half in the statutory sector in the Redbridge Early Intervention in Psychosis team; the other is based at the 19 Mansfield Road mental health day centre run by Family Mosaic. These two workers are strategically very well placed to enable them to carry out the four key roles of CDWs as illustrated below.

Figure 1: The four key roles of Community Development Workers
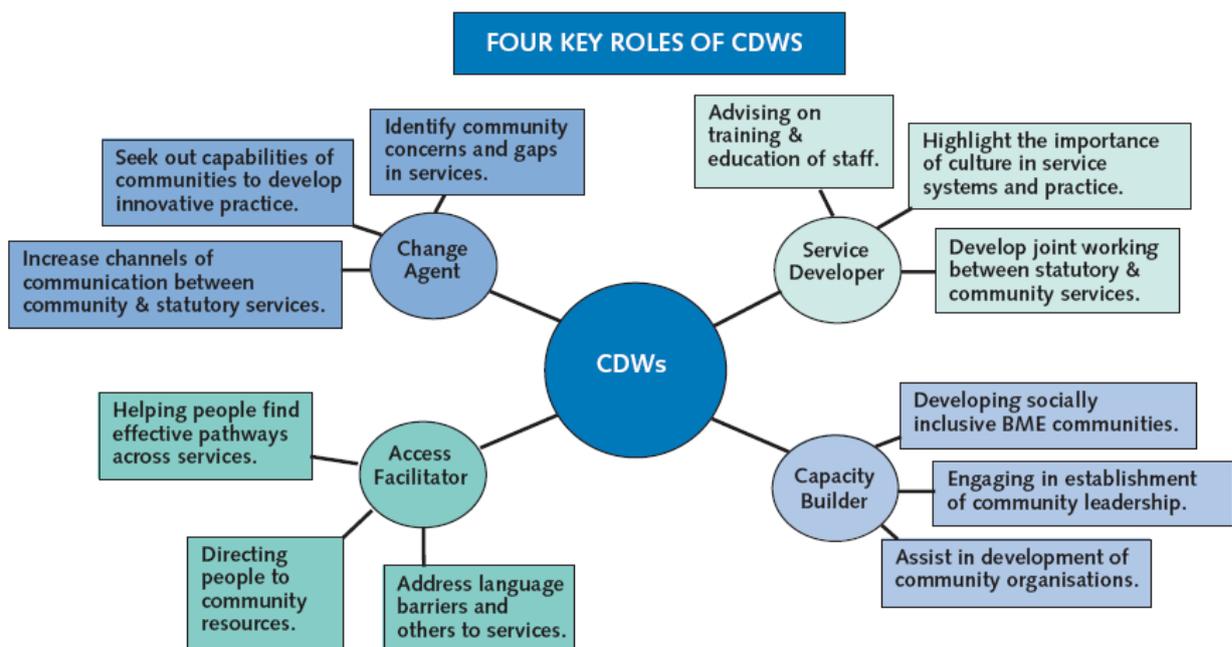
CDWs are key workers in the DRE agenda but it is important to highlight that fulfilling the twelve objectives of the programme is certainly not the responsibility of them alone. Delivering Race Equality in mental healthcare is everybody's business. This report outlines the areas in which their involvement is imperative but also highlights the critical areas for development by mental health services themselves.

DRE highlights the fundamental role of the voluntary community sector in improving the delivery of mental health services to ethnic minority groups:

> *All communities have a role in preventing mental health problems and providing an environment where people who have become ill can recover and prosper. BME communities often have to go further, filling the gaps between their needs and NHS mental health service provision. Though sometimes under-resourced and poorly integrated into the wider mental health economy, the BME independent sector has continued to develop innovative services and has higher patient satisfaction ratings than statutory services.*

<div align="right">Delivering Race Equality in Mental Health Care, Department of Health (2005)</div>

2.8 The goals of Delivering Race Equality

The specific goals of DRE aim, by 2010, for mental health services to be characterised by:

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

Points 5, 6 and 7 fall outside the scope of this report. They are important goals in Delivering Race Equality and must be addressed by the relevant services but will not be discussed here. Point 9 is to some extent an indirect measure of the efficacy of Early Intervention Services: if Early Intervention Teams work well, we should expect to see a reduction of ethnic minorities with mental health problems represented in prison populations. Ways of addressing the other eight goals are raised by the discussion with community groups outlined in this report and a series of recommendations follows accordingly.

2.9   The limitations of these goals

It is important to note at this stage, however, that objectives 3 and 4 in particular are long-term goals which cannot be achieved rapidly because they relate to complex interactions between ethnic minority groups' mental health, fear of services and the quality of treatment these groups receive. To some extent objectives 3 and 4 are informed by the view that mental health services are institutionally racist and almost suggest that there are significant numbers of ethnic minority service users who could be discharged from wards, because they are simply not ill. As I have outlined, this is a contentious view which is difficult to substantiate. It is nonetheless important to acknowledge that much more can be done by services to reach out to at-risk groups of people and in this, Early Intervention Services are pivotal in diverting ethnic minority groups from the paths of inpatient admission and compulsory detention. In his reply to a British Medical Journal article on the subject of institutional racism in mental health services, Paul Fearon and Robin Murray of the Institute of Psychiatry point out:

> *While DRE offers a plan to tackle the observed differences between groups in MH [mental health] care, its weaknesses lie in its assumption that these inequalities have their roots primarily in discrimination within services. To take but one example from the 12 targets set by DRE: 'A reduction in the rate of admission of people from BME communities to psychiatric inpatient units'. If this target was set for any other disorder known to affect BME groups (e.g. hypertension or diabetes in African Caribbean people, or coronary artery disease in South Asian men), such a target would be regarded as discriminatory.*

<div align="right">Fearon & Murray (2007)</div>

2.10   The role of Early Intervention in DRE

Early Intervention in Psychosis is an approach to mental health services which emphasises the importance of intensive treatment as soon as a person experiences symptoms. It comes from a strong evidence base first piloted in Australia and is part of three strands: "Promotion, Prevention, Early Intervention" to reduce the number of people with disabling levels of serious mental illness. It is anticipated that all boroughs in England will soon have an Early Intervention Team in place, meaning that when a client moves away from Redbridge he or she can expect to receive the same level of care elsewhere in the country. The Redbridge Early Intervention Team, set up in May 2007, aims to:

*   Provide a comprehensive, integrated package of care to young people aged 14-35 living in Redbridge experiencing or suspected of experiencing a first episode of psychosis and to:
*   Ensure the duration of untreated psychosis is no longer than 6 months for any one individual, with a service mean of 3 months.

The service is delivered by a multidisciplinary team, including occupational therapists, community psychiatric nurses, social workers and psychologists. A client's Duration of Untreated Psychosis (DUP) is defined as the number of days from the first onset of psychotic symptoms until the first time anti-psychotic medication is taken. A shorter DUP tends to correlate with a better prognosis for recovery.

The placement of one Community Development Worker within both the voluntary sector and the Redbridge Early Intervention team is ideal, because Early Intervention is such a critical aspect of ensuring race equality in mental health. The team is also unusual in that one of its objectives is to reach out to key community figures including schools, colleges and GPs to publicise its services and raise awareness of psychosis, an aspect which a CDW can be very involved with.

2.11 Redbridge's ethnic diversity

Redbridge was the ninth most ethnically diverse local authority in England and Wales at the 2001 census and GLA population projections in table 1 and figure 2 reveal growing percentages of ethnic minority groups and corresponding reductions in percentages of White British residents. At 16% Indian, 8% Pakistani and 3% Bangladeshi, South Asian communities make up the largest ethnic minority at 27%, followed by Black African (5%), Other Asian (5%) and Black Caribbean (4%) communities. The concerns raised in this report about South Asian communities' mental health and the projection for 37% of the population to be South Asian by 2026 together implicate the need for Community Development Workers to target a specific portion of their work at this ethnic group.

Table 1: Redbridge Ethnicity Populations Projections 2001-2026

| Ethnic Group	2001 No.	%	2007 No.	%	2012 No.	%	2017 No.	%	2022 No.	%	2026 No.	%
White	153,589	63%	135,967	54%	125,060	49%	124,010	45%	117,993	42%	114,497	41%
Black Caribbean	9,235	4%	11,052	4%	12,068	5%	13,354	5%	14,005	5%	14,404	5%
Black African	7,942	3%	11,617	5%	13,186	5%	14,954	5%	15,341	6%	15,457	6%
Black Other	3,807	2%	4,642	2%	5,025	2%	5,519	2%	5,714	2%	5,804	2%
Indian	33,804	14%	41,484	16%	46,586	18%	52,419	19%	56,197	20%	58,698	21%
Pakistani	15,131	6%	21,001	8%	24,844	10%	28,770	11%	31,443	11%	33,129	12%
Bangladeshi	4,281	2%	6,648	3%	8,240	3%	9,931	4%	11,065	4%	11,765	4%
Chinese	1,981	1%	2,171	1%	2,243	1%	2,417	1%	2,436	1%	2,442	1%
Other Asian	9,212	4%	12,300	5%	14,122	5%	16,103	6%	17,201	6%	17,825	6%
Other	2,912	1%	4,545	2%	5,430	2%	6,312	2%	6,686	2%	6,833	2%
All Ethnicities	241,893	100%	251,428	100%	256,804	100%	273,788	100%	278,082	100%	280,854	100%

Source: © GLA 2006 Round Ethnic Group Projections

Figure 2: Ethnic trends over time, 2001-2026
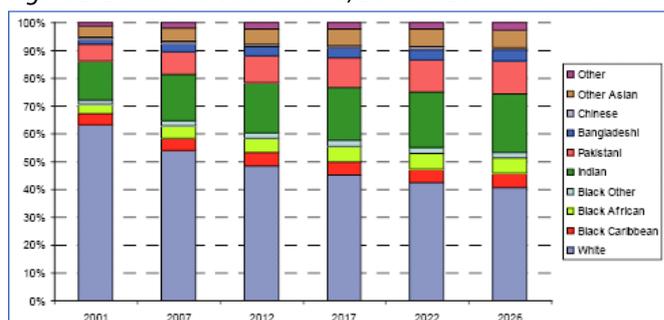
Source: © GLA 2006 Round Ethnic Group Projections

Figure 3: Redbridge ethnic composition 2007
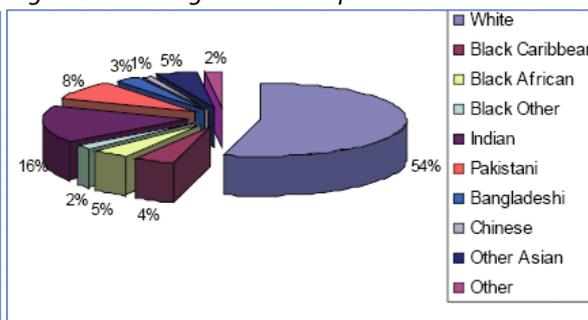
Source: © GLA 2006 Round Ethnic Group Projections

2.12 The disproportionate representation of ethnic minority groups in Redbridge acute mental health services

Black Caribbean, Black African and 'Black Other' groups currently constitute a smaller ethnic minority at 11% of the population in 2007 than South Asian groups. However, rates of psychiatric inpatient admission of Black people by the North East London NHS Foundation Trust (NELFT) across Redbridge, Waltham Forest, Barking & Dagenham and Havering were 85.89 admissions per 100,000 in the population compared to 43.84 per

100,000 of all White people and 32.63 per 100,000 of all Asian people (National Mental Health Ethnicity Census, 2008). This suggests that Black Caribbean, Black African and Other Black populations constitute a significant group at which Community Development work and mental health outreach education must be targeted. These figures also suggest that Asian groups in general are under-represented; perhaps Black communities wait until their illness is so severe as to require inpatient admission to seek help whilst Asian communities also hide their mental health problems but perhaps manage better to contain them within the community. Both groups require targeted education and mental health promotion to demystify mental health services and make treatment more accessible and less intimidating.

In Redbridge 22.08 Black people per 100,000 of the Black population were detained under the Mental Health Act in 2008 compared to 9.90 White people per 100,000 and 10.06 Asian people per 100,000. Importantly, 34.30 "Mixed Ethnic" people were detained per 100,000 people in the population. This finding is important as it has been previously found that there are elevated levels of mental health problems among mixed White and Black and Mixed White and Asian groups of people.

Ethnic mental health inequalities are a complex field in which many questions remain unanswered. The ethnic diversity of the Redbridge population is growing and there is clear evidence of over-representation of Black groups on inpatient wards and detained under the Mental Health Act and under-representation of Asian groups on inpatient wards. This forms compelling evidence for a need for services to reach out to ethnic minority groups and change referral pathways and service options so that the most vulnerable communities feel able to seek help for mental health problems as soon as they arise. The creation of a Redbridge Early Intervention Team and the appointment of Community Development Workers in the borough were the first step to ensuring that services truly are *Delivering Race Equality in Mental Healthcare*. The second step is the fulfilment of the recommendations outlined in this report, as a direct response to the views of Redbridge's ethnic minority communities.

3.0   Methodology

In order to find out what ethnic minority groups in Redbridge think about mental health I spoke to a selection of community groups and individuals.

3.1   Participants

The participants constituted:

- Four different groups of **South Asian women** from across India, Pakistan, Bangladesh and Sri Lanka aged predominantly in their thirties, forties and fifties. Most of the women were born abroad and migrated to Britain later. One of these groups met because of their common involvement with mental health services, one group met because of their shared experience of "depression" (which covered a range of mental health and social problems) and one was a social group.
- Two **South Asian women** working with South Asian women's community groups also gave detailed interviews.
- **South Asian men** using a mental health support group filled in questionnaires about their experiences. They were predominantly Indian in their forties and fifties and several were from Bangladesh.
- **Jewish men and women** using a Jewish mental health day centre, most of whom were born in Britain.
- **Black Caribbean men and women** using a Caribbean older people's social group.
- A **Black Caribbean couple** who have been caring for a relative with mental health problems for more than twenty years.
- **Black African young men** aged between fifteen and twenty-one who were using a youth drop-in centre, most of whom had been born in East or Central Africa and had migrated to Britain with their families as children.
- Three **members of faith communities** representing their faiths on the Redbridge Faith Forum.
- Three multi-ethnic groups of **male and female mental health service users**, using a mental health day centre, a supported volunteering service and a hearing voices group, most of whom were White or South Asian.
- One multi-ethnic group of people caring for loved ones with mental health problems.
- A range of voluntary and statutory sector staff of all ages, ethnicities and genders.

Groups which I planned to consult with but for a range of reasons was unable to meet in the time available included refugees, migrants and asylum seekers, representatives of the Muslim faith, the Somali community and Eastern European groups including the Roma traveller community.

It is important to acknowledge the diversity which lies behind ethnic categories. For example, by saying 'South Asian' or 'African' I do not imply that there is no difference between people from one part of this region and another. South Asia and Africa of course encompass diverse cultures, languages, faiths and nations. When I use such phrases to group ethnic minorities together it is simply to illustrate that a certain view was common to representatives of that region, and not that it applies to everyone or that those people are 'all the same'.

It was important to hear the views of South Asian communities since they constitute by far the largest ethnic minority group in Redbridge. The borough's population is 54% White, 16% Indian, 8% Pakistani, 3% Bangladeshi (27% South Asian in total), compared to 5% Other Asian, 5% Black African and 4% Black Caribbean (Redbridge Public Health Report 2007-8). There is a somewhat more established voluntary sector within the

Redbridge South Asian community than in some other ethnic minorities, which made consulting with large community groups easier.

The more limited voluntary sector for other ethnic minorities should not be seen as a barrier to working with them, however. There are other ways of engaging with ethnic minorities, such as through churches and other religious centres, social activities like music events, local businesses including barbershops, hairdressers and clothes shops, etc. For the purposes of this research, however, there was more extensive discussion with the South Asian community, which was considered appropriate since it is by far the most numerous ethnic minority in Redbridge.

3.2   Method

The key questions which I sought to ask groups are listed below. In many cases, however, conversation flowed naturally from one issue to another, and the key themes about GPs, spirituality and so on came entirely from the speakers themselves. In many cases I was instructed by staff not to use the phrase 'mental health' and instead to talk about 'emotional wellbeing', 'depression', 'worry' and 'stress'. The genuine stigma even around the basic term 'mental health' has implications for engaging these communities with services. It will be interesting to see whether the change of name of the North East London Mental Health Trust (NELMHT) to the North East London NHS Foundation Trust (NELFT) has any impact on engagement or if it just causes confusion.

For the South Asian men's group the questions below were simplified to produce a written questionnaire. For the young men at the youth drop-in centre, I showed them two clips from the film *Donnie Darko* in which a young man experiences psychotic symptoms, hallucinating that a human-sized rabbit with a skull for a face is telling him to commit crimes. I then asked them to tell me how they explained his experiences and other questions modified from those below to relate to the film such as "If this happened to you, what would you do?"

1. What does it mean to have good mental health? What things do you need in life to have good mental health?
2. What does it mean if you do not have good mental health? If someone you knew was suffering from a mental health problem, how would you explain it? What has caused it?
3. Are you happy to talk about mental health in your community? Who would you talk to about mental health problems?
4. If your friend started to act strangely, perhaps having a changed mood or personality or hearing voices which were not there, what would you advise them to do? If it was your son or daughter what would you do? Where would you go?
5. If you were not born in the UK, what would you advise the same person to do if you were living back home?
6. What services are there for someone having mental health problems? Are there services which you think should be there but are not there?
7. What stereotypes come to your mind when you think about mental health?
8. If you or somebody you know has ever used any mental health services, how did you find them? Before you used them, did you expect them to be different to how they are? If you could make services better what would you do? Do you feel like you could make a complaint about your care if you wanted to?

3.3   Limitations

This document was intended to investigate and outline the views of ethnic minority community members about mental health and the barriers they face in seeking help. There was therefore no scope in my work to investigate how accurate people's perceptions were, for example whether it is really true that many GPs prescribe anti-

depressants to individuals from ethnic minorities as a default measure. It is therefore important to make clear that the views expressed in quotations are not intended as direct criticisms of services and are not necessarily my views or those of RedbridgeCVS. It is, however, important to give these views a platform because they illustrate what many community members believe to be true and therefore what holds them back from seeking help.

Furthermore, there was no scope in my work to find out how clinicians themselves would respond to the beliefs and views expressed here by the community. The document is very much one-sided insofar as it represents community recommendations without consulting clinicians, commissioners and other stakeholders on their own views. All of the information provided here is accurate to the best of my knowledge at the time of completion (August 2008).

All of the participants spoke English fluently except for a significant number of South Asian women. Unfortunately I do not speak any of the important languages which would have helped me to communicate with them, which they identified as Hindi, Urdu and Punjabi. Wherever possible, other women translated on their behalf but it was obvious that by virtue of not speaking South Asian languages the views of a significant number of women were not heard. The views of these women may indeed be the most important to hear since they are the people most likely to struggle to ask for help from services. I therefore recommend that when recruiting for a new Community Development Worker, the post be advertised in publications likely to be seen by South Asian workers and to give some weighting to community language skills when short-listing applicants.

I could not be said to have consulted a sample which was truly representative of the breadth of ethnicity to be found in Redbridge (England's ninth most diverse borough) and I never pretended to. Since I did not have the capacity to conduct a fully comprehensive survey, I spoke to groups of people and individuals who were happy to talk to me about mental health, to gain a flavour of community views as a starting point from which community development work in the borough can only expand. It is therefore likely that there are people in Redbridge with much more stigmatised views about mental health than those represented here. It is also likely that some people censored their views about mental health since they knew that I had some involvement with mental health services.

3.3   Strengths

I was very impressed by the honesty of all of the people I spoke to and the breadth of views which I was able to capture. Although many discussed the challenges of speaking openly about mental health in their communities it was clear that in an open and understanding forum many people were very comfortable to talk candidly about their views and experiences. This suggests that it is the fear of what other people will think and say rather than an essential reluctance to be open about mental health problems which bars many people from seeking help early on. I was also struck by the broad similarity among the views of people from quite diverse backgrounds. The themes discussed in most detail here are selected because they came up time and again without any prompting from me on the subject.
While I may not have been able to speak community languages, all participants were positive about the discussions. The young men I spoke to really responded to talking about mental health with reference to film clips and this is a useful method which should be used more often to engage young people around mental health. Many service users said they wanted more public opportunities to discuss mental health and many people had questions to ask me about their own or a loved one's mental health. This was clear evidence that communities were keen to be more engaged with mental health information and promotion but did not know where to look for it. The role of Community

Development Worker, as ambassador for services and sign-poster to important sources of help, is clearly a worthwhile one in Redbridge, where there is a lot of work to be done.

The value of listening to what people say about mental health in Redbridge is to get a glimpse of what people may say about it behind closed doors; the most stigmatised views may never be aired with a total stranger. It cannot tell us 'what everybody thinks' because of course everybody is different and thinks something different. What I hope this report highlights is that people's views and experiences are starkly personal and so for services to be appropriate to everyone they need to be far more flexible and do a lot more listening to what the individual needs. It also shows that current views are practically universal: many people have the impression that their GP is not approachable, accessible or appropriate for mental health problems. Something so fundamental illustrates a key area which community development work can target: working to improve the public perception of GPs among communities but also with the professionals themselves.

Ultimately the message of this report must be that whilst the complex area of over-representation of ethnic minorities in mental health services is one which we cannot expect to be fully understood for many years to come, there is a wealth of practical, easy changes to be made and projects to be implemented which can ensure that the accessibility and approachability of services for all is maximised. I will discuss recommendations later on but for the following sections I have tried as far as possible to let the words of the community members who gave their time so generously speak for themselves.

4.0 Barriers to Acknowledging Mental Health Problems

Mental health problems were universally acknowledged by all of the people I spoke to as being stigmatised within their community. Why this is, is a complex issue relating to historical, cultural and societal attitudes to mental health. It seems that ignorance about mental health problems coupled with the fact that symptoms manifest in beliefs and behaviours considered abnormal lead many people to perceive them as in some way the 'fault' of the individual. It is, for example, difficult for families to understand why a relative's delusion is so fixed. Society in general does not have a culture of sympathy towards mental health problems and they are very much placed in a markedly separate category from physical health problems perceived to be beyond the sufferer's control, such as cancer. As this report will outline, mass media (not always well known for their accuracy) are most people's principal sources of mental health information and as such, stereotypes of 'crazy' people who are 'dangerous' predominate. In many ethnic minority groups this broad stigma is compounded by cultural concerns, for example about children's marriage prospects if mental ill-health is known to 'run in the family'. Furthermore, the general public is understandably not very aware of what mental health services are like and the iconic images of asylums and their archaic practices have been enduring. All of these factors lead to communities struggling to talk about their mental health, with ethnic minority groups facing additional barriers to seeking help. The first step is to acknowledge that you are not feeling well mentally. As this section outlines, there is a number of reasons why people from ethnic minority groups in Redbridge fall at this initial hurdle.

4.1 Summary

- Some Jewish and South Asian groups felt it was their responsibility to deal with mental health problems within the family and saw acknowledging a mental health problem as a sign of personal and familial failure.

- Some ethnic minority groups will not acknowledge a mental health problem because they experience their symptoms physically and so are more likely to be viewed by services as hypochondriac.

- Negative and out-dated stereotypes of what a mental health problem is like mean that some people do not consider their symptoms a mental health problem because they do not correspond to that image.

- Gossip, social rejection and negative community reactions to people with mental health problems meant that many people from ethnic minority groups do not feel comfortable considering themselves to have a mental health problem. Lack of understanding and fears about who you can trust were common. Ultimately this points to severe ignorance in the general public about mental health.

- A range of groups wanted community education about mental health, and for this to start with children in schools. Two important projects are due to commence in Redbridge schools but neither will work with young people themselves.

- Many people identified spirituality or religion as critical to their recovery but the NELFT provision of chaplaincy is extremely limited. Faith leaders were identified as key partners who needed to be worked with for better community signposting and referral to services. There are also common religious interpretations of mental health problems which can sometimes be very negative and can be remedied by greater community awareness about services and support available.

- Hearing about famous people who have had mental health problems has a profound impact on people's perceptions. Positive promotion around mental health is being taken up nationally and can also be achieved by CDWs on a local level. High levels of mental health stigma are to be found everywhere, including the voluntary sector and to some extent may be attributable to the misleading depictions of mental health in the media. It will be important in Redbridge to make creative use of local media to combat stigma and ignorance.

4.2 'Asking for help means that you have failed'

There was general consensus among all of the groups I spoke to that mental ill-health remains a taboo, stigmatised subject.

In the South Asian community, people talked about a lack of acceptance of mental ill-health as a problem for this group:

They think 'just get on with it'; you're not allowed to be depressed.

There is a strong sense from South Asian and Jewish people that family mental health problems are kept secret. They cause embarrassment and families will worry what other people will think and say.

People from South Asian, Jewish and Catholic communities all talked about how admitting to having a mental health problem and asking for help means admitting a failure to deal with a problem yourself or within the family unit and:

They feel it's a reflection on them being a bad parent, husband, spouse, because they've not been able to deal with it.

One Rabbi commented that people could feel shame and embarrassment to return to their synagogue after having a mental health problem: it is considered akin to a personal failing rather than something which a person cannot avoid like heart disease or cancer.

One South Asian woman using mental health services commented that being with people who were afraid of mental health problems made her feel like they must be right. It is clear that the current community levels of fear and stigma surrounding mental ill-health will impact negatively on the self-esteem and recovery of people coping with mental health problems.

4.3 Mental health problems are experienced as physical health problems

Research suggests that some people may experience what those in the West call a 'mental health problem' through physical symptoms, 'somatising' their emotional experiences (Rack, 1982). One example is the 'sinking heart' discussed among Punjabi people (Krause, 1989) which we in the West approximate to depression. Some ethnic minorities may not acknowledge that mental health problems of any kind affect their community because they perceive mental health in physical terms. This has been observed in Redbridge by the Accident and Emergency Psychiatric Liaison service:

We have noticed that the Asian community can try to physicalise it. Some can seem to be hypochondriacs, coming to A&E for many minor physical complaints. They can present with a physical presentation, then the physical doctor may refer to us... An Algerian man collapsed with chest pain and he was being bullied at work and was clinically depressed; he was physicalising.

4.4   Negative stereotypes

Very negative and quite out-dated stereotypes of people with mental health problems were commonly discussed by South Asian people I spoke to:

Someone who can't cope with things themselves. They don't have the right faculties, not able to think properly, not able to do day to day functioning properly. Need to be looked after, can't be left alone. I don't think of milder problems when I think of mental health.

It was mentioned that learning disability and mental health were confused or considered to be the same thing by some people, which echoes the findings of studies conducted in the United States in the 1980's (Caruso & Hodapp, 1988). This again implicates low levels of community mental health knowledge.

Because mental health is rarely talked about, people may assume that the only people with mental health problems are the small minority who are visibly unwell:

There is a perception of people with mental health problems as the 'down and outs', but when… [someone I knew] was mentally unwell it is true, he did look odd. I felt the medication made him look peculiar: he had tics, a shambling walk, personal hygiene problems. What you see of people with these problems is looking 'untouchable', disreputable, a 'loony' Sometimes they may latch onto you, so you walk past them quickly. It makes denial easier for other people with mental health problems. They can say, "Look, I'm not like them" or "I don't want to be like them".

4.5   Gossip

People from ethnic minorities who had mental health problems frequently reported very negative reactions from people in their community. Those who had not told anyone outside their family were often very afraid of being gossiped about. The close knit nature of South Asian communities in particular creates genuine fear that if one person finds out about their mental health problem it will soon be known by everyone. Again, the theme that mental health problems are a personal failing rather than something out of one's control was recurring.

Examples of South Asian men and women's negative experiences are of rejection and isolation by their community:

My neighbour and I had a fight and she told me that she had cursed my son, who has mental health problems, so you see, if you talk about it this is what happens.

If you tell your community they give you bad looks… They'll say "This person is mad" behind your back, "Don't talk to him", they don't give you support.

When I try to mix with people they always push me away. They say "you always talk rubbish, stay away". Nobody wants to do things with me.

Yes, lots of men and ladies have mental health problems but they are hiding it because they feel embarrassed. Pakistani and Indian people laugh at them, bully them… Knowing your weakness they will tell the whole community you're mad, don't talk to them, don't sit with them. They don't respect you, they don't respect anyone, even their own family.

And a general lack of understanding:

They don't understand. I thought I was normal but they said I'm mental… They said "you look ok, there's nothing wrong with you, you've got a family, a house, a husband, you're not an ill person."

This notion that people who have families and homes could not have a mental health problem illustrates a grave need for community education to improve understanding about the pervasive nature of mental health problems and the range of severity. In addition,

People may worry about its effect on the family's marriage prospects. Even dementia may not be mentioned to neighbours because they will think it runs in the family and that will affect marriage.

Only speaking to people you trust, people who are not strangers, was a recurring theme mentioned by many South Asian people. Since it is frequently reported that ethnic minority groups are often mistrustful of mental health services, this will be a key issue when encouraging these groups to seek help from services as soon as they experience symptoms.

Although these negative experiences were particularly pronounced among South Asian people I spoke to, many issues were common to other ethnic minorities. The Jewish group discussed how it is important for them that the building where they meet has no sign identifying it as a mental health centre. They commented that they like the fact that people on the street wouldn't know where they were going.

> *One woman when I did tell her where I go, she looked at me in horror, 'Oh, oh', she said.*

This obviously has significant implications for people accessing mental health services based at Goodmayes Hospital, which is a well-known building only accessible by a limited number of bus routes. Whilst attitudes to mental health remain highly stigmatized, this suggests that services need to be placed in discrete, approachable locations which people feel able to access. However, the root cause of community misunderstanding and fear also need to be tackled head-on.

It is important to acknowledge that these negative experiences of stigma are in no way exclusive to ethnic minority groups. Several White British people using a mental health day centre mentioned how difficult it is to talk to their communities about mental health and that they will always choose to speak to fellow service users instead.

Mental health problems mark you for the rest of your life. It's unfair, it happens to all of us but people think they have to be careful of us. It goes against you, for example when applying for a job but they won't take it off your record. We need more respect for all of us.

The point that these discussions raise is that there are additional cultural and social factors such as the closeness of communities which (while being positive in many ways) can magnify the extent of the negative experiences of ethnic minority groups and contribute to them waiting to seek help until they reach a point of crisis.

4.6   Lack of understanding

There was universal agreement among those that I spoke to that there is insufficient education about mental health for the community. Many people suggested that mental health needs to form part of Personal, Social and Health Education programmes in schools. A group of young men also suggested that there should be education provided at university level since this is a time when a young person's life really begins to change, and that students would then pass on the knowledge to their younger siblings. In fact, universities tend to provide extensive pastoral care and mental health support to those who need it, which far exceeds provision in schools.

> *Jewish Care has developed an innovative service working to raise awareness and acceptance of those who have mental health needs. By educating people in schools, synagogues and other community organisations, they hope to break down prejudice, fight ignorance and promote social inclusion. They deliver creative presentations that bring mental health issues to life and deal with them in straight-talking, easily understandable language. Service users, their carers, volunteers and professionals take part in presentations that use drama, life stories, art, audio visuals and music. Some workshops offer an introduction to emotional wellbeing whilst others focus on more severe mental health issues such as schizophrenia, bipolar disorder or depression. They comply with the National Service Framework standard one for mental health. They work with Jewish and non-Jewish secondary schools, employers, synagogues, community social groups and businesses. The service works in partnership with the Department of Spiritual, Religious and Cultural Care at the East London and Hackney Mental Health NHS Trust*

In Redbridge, funding has been secured from the London Care Services Improvement Partnership (Children and Families) and the Charlie Waller Memorial Trust for a training programme to improve the quality of school mental health. It aims to equip school staff for early identification of mental health problems, to promote children's resilience and to support those children most at risk of developing problems. Its principal objective is an improvement in mental health knowledge and attitudes, an alteration in referral patterns and an increase in confidence about providing support at the lowest level.

The Redbridge Child and Adolescent Mental Health Service (CAMHS) is also piloting a new schools mental health worker role in addition to the support their senior Community Psychiatric Nurse provides to the three schools with the highest proportions of referrals and the Hear and Now counselling service provided in schools. However, there has not yet been a programme of mental health education for young people themselves:

We should start making school children aware that mental health is classless, it doesn't matter who you are, it can happen to you.

One man pointed to the success of Drugsline's Joining the Loop project, a collaborative drugs information line between the Jewish and Muslim communities in Redbridge, as evidence that disparate groups can work together to raise awareness of taboo issues because their problems are essentially the same.

> *Joining the Loop is a pioneering partnership project initiated between Rabbi Aryeh Sufrin of the well-established Redbridge charity Drugsline and Imam Haroon Rashid Patel, Qalb and the League of British Muslims. The project acknowledges the high levels of stigma that surround drug use in Jewish and Muslim communities and the extreme reluctance to talk about the issue openly despite widespread usage. With a £115,000 grant from Redbridge Council they were able to expand Drugsline's existing telephone helpline with specialism for Jewish callers to also support Muslim groups, delivering support in English, Bengali, Urdu and Gujarati by Muslim community volunteers. Manager Christina Ball comments "These callers would find it much harder going to a mainstream service where people don't understand their background. This could be the only service they feel comfortable using as a first step."*

> *I'm open but I get varied reactions but by and large people don't really understand. There is a lack of awareness in terms of mental health. Not enough is done by the mental health system to make things known, there is a lack of insight. You need more campaigns, posters, leaflets, stuff circulating publicly. World mental health day isn't enough, you need more events to reach out to the public, more in the street.*

Mental health service users were looking for more openness:

> *They should have public forums where people can talk about it. If it's swept under the carpet misconceptions get worse.*

> *They shouldn't segregate treatment. It should happen at health centres, GPs, it should be just like any other condition.*

But not everyone spoke of being unable to talk about their mental health problems. Particularly among people who had been living with mental ill-health for several years, some people do feel able to talk about mental health in ethnic minority communities. These individuals could play a critical role in campaigns to raise awareness among the general public.

4.7   The role of spirituality

Spirituality was a key theme raised by many people and without any prompt from me. A number of South Asian service users said that spirituality, religion and meditation were critical to their recovery. People who had spent time on inpatient wards said that they would have liked to have had a place to pray, reflect or meditate:

> *Mental health [services] should provide more opportunities for spirituality, meditation. Don't force people, just offer it – I helped myself. They could have candles and a place to think. You get to know your inner self, you are a child of God just like everyone else. To value God. To be non-denominational.*

> *I saw Jesus in a dream and converted to Christianity, it helped a lot. I used to go to the chapel in Goodmayes when it was there. Places to pray are excellent. I like to have a church, I like to have a room for meditation.*

The Goodmayes chapel has now closed and there is just one chaplain to serve all four boroughs in the North East London NHS Foundation Trust (NELFT) in addition to serving Whipps Cross University NHS Trust. Neighbouring mental health trusts serving similar-sized populations provide the equivalent of four full-time chaplains, broken down into sessions provided by mental health-trained spiritual workers representing a breadth of faiths. The complete lack of sufficient chaplaincy provided by NELFT indicates a total disregard of the importance of spirituality to many ethnic minority and indeed White British communities, and of the role it has to play in recovery. This has been acknowledged by the Healthcare Commission (2008). Under the question "Is the care and support provided appropriate to individual needs?" NELFT inpatient wards scored just 1 out of 4 for assessment of, and access to staff support for, cultural and spiritual needs (Healthcare Commission (2008).

Members of the Redbridge Faith Forum highlighted the significance of faith leaders in the process of referral to mental health services and it is obvious that links need to be forged between faith leaders and services. One Jewish organisation had received feedback from synagogue workers that some felt frightened and ill-equipped to deal with the needs of people with mental health problems. Redbridge Faith Forum is seeking funding for mental health awareness training for faith leaders. Barking and Dagenham's mental health Local Implementation Team has decided to prioritise delivering Mental Health First Aid awareness training (a Department of Health and Care Services Improvement Partnership backed course) to all faith leaders in their borough. Such initiatives present an excellent start to developing links between faith groups and mental health services but this will also require meaningful time to be spent by both sides to understand one another. Community Development workers can be pivotal in facilitating this work.

A person may not be able to ask for help and a faith community can be there to identify where this is needed. We confirm that having a mental illness does not make them a bad

person: we can push away stigma… we believe very strongly in the power of prayer… but one must also seek the help of a competent physician. People come to them [local spiritual assembly] for advice and help, signposting, loving support. We encourage a prayerful attitude but acknowledge that prayer isn't the answer to everything.

Faith beliefs may interact with a person's mental illness and faith leaders can provide important non-clinical support for people who ask for it:

Exorcism is not part of our culture but a very distressed woman asked for an exorcism and her Rabbi did come up with Hebrew verses to soothe her. She hasn't been back.

There was a perception from some people that mental health services do not understand basic faith needs such as festivals, dietary requirements and holy days on which meetings shouldn't be scheduled. A greater focus on cultural sensitivity and understanding from services is needed. Cultural competence training is the first step. For example people from faiths which celebrate many festivals with focus on family interaction may be more affected by social isolation as a result of their mental health problem at certain times of the year. Perceptions of not being understood are likely to hold people back from seeking help and make them afraid of inpatient treatment. It is very positive, for example, that there are no mixed-sex ward environments at Goodmayes hospital, but it is unlikely that ethnic minority groups are aware of this fact.

Other people have had very negative experiences of their mental health problem being ascribed to Satan, demonic possession, djinns or other spirits and have endured unpleasant ceremonies to get rid of the spirit. For those who do not want such treatment, this only adds to the feelings of isolation and abnormality. Much of this could be remedied by ensuring better information and understanding about mental health problems and services in the community. Whilst traditional beliefs are very entrenched and likely to remain, it is important to ensure that as much information is available as possible and that faith leaders become more active signposts to services where appropriate.

Faith beliefs can also contradict the message of mental health services. Services must strive to work together with faith groups to show that treatment options are not mutually exclusive. A person can receive mental health services while getting support from their faith community at the same time:

I saw one Catholic couple whose daughter had real problems; a social services person pulled lots of strings to get her support, but the parents didn't attend the appointments. The grandmother was a nurse and said they shouldn't go, they would offer up a mass for her instead. There was real ignorance despite her medical profession. She was scared of where asking for support might lead.

Of course not everyone who has a religious community will use it to seek help. People may stop attending their place of worship when they are unwell and it may be important to make a show of success to one's faith leader. What is important is that faith involvement is comforting to some people and gives a sense of belonging where mental health problems can encourage isolation.

These comments from a multi-ethnic group of mental health service users reveal the complex and diverse relationship between faith and mental health and the importance of acknowledging its role.

> *"My faith has really helped me."*

> *"Religion can twist what mental health is."*

> *"Religion has helped me."*

"Some people with religious beliefs can attack you."

"If I dwell too much on religion I end up not knowing what to do but a little   guidance helps."

"Bad spiritual forces can cause strange experiences."

"You are very vulnerable and feel like the worst kind of person. Sometimes religion gives you something to believe in."

4.8   The role of the Media

Many people commented on the impact a famous person having a mental health problem had on the views of the general public. Stephen Fry's documentary, 'The Private Life of the Manic Depressive' was often cited as a good illustration that a mental health problem is not the whole of you. Stephen Fry is a successful, intelligent and charismatic person. It seemed that the message that a person like this can have a mental health problem really was radical for many people. One carer talked about how hearing that chat show host Trisha Goddard had had mental health problems made those of her own family less embarrassing. Even the news story about a wealthy barrister who had alcohol problems and was shot dead by police was said to make mental health problems seem more common: they can happen to anyone.

An internationally acclaimed long-term media campaign in New Zealand called Like Minds, Like Mine, has targeted both White and Maori communities across the country. It produced a series of award winning television and radio advertisements featuring both ordinary people and celebrities such as the rugby player John Kirwan talking candidly about their experiences of mental ill-health. One advert featured Kirwan's team-mate Michael Jones talking about how difficult it was at first to understand what his friend was going through. Its central message was that mental illness is an illness like any other and can be treated. Members of the public commented:

> I'm not a rugby follower, but I knew he had a high profile and to me he looked normal in everyday life. I mean, he's as normal as I am – and then to see that he had had a mental illness, it's like as if I had a bad cold… there's a treatment for it, you can get over it, and for some reason it just made me feel non-threatened. Yeah, non-threatened by it, I guess, is the word.

> He's a family man, he goes down to the park with his children. That aspect for me really portrayed how okay it was. He was a Dad like my husband is a Dad to his children.

This initiative illustrates how valuable open, honest and normalising accounts of mental ill-health can be. £18 million has been awarded to Mind, Mental Health Media and Rethink to run the first ever major mental health anti-stigma campaign in England, to be evaluated by the Health Service and Population Research department at the Institute of Psychiatry. Time for Change is based on the model implemented in New Zealand by Like Minds, Like Mine and in Scotland by See Me and should complement the work of Delivering Race Equality and Community Development Workers. It will include service user-led education programmes to target trainee doctors and teachers at the start of their careers to combat mental health stigma and discrimination. Get Moving! events will encourage physical exercise to be taken up by people with and without mental health problems, side by side.

People spoke less often about the negative views expressed in the media that mental ill-health equates with danger and violence, but this view is known to be extremely common (Thornicroft, 2006):

Schizophrenia gets a bad press. It's associated with killing so the public are afraid and we are discriminated against.

> People have said to me "why don't you keep it quiet?"

There is an awful lot of stigma even in charitable organisations. When organising volunteer placements for people with mental health problems it was very hard. I was astonished at the lack of understanding. I felt very angry, these organisations were subscribing to whatever the media says about mental health, that people are dangerous.

I can personally attest that there is mental health stigma at even the highest levels of the voluntary sector. Within full hearing of a group of South Asian women with mental health problems one very senior voluntary sector committee member said:

> Those women are mentally disturbed… What, you want me to pretend that they are normal? That they are just like you and me?

This shockingly blatant expression of prejudice illustrates how people with mental health problems meet with overt stigma and discrimination in the most unlikely of places. We cannot assume that anyone is immune to the discriminatory approaches to mental health propounded in modern society everywhere from newspapers to television programmes. Greater tolerance and understanding need to be encouraged at every level, including among staff working with people with mental health problems, from the voluntary to the statutory sector.

One fifteen year old young man I spoke to knew a surprising amount about schizophrenia, the Mental Health Act and the effects of cannabis. He said he had heard about it through books and his mum's 'Take a Break' magazines. It is important to investigate which forms of media people pay attention to and to make use of them creatively; leaflets are unlikely to be the best way to communicate with people. Where they are used, leaflets can be distributed better. For example, Drugsline has placed its leaflets, translated into South Asian languages, in the changing rooms of sari shops on Ilford Lane: a discrete location where people can access information privately.

People I spoke to wanted to see more evidence of success stories, in magazines for example. This highlights the critical role the media has to play in public perceptions of mental health. There is a clear need for collaborative work with local media to complement national projects around positive reporting of mental health problems being conducted by the Care Services Improvement Partnership's project called SHiFT (www.shift.org.uk).

These considerations reveal that the first step of acknowledging mental health problems in oneself or others is obstructed by a range of serious barriers. As we shall see in the coming sections, even if ethnic minority groups do overcome these obstacles to acknowledge a mental health problem there are further barriers to seeking out and then making use of the help available.

5.0   Barriers to Seeking Help

5.1   Summary

- Many South Asian people cited a medical professional as the first person they would seek help from for a mental health problem. This jars with the evidence that Asian groups are under-represented in mental health services.

- Several South Asian people held the view that talking about mental health problems only makes you feel worse; this view may prevent people from seeking help and may encourage them to struggle with their symptoms in silence.

- South Asian people who did not feel able to talk to their family about their mental health seemed less likely to seek help. These issues are likely to be exacerbated for refugee, migrant and asylum seeker families.

- By contrast, young Black African men commented that a doctor would not be the first person they would seek help from for a mental health problem. They favoured less formal services such as Connexions. This highlights that it is not helpful to view all ethnic minority groups' help seeking behaviour as the homogenous patterns of "BME" groups as a whole; different cultures have very different reasons for failing to seek help.

- Young Black African men elaborated that psychotic symptoms were a spiritual problem and they would seek help from a religious leader, underscoring the role of faith leaders in signposting and referral. They were very suspicious of mental health services and were not confident in the efficacy of medication. Their views were somewhat informed by mass media including films, emphasising the need for positive promotion demystifying what mental health services are really like.

- A number of people were unaware of the services available which may explain why some ethnic minority groups wait to seek help and then attend Accident & Emergency services.

- Several service users found acute services to be much better than they had anticipated. It seems that negative expectations of what mental health services will be like also delays ethnic minority groups from seeking help sooner.

5.2   South Asian community

5.21 Using GPs
Many South Asian people I spoke to, both using and not using mental health services, raised seeking professional help as the appropriate course of action when first experiencing symptoms. It is anecdotally suggested that there is a traditional respect for the medical profession among some South Asian communities which may be why so many people said they would see a GP, a psychiatrist, a counsellor or social worker for help. Mental health service users from all ethnicities considered staff at a local mental health resource centre as key people they could talk to, underscoring the vital support role provided by these centres. Highly significant barriers to actually using GP services are discussed in the following section.

5.22 Not wanting to talk
Several South Asian mental health service users said that they did not want to talk about their feelings and problems because that would make them feel worse and they would rather distract themselves.

At that time I had a daughter but when I talk about what went on at that time it distresses me so I don't want to share it. When I try to talk I can't talk because my brain gets tired. If I repeat my story then those wounds are opened again.

One women's group which had received a visit from mental health professionals who gave a talk about depression complained that the talk itself was depressing; they wanted activities and events to combat depression, not to talk about depression. This echoes the comments from voluntary sector staff that South Asian people usually come to a day centre or a group for purposeful activity, such as a meal, an exercise class or an activity like singing or art, and that it is very difficult to attract people to events focused on discussion or talks in groups. This has important implications for engaging South Asian communities in both mental health promotion and talking therapies. More creative promotional methods need to be employed to gain the attention of groups that may think issues like mental health don't affect their community or would rather not talk about them.

One community group commented that some Asian women struggle to seek help because their husbands restrict what they can and can't do. This suggests that to reach some people, services will need to be more flexible, in going out to places men and women are 'allowed to' go to and feel comfortable in. For example, Diabetes UK set up a mobile testing centre for one day in the pedestrianised area of Ilford High Street in front of Ilford Town Hall, in order to reach out to the South Asian community. It was the most successful public screening they had ever held, with forty minute queues of people lining up to be tested for diabetes, a condition which people notoriously wait long periods to seek help for.

5.23 The importance of family
Having family members who you feel able to talk to was a key factor in whether South Asian mental health service users felt they would share their feelings with others. Children in particular were often the principal family member mentioned who would be consulted for help, although people also worried about being a burden on their children. The problems already discussed about gossip in the community and feeling like a failure are big obstacles to South Asian people being able to talk to friends about mental health problems. Some people had had such negative experiences with their communities that they said they simply would not talk to someone South Asian about a mental health problem. This has important implications for the ethnicity of staff including care coordinators and interpreters. Some people struggled because they felt their spouses did not want to talk about their mental health problem.

These findings are consistent with the evidence that absence of family involvement when seeking help is associated with compulsory admission (Morgan et al., 2005). For example one gentleman said that having his daughter there for him meant he would go to hospital as a voluntary patient, which he preferred, rather than waiting to be sectioned when he became more unwell. This highlights the importance of support for ethnic minority carers and greater education in minority communities about mental health and the services available since it is clear that families are often critical for help seeking.

Several South Asian people felt they were not understood by family and did not have someone they could talk to. Problems which contributed to this included rigid family rules (one woman was not allowed out of her family home after 5pm by her brother-in-law), problems at home such as living in an over-crowded house with extended family and going through a difficult divorce.

It's very stressful waiting for a home office decision… I've been waiting for 11 years. It's like an open jail, you have no human rights. At home there is just food and shelter. There is so much stress, I can't do my English homework because there is no space in the house. I can't sleep because my brother-in-law's friends are always there.

The South Asian groups of people I spoke to provided evidence that there are additional stressors on ethnic minority groups in Redbridge which makes talking about feelings and mental health problems and seeking help more difficult than it is for White British communities. This highlights the important role played by the voluntary and faith sectors and other community leaders who can provide sign-posting and confidential advice. There is a clear need for mental health services to be more sensitive to the specific challenges faced by different minority groups, which should be addressed by comprehensive programmes of cultural competence training.

According to the Refugee and Migrant Forum for East London (RAMFEL) there are an estimated 17,000 refugees, asylum seekers and migrants living in Redbridge today, although the numbers are notoriously difficult to estimate accurately. In the neighbouring borough of Waltham Forest the psychology service provides dedicated workers for refugees and asylum seekers but at present there is no such provision in Redbridge despite its very ethnically diverse population. The need for something of this kind in Redbridge is articulated by the funding bids put forward by the Redbridge Psychology Service in partnership with RAMFEL for a dedicated worker to be seconded to the voluntary sector. They would provide support for people who may feel unable to engage with statutory services in their more formal guise. It is disappointing that their funding bids have so far been unsuccessful since such a worker would be well-placed to improve communication between mental health services and refugees and asylum seekers.

5.3   Young Black African men

Three groups of young Black African men provided an insight into where young people from this ethnic minority group would seek help.

5.31 "It wouldn't be a doctor"

Many of the young men said they would talk to their mother or a close friend about a mental health problem. Interestingly, two central African young men made a marked distinction between seeking help from a 'mental health advisor' in their words, and a GP.

> *Researcher: What help do you think there is?*
>
> *A: Mental health centre or something, you hear me.*
>
> *B: You have to analyse the situation first, analyse the situation and see what's wrong and*
> *A: Mental health advisor definitely. There's always numbers you can call… maybe I would come to the Connexions or look up for the number innit, there's always a way to find a mental health advisor you understand 'cause there's so many about… like there's always help out there…*
> *Who do I talk to? Most probably I would tell a friend first and then my Mum, someone in the family, do you know what I'm saying, a friend, someone in the family.*
>
> *Researcher: Or your GP? Or maybe not?*
>
> *A: Like, it's not, I could have, it's not, it's not a problem.*
>
> *Researcher: But you wouldn't think that's where you'd go?*
>
> *A: That's not the first, that's not the first -*
>
> *B: No, it wouldn't be a doctor.*

It is clear that these young people perceive youth services such as Connexions as more approachable and perhaps less threatening than medical services. Mental health teams such as the Redbridge Early Intervention Team already have close links with youth services, but this suggests that GPs need to change their image or work on promotion in order to appeal more to young people, particularly for a sensitive and confusing problem such as a mental health problem.

A sixteen year-old East African young man knew a lot about mental health services from reading and from his mother's magazines. Whilst his level of knowledge was far above that of the other young men interviewed, he acknowledged that many people retain old-fashioned ideas about what mental health services are like:

> *Researcher: And what do you think the GP would do for you?*
>
> *C: They give you information, like they diagnose you or if they can't, they can send you to a person who's in that field and they'll diagnose you and find out what's wrong with you.*
>
> *Researcher: OK.*
>
> *C: And then you either get put on medication or you can't, or they section you… At the end of the day yeah they're there to help, yeah. And if you don't want to get help and you want the dreams to keep continuing it's your problem, innit… There's people they think they're gonna get put in the mental hospitals and put in like straightjackets or whatever… Listen to the guy 'cause he knows what he's talking about, innit?*
>
> *Researcher: But how would you know who was right?*
>
> *C: The doctors know about these things so you trust him.*

5.32 "How can a pill take away the voices? That's a spiritual thing"

Two central African young men were very clear that medication could not help a spiritual problem and that church would be the appropriate place to seek help:

> *Researcher: …What can you do about that?*
>
> *B: Go to a church.*
>
> *Researcher: … And what would you want the church to do?*
>
> *B: Pray for me…*
>
> *A: Hundred percent.*
>
> *Researcher: And what would you think if they gave you medicine?*
>
> *A: Ooh medicine, ay. I don't know about medicines.*
>
> *B: I'm not sure about medicines.*
>
> *A: Nah, I wouldn't like that 'cause how can a pill take away the voices and the things that actually, […] 'cause that's something that's in the mind, that's like, it's deeper, it's deeper, it's not, it's not like a illness or whatever little thing, no, no, no, that's actually the mind […]. So pills wouldn't help me, that's a spiritual thing […] like it's more like a spiritual, like a mental thing so spiritual, yeah.*
>
> *B: [inaudible] I will still end up going to church.*

Researcher: I mean would you go to church for help with that kind of thing?

A: Yeah, yeah, yeah, definitely.

Researcher: What kind of church is it? Are you catholic or -

B: Pentecostal… when that comes, when them sort of things come, don't get it twisted. [inaudible] It's spiritual, it's not anything else… No, I've seen cases like that happen and the only time I've seen something like that get sorted properly [inaudible] is redemption… Power of prayer, power of prayer.

A: It's basically yeah, the power of prayer, it's your faith, innit. […] If you really believe that God can help you that's when God gonna show you yeah, this is, […] it's gonna, it's gonna help you.

This poses clear challenges for engaging communities which have different models of mental health problems with medication and other treatments which form part of a more biological model. In addition these young men had very negative perceptions of mental health services:

A: Because I've seen a lot of people like maybe you see it on telly or whatever, and you see programmes and everything, […] little documentaries and every, people that go to them places, [psychiatric hospitals] they there for all their lives, they never come out no more. […] They're always on medication but the medication, what does it do to them? […] It doesn't help, it just, it's like the case is getting worse and worse […] Maybe other ones, they let them off, they go back home but they still, they still get that […].

B: Instead of fixing a problem somewhere else, like destroying another part of you.

Once again, the role of the media in people's perceptions of mental health services is significant. This provides further support for improved community education and extensive work with local media to disseminate positive perspectives on mental health problems. Until ethnic minorities believe that services work collaboratively with service users rather than against them, these negative stereotypes will continue to be held and passed on to younger generations.

D: Probably for a person like me who believes in magic I would go to like a magician or something… I'm a Muslim

Researcher: Ok so are there people in Islam around Redbridge who you think you could speak to for help?

E: Yeah there's a lot

Researcher: Like who?

E: Like scholars and things, innit, people like scholars.

Researcher: You think you could talk to them? And what do you think they could do?

D: Pray for me.

Researcher: Would you [to F] want to do that do you think, would you want them to pray for you?

F: Yeah. And seek advice from elders. They might have had a similar experience…

D: I think those mental people, [staff] they don't do anything they just make it worse… They just give you injections and that, they think you're crazy when you're not.

E: Like a placebo.

D: Like that movie Gothika, it's like the same thing… they thought this woman was crazy but she wasn't.

Researcher: And what happens?

D: And they put her in this mental thing and nothing good happened. More bad things happened to her when she was in her cell, she got cuts everywhere…

E: They'll test you and that and inject you.

Researcher: And do you think it would help you?

D and E: No.

E: 'Cause you go even more crazy.

D: Yeah because all they do is put you in one room, white room, small room, smaller than this actually and they just leave you in a room and then you can see more of the rabbit [hallucination] there. And the rabbit can tell you more things that you should do.

This conversation highlights the importance of the esteem in which faith leaders are held by young people and the need for greater partnership between mental health services and faith leaders and making direct referrals easier where appropriate. Again, mass media such as cinema is raised here. Gothika is a horror film which is not designed to be realistic but these young people have nonetheless taken very seriously its message about mental health services. This is unsurprising given that film, television and news media remain the major sources of information the general public receives about mental health. Trusts need to take an active role in combating these negative perceptions by ensuring awareness and understanding of what services are like, and doing so in a way that is meaningful for different ethnic groups, ages and genders. These young people were happy with the idea of seeking medical help for a drug problem, so it is not an essential aversion to medical services at work here but specific fears about mental health services.

5.4   Lack of awareness of services available

Several people suggested that members of their community were unaware of the services available.

I have no idea where to go for mental health problems. I would phone the Samaritans or ring 999. I don't know where to take someone.

I didn't even know to tell the doctor. I didn't know what stress was or how to explain it. When an Indian person would ask me, I would say, you know, when you feel sad and worry. I didn't realise because of feeling sad and worried that this problem could get worse… I found out too late. In the end my friend noticed it. My family noticed it as well but they would turn around and say she has a really bad temper and is very hyper. But no-one noticed there was something else wrong. Because no-one noticed there was something else wrong I kept quiet as well. I would just stay at home and keep quiet and suffer on my own. And just stay at home lying in bed all day.

Being unaware of what is available is likely to contribute to people waiting for extended periods before seeking help. Seeking help requires greater motivation if you do not know what is available than if you know exactly where to go and who to speak to. An important aspect of the government's Delivering Race Equality agenda is 'More and

Better Information' This will include having information available in the most common community languages and distributed in locations where ethnic minorities will actually see them, such as in local businesses, places of worship and social centres.

It is also important to acknowledge that mental health services have changed significantly over a short period of time and many people who have not used services retain their perceptions of the old asylums where people were 'locked up'. Indeed, most of Redbridge's mental health services are still based in the old asylum building at Goodmayes Hospital. It is therefore unsurprising that many people are quite afraid of mental health services and do not know how much they have changed.

Mental health services can be scary to access because it seems so clinical. My mum used to say "oh they'll come and take me away in a White van": people's associations about mental health are very strong.

5.5   Expectations of Mental Health Services

People of a range of ethnicities who had used mental health services commented that they were pleasantly surprised by them in comparison with what they had expected. This White British man's comment shows that some people would seek help sooner, when they were less unwell, if they had more realistic expectations:

I didn't expect all the services and doctors to understand as much as they do. I didn't expect it to be as good as it is. If I'd known more about how it is I would have gone to a doctor sooner. I heard about the services I go to by word of mouth and getting referred is easier than I thought, it gets me out, I get a nice hot meal. I would have liked more information from the GP and in the surgery.

The comment about wanting more information highlights that GPs are a key hub for mental health problems and that for some people they are a crucial source of information. Several South Asian people felt that mental health inpatient services bore no resemblance to their preconceptions. One Indian woman said:

> *I had a feeling they wouldn't be understanding, it [depression] would be something against me as it were. In the ward I was pleasantly surprised, it was much better than my impression… I thought it'd be dark, dreary, there would be restrictions, medicine would make me shaky, I wouldn't know what happened. It was an airy ward, I was treated like a human being, was listened to, treated like an individual with a problem, not a problem. I needed it more than anything… I had thought I had Alzheimer's because your memory goes with depression, but when my GP, who was very good, very young, talked to me and listened to me and told me it was depression I was so relieved, because there's treatment. I was so relieved to let go… I should sometimes say "Thanks, depression" because the negative things can be very positive.*

This quotation shows how positive some people's experiences can be. Greater effort should be made to use positive personal testimonies and stories within ethnic minority communities to make services more approachable.

The social marketing company, Forster, commissioned to work on the Department of Health's Delivering Race Equality agenda, investigated the responses of Bangladeshi and White British women aged 50-70 to messages aiming to increase uptake of breast screening in Tower Hamlets. The Bangladeshi women responded better to the advice of a doctor whilst the White British women responded better to the advice of a woman they perceived to be like them. This approach should be used in Redbridge to tailor mental health promotion to specific communities.

An Indian man said:

> *Being admitted to hospital a few times, I realised it wasn't a kind of nutty house like I thought, it was just a decent ward… I expected to see people drugged up lying around in corridors, not people sitting in rest areas, reading papers, listening to music.*

Another Indian man had been in hospital twenty years ago and had a very negative experience:

> *I'd never been to hospital before but I found it amazing, they put me in a corner, secluded me, tied me in a straightjacket in an armchair, it was very hard, a very nasty experience. I was helpless, they gave me an injection but I had no idea what it would do.*

Evidence suggests that negative experiences get shared with others far more frequently than positive ones. The man quoted above had also been physically assaulted by a member of ward staff. It is important to remember that while this experience occurred over twenty years ago, the memories and first impressions of mental health services will remain vivid and are likely to be shared with one's community. These perceptions contribute to suspicion about services and hold ethnic minorities back from seeking help. It is therefore up to the North East London NHS (Mental Health) Foundation Trust to promote its services as they are today and to combat the knowledge people have about how services were decades ago. All of the quotations here point to the obvious need for community promotion and prevention education around mental health to combat decades of negative stereotypes and media messages. De-mystifying services needs to be a key priority if we are to expect all ethnic groups to engage with a, for many people, very different model of mental health to their own.

6.0 Perceived Causes of Mental Health Problems

Asking people: "What causes mental health problems?" yielded a profound insight into their frameworks of health and illness. People's explanatory models for mental ill-health differed significantly but the almost total lack of a biological model of mental illness was conspicuous. It poses serious problems for engaging communities in using services and particularly in taking medication if they simply do not believe in the same explanation of their illness that services adopt. This highlights the need for greater consultation with different ethnic groups about what they expect services to deliver, and greater individual exploration between clinicians and individuals of how they personally explain their own symptoms. Services need to work towards a model which takes the lay person's and the clinician's explanations seriously, and implements treatments which make sense from both perspectives. Medication, for example, can be used in conjunction with a person's belief in the importance of prayer. Since many people perceived the cause of their mental health problems to be situational, there is a need for greater partnership working between health and social services than currently takes place, and more focus on the role of the family. It became clear that differing explanatory models of the causes of mental health problems constitute one big barrier to seeking help in itself.

6.1 Summary

- Isolation was considered a key explanation for mental health problems by people who were not working. South Asian women whose children had grown up and their role in the family had changed often explained mental health problems via boredom and loneliness.

- Combined pressures experienced by both men and women in South Asian families such as care responsibilities, financial problems, societal expectations were cited as causes of mental ill-health.

- Among families where the parental generation migrated to the UK from abroad and the children grew up here, the clashing behaviours and ideals of the two generations was perceived as particularly stressful.

- Even among families that have lived in the UK for many decades, a number of people acknowledged that the more anonymous and fast-paced nature of life in London affected their mental health.

- The challenges faced in life were common explanations for mental ill-health. These included physical health problems, bereavement, frustration, crime, the stress of migration and social deprivation.

- Stress more generally was considered a cause of mental health problems. This highlighted the need for people to be able to access low-intensity talking therapy at the primary care level before they experience any symptoms, to enable ethnic minority communities to better manage the stress that they face.

- Some people discussed the well-publicised link between cannabis and psychosis but a number were rightly dubious about the extent to which cannabis can cause mental health problems. The extent of misinformation in the public domain about the role of cannabis in *causing* mental health problems meant young people were rather confused about it. This highlights the need for clear and not alarmist approaches to educating communities about the role of substance misuse in mental ill-health.

- Black African and South Asian people talked about psychological explanations for mental health problems such as negative childhood experiences as well as guilt, a bad conscience, fears, phobias, thinking too much, an over-active imagination, insomnia and bad dreams.

- Rarely did anyone mention a biological or medical cause of mental ill-health, including large numbers of service users who were actually taking psychotropic medication. When they did it was usually a vague reference to an organic problem with the brain. This significant disparity between ethnic minority community explanatory models for mental health problems and those adopted by services constitutes a genuine barrier to these people seeking and engaging with help from the statutory sector.

- Several Black Caribbean women (who had actually worked as nurses at Goodmayes in the past) believed that psychiatric medication could in fact cause people who were well to develop a mental health problem. Black African men also said that medication would 'only make you worse'.

- Many Black African men had strongly held spiritual explanations for mental health problems which echoed the findings of Nigel Copsey's in-depth study of Newham's ethnic minority communities. This again underscored the importance of engaging with community faith groups and leaders in order to encourage ethnic minority groups to seek help from services early on.

6.2   Family problems

Family problems as a cause of mental ill-health were a recurring theme among several ethnic minority groups I spoke to but it was generally the most common explanation among South Asian people. This is perhaps unsurprising since the family values and traditions of South Asian communities mean that family life has a more central role than for many White British people I spoke to. This is a complex issue however, since it is a common stereotype that South Asians have close, insular families and anecdotally, carers can struggle to get information about their relative's care because they are sometimes perceived by staff as 'part of the problem'. It is therefore important that statutory cultural competence training deals with cultural stereotypes and encourages seeing every client and his or her family as an individual.

6.21   Boredom, loneliness and isolation

Boredom, loneliness and isolation were brought up many times as being a cause of depression (a word used in very varied contexts to encapsulate a range of mental health problems). This was particularly mentioned by middle aged women who seemed to feel they had lost their role in the family as their children became self-sufficient:

> *You want attention from your family.*

For example some people explained hearing voices as an expression of isolation, of wanting company.

Loneliness, isolation in this country. When you feel sad, nobody to talk to, feel like committing suicide, feel humiliated to talk to someone, especially can't talk to your relations or friends because you feel shy, embarrassed, afraid that people will take the mickey, that it shows weakness.

Especially among people of all ages who are not working, isolation was considered a crucial factor in someone's mental state by a range of ethnic minority groups:

> *A: Sometimes I think what people need is someone to care. Some people are lonely and they get depressed, you know? … Many people [who] go mental, it's because they don't have laughter in their lives.*
>
> *B: Yes, that's the other thing.*
>
> *C: A lot of people are isolated. I think that can lead to depression.*
>
> *A: Loneliness is the biggest killer, isn't it?*

6.22   Combined family pressures

All families will suffer challenges but it came across in the discussions that there are many pressures placed upon the different genders within South Asian families. Women may struggle with household responsibilities, raising children, surviving with little money, caring for parents-in-law and so on whilst men can struggle with the responsibility of being the sole breadwinner for a large and growing family (and sometimes also for relatives abroad) or the emasculating experience of changing gender roles; at times domestic violence can become a way of coping. These comments from three South Asian women express this:

> *I went to India, my father arranged the marriage. My husband saw there was something wrong with me [mental health problem] but somehow we stayed together. He's very understanding now but sometimes he goes out of control, shouting, he slapped me once or twice. He drinks a lot of beer and alcohol as well which I'm a bit worried about 'cause he's the only worker. My son and I have to hide the drinks from him to stop him and he's a very heavy smoker… now it's much more, he needs a drink to get to sleep. Smoking as well and if you tell him [the health risks] he'll say "Well, I want to die".*
>
> *You feel tearful, low, sad inside. It came from shock in life, family deaths, an overcrowded home, being overworked, physical health issues, no energy, suffering inside, needing people to listen. I didn't get support from the community. I'm from X so I don't have my own community here to support me. I kept my depression to myself because people laugh or your [extended] family won't believe you.*
>
> *Feeling helpless. Your home environment, your family not understanding each other, the problem can be your mum or dad. They may not care about their children, just their own problems. They aren't thinking about what their children want or need or what they will lose. There is stress on the father: bills, education, he gets angry about not having enough money, he comes home, shouts at his wife, then his wife's angry, shouting, hitting the kids. Then you all live in a very small house.*

The common practice of arranged marriages was cited by some South Asian women as a source of marital and family breakdown, particularly when a partner was brought over from abroad to marry someone who had been brought up in Britain. People's comments also illustrated that the family environment can become unsympathetic to people starting to experience mental ill-health, which may affect their prognosis for recovery:

Family problems, bereavement about your parents' deaths or losing touch with your parents. If you don't do much in the house it makes your family angry. You can worry and get depressed. Your physical health is a problem. You may have arguments with your husband or wife, your memory gets worse, you forget things, it makes your family angry and causes fights.

6.23   The generation gap

With communities that have migrated to this country there is likely to be a significant generation gap between the values, behaviours and ideas of the generation brought up abroad and the children brought up in the UK, attending school with English children:

The younger generation has only been here for a few years and yet they think they know so much more than their parents. That makes us depressed.

In communities with strict beliefs around behaviours which are fully permissible in English culture this is likely to be exacerbated. For example, parents with one set of views around alcohol, appropriate attire, relationships and so on will have children learning a quite different set of views from peers at school. This is often worsened in communities where some family members do not speak English well, creating a power imbalance between parents and children.

Your family can be angry because you take tablets, you may have a language problem. Your children don't understand Gujarati because they were born here, they speak fluid English which I sometimes don't understand so they can get angry. I have to ask several times and they shout back.

Parents may expect more time from children and a different level of support than children with more anglicised views may wish or be able to give:

> *Our children don't want to listen, have their own problems, they say "Mum you're always pretending". You call your daughter, she says "Go away, don't talk to me". The children don't have time for us, no-one takes me out, takes me to doctors' appointments.*

A generation gap will occur in all ethnic groups but the point here is that in some ethnic minority communities the associated rejection of traditional values is treated much more seriously. One Caribbean woman talked about how the frustration of children towards older parents could lead to abuse, and how that impacts on the mental health of the parental generation:

> *"Mum got to stay back, when I've got time to attend to you I'll attend to you after the children". Now if she becomes impatient and she starts, that is where the battering comes. She will come and say "What you making a noise for? Oh shut up." And sooner or later someone like X we would have at the doctor saying "This woman, I'm not too sure what's going on but she's depressed, I think she needs to go to a day centre, I think somebody ought to be working with her."*

6.24   Cultural and societal differences

Even for people who have lived in Britain for many decades, many acknowledged that some cultural differences would always affect their mental state:

Back home everyone said hello, looked for you if you weren't around. Here people keep to themselves. Back home people cared for you more and were more kind-hearted. The people in your house are so busy.

Society is not caring enough, need a community feeling. In India where I grew up, if I misbehaved someone would tell my mother. I live in a street where I can go to people but I needed to make an effort when I moved in to introduce myself.

Life is so fast here, when you think back to your childhood. Even teaching Art, you wouldn't believe how much paperwork there is nowadays. I know many teachers who

left their jobs. The changing pressure of working life – meetings, seminars, low money, high tax and national insurance… after a year, they have no job, after 6 months they have depression.

It can be difficult for couples to adjust to the different gender roles in a country different to the one they were brought up in:

Asian men don't like to share, it is common, men are more egoistic in our culture. In all these years my husband never took me out for dinner [all the women laugh]. They are all laughing because it is true for all of us.

6.25   Abuse

At the extreme, people talked about abusive family relationships. Domestic violence from parents-in-law and other extended family as well as from spouses was discussed:

It's common in our society to try to prove someone is mental so they can keep her child and get rid of her [their daughter in-law]. Educated, well-off people are doing these things. We try to keep it under cover, "No it doesn't happen to us", but it does.

Even in this extreme case, a very old-fashioned and disturbing view of mental health problems is suggested by the idea of 'passing someone off' as 'mental' to 'get rid of her'. This case highlights a fundamental lack of understanding about mental ill-health within the community.

6.3   Difficult lives

Having difficult life experiences was raised by a range of ethnic minority groups as a cause of mental health problems. The sense is therefore that symptoms constitute a reasonable reaction to difficulties. This corresponds to the fact that some communities find it difficult to understand how people with seemingly good lives "you have a house, you have a family" could experience mental health problems. Again this emphasises the need for community education. Examples included:

6.31 Physical health problems
I was depressed but I didn't realise it. I had operations, illnesses. I went to the surgery and started to cry, saying "I don't want to live". The GP sent me to Goodmayes. Physical illness can drive you to suicide.

I mean even a slight thing like someone going for a major operation, they start getting depressed, worrying and it just goes on and on and on. And they're afraid to let their partner know how they feel about it because they think "He's not going to be sympathetic to me when I come out, he's going to expect me to be able to do this, that and that", and they start to worry.

6.32 Bereavement
Someone suffering from serious bereavement may be behaving very oddly, may need counselling. One woman who was recently bereaved says she sits in the chair talking to her husband but he doesn't answer her.

6.33 Frustration
They can be depressed… when children take on board to find themselves fed up of not having things their own way… that is where the depression going to come in, because "Mum, you don't tell me what to do, I want to do this, I'm not listening to anyone and I am going to do it my way" and when the parents come down to them it all starts with a rage and sooner or later they sit and they sulk, they even reach a point where they throw

a tantrum, that helps to bring on the depression, because they're still not getting the object they want, to get what they want.

Within this group of Caribbean people several members found it difficult to believe that a young person could be depressed without an objective reason.

6.34 Crime

Two East African young men made the point that the challenges young people face such as bullying and street crime affect their mental health.

> A: [I was a witness] yeah but I didn't say nothing so he's my friend innit. I didn't say nothing so the guy got called innocent but it wasn't my fault. You can't snitch, if you're snitching it goes worse, it goes to stabbing, get punched up, it's like the street rules [inaudible].

> B: If you see them do something yeah and you tell someone, they say "You're gonna die". And not only that yeah, they come for your family.

> A: And you don't want that so keep your mouth shut.

6.35 Migration

A young central African man talked about the mental health implications of the experiences of ethnic minority groups in their home countries and the challenges of coming to Britain. Interestingly he also suggests that "if you was nice and wealthy", these problems would not be such an issue.

But if you was nice and wealthy like […] that would be a different story. I think there's other people that suffer out there, when they come here [to Britain] they trying to make something out of their life. Because there [home country] it's always war and everything so they see things that people here usually don't see, […] little children walking around with guns and everything. […] Like it's, it's all a bit crazy out there […] not only in Africa, I know, on the other sides as well, […] Eastern Europe and everything. All them places, in Iran, Iraq, there's a lot of things happening but, but here it's nice and quiet, it's more peaceful […] yeah there's gun, there's street crime going on but, but it's not the same as when you go back home […] a bit more of a struggle out there and large parts there are suffering.

And before you can do certain things actually you have to, you need papers for this, papers for, […] other people they can't just come and start working even if they are legit, […] they need work permits or whatever… so you have to go through a lot of things like, you can't just, come here, settle down and you start whatever you wanted to start, nah you have to go through a longer way than everyone else who lives here or that's from here […], *they* can just, they stand up to them, they go boom I want a job, they go and they get the job, but you now, 'cause you're not from here, you got different like, […] seem different innit so it's a bit, yeah harder.

This articulates very well the challenges faced by Redbridge's growing refugee and asylum seeker populations.

6.36 Social deprivation

Other difficulties in life relate to social deprivation experienced by many people suffering from mental health problems. Some causes mentioned by a group of service users were:
-
- Poor Housing
- Unemployment
- Bad relationships
- Money
- Getting beaten up

- Bullying everywhere

It must be acknowledged that the social deprivation in which many people with mental health problems live may contribute to a vicious cycle in which poor housing, unemployment and financial difficulties worsen a person's mental state. Once again greater collaboration between health and social services could remedy this. Many people report the attitude from mental health professionals that 'your social issues aren't my problem'.

6.4   Stress generally

Stress of many different forms was considered to cause mental health problems, be that over-work, the stress of raising young children, financial troubles or losing one's job.

> *Yes, I think you probably have young mums who do get depressed and stressed out with the kids, you know, and people may think they're going mental when they're just stressed out.*

There was a sense that there are so many pressures upon us in today's society that some people feel overwhelmed, and there is little help on offer. Providing low-level talking therapies in accessible locations like community centres and GP surgeries, perhaps of the type advocated by the Improving Access to Psychological Therapies agenda, could therefore present an excellent opportunity for early intervention. People have said things like 'I wish someone had told me I needed to slow down' or 'I was really grateful to the GP for telling me to take three weeks off and have a holiday'. This kind of brief, early assistance with common life stresses could be invaluable in trying to prevent the challenges of daily life from escalating. It would also ensure that people are aware of the services available so that they come back to seek out further help when they need it, rather than feeling their GP could not help and so suffering in silence.

However, the money available for each borough from Improving Access to Psychological Therapies is limited. The voluntary sector presents an excellent alternative way to provide not counselling but informal support groups where people can share their daily difficulties and get information about further help if it is needed. The isolation of living in London can mean many people don't have a friend or relative they can offload their stresses to, and faith and community organisations are well-placed to provide low-cost, accessible support at the lowest end of stress-related mental health difficulties. The development of such initiatives requires capacity building work by the statutory sector, for example providing small grants to organisations to help them set up support groups.

6.5   Substance Misuse

The Black Caribbean and Black African people I spoke to were very aware of the highly publicised association between cannabis use and psychotic symptoms in *some people*. This was rarely raised by South Asian groups although cannabis use is known to be prevalent among all ethnic groups. It is, however, well-known in the academic literature that it is not possible to demonstrate any robust *causal* connection between cannabis and psychosis. Government drives to re-classify cannabis as a class B drug and promotional campaigns have tended to ignore this fact, using statistics to suggest a causal link:
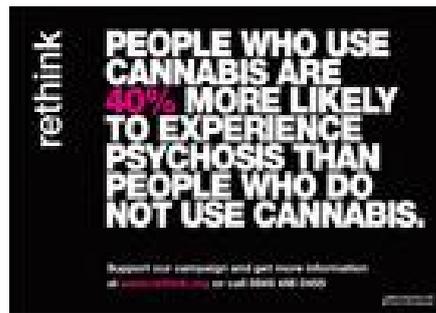
It was therefore interesting that a group of Caribbean senior citizens were well aware of the lack of evidence of any causal link and it is important to acknowledge that this contributes to an extent of confusion and misinformation among the general public:

> *A: I hear that some drugs that people take can start them on schizophrenia.*

> *B: I listened to a professor on the telly and I could shake his hand, he said what people fail to realise, for instance, the weed, these things have been existing in South America, the West Indies for years and all people have used it and whatnot – why don't you get a high proportion of mental illness to say it is reacting on you? Because as he said, a lot of those things had hemp as medicinal purposes. But what the youngsters, a lot of the youngsters are doing, is mixing, that is what they are doing, they are mixing these things, but they are not only on just that, they are on other drugs.*

> *C: And alcohol.*

In two groups of Black African teenagers I spoke to, some young people were aware of the hallucinatory effects of cannabis but there was a lot of confusion about it and the differing effects of other illegal drugs. Only one sixteen year-old man made a deliberate connection between cannabis and mental health problems and in that case he seemed to think that the relation was absolute:

> *Researcher: What do you make of all that [people experiencing psychotic symptoms]?*

> *A: Schizophrenic.*

> *Researcher: What does that mean?*

> *A: It's like a disease, innit, you get paranoid.*

> *Researcher: … Do you know where you heard it or you just –*

> *A: Yeah, at school.*

> *Researcher: You heard it at school? Where, like from friends or from teachers or –*

> *A: Teachers.*

> *Researcher: What did they say about it?*

> *A: Like, people smoking drugs that happens to them.*

The conflicting messages received by both younger and older people compete with their own direct and indirect experience of drugs and lead to a significant amount of confusion. Some people have many peers who use large quantities of cannabis but do not develop psychosis. This means that some people will completely ignore the health risks of drugs while others will have exaggerated ideas of the effects of cannabis on mental health, perhaps leading them to assume that the majority of mental health

problems are caused by drug use. Neither position is desirable, and in this the media play a crucial part in people's understanding. A concerted effort is needed to demystify the ambiguous role cannabis plays in mental health problems and to ensure that drugs education in schools delivers an accurate account of the impact of cannabis on mental health. It may be tempting to use scare tactics to warn young people away from all drugs. But when public health messages jar with experience, young people are likely to ignore health warnings altogether.

6.6   Psychological cause

Young Black African men raised psychological explanations for mental health problems. Guilt and a bad conscience were commonly mentioned, as well as fears and phobias, thinking too much, having an over-active imagination and having bad dreams. Insomnia and having an underlying condition like autism were additional explanations offered by White British service users.

6.61 Childhood
Suffering a traumatic childhood was a common explanation for mental health problems given by both South Asian and Black African individuals. People did not elaborate on exactly what kind of childhood experiences could cause mental health problems but there was a sense that both an unloving and isolated childhood as well as a more explicitly abusive one could affect your adult mental health.

These kinds of psychological explanations suggest that for many people, receiving talking therapies and psychological support will be integral to their engagement with medication since they do not see mental health problems within a biological framework.

6.7   Biological cause

Only very few individuals that I spoke to mentioned any biological or medical cause of mental health problems and these tended to be quite vague references:

> *It's something in your brain, it's partly something in here that isn't quite right.*

Nobody mentioned medical hypotheses such as the role of dopamine in schizophrenia; where biology was mentioned it was more in reference to a more physical, organic cause in the brain or other parts of the body rather than a problem with neurotransmission:

> *… Her depression that she was expressing, that she can take an overdose and all these things, it's got to be something more deep-rooted and actually it's got to be something organically wrong inside her body, something health-wise. Because a lot of people don't know, certain of your organs that is not producing certain things, even for instance the insulin, that can react inside of you in such a way that you come out fed up of life…*

The few individuals who did mention a medical cause distinguished between such illnesses and stress-related mental health problems. One Jewish woman discussed an interaction between the initial biological cause and the resulting social problems as contributing to the development of mental health problems:

> *That [problem in your brain] causes people not to understand how you communicate and then you become something else, then you can't interact with society and it becomes a vicious circle. And until someone acknowledges that there's actually a physical problem, physical in your brain, it becomes a mental health problem because it's something you don't understand and something nobody else understands.*

The surprising lack of biological explanations for mental health problems, even among current mental health service users who are taking medication, implicates a significant disparity between the explanatory model adopted by mental health services and the lay-person's understanding of mental ill-health. It is not at all surprising that services struggle to engage a range of ethnic groups in taking medication: according to most people's explanation of their mental health, medication would be totally irrelevant. There is a clear need for greater understanding by services of the models adopted by the general public and indeed a need for more awareness in the general public of medical hypotheses for explaining serious mental illness. Medical explanations, ascribing a problem to forces outside one's control, are much less stigmatising than social or psychological explanations, which have an element of blame to them. It was common for service users to comment that they wished people could see their mental health problem just like a physical illness like cancer or a broken leg.

6.8   Psychiatric medication

One Caribbean woman who had worked as a nurse at Goodmayes hospital strongly believed that medication administered to patients as treatment was a cause of greater violence and criminal behaviour:

Up to today there are a lot of youngsters who are still actually reacting towards the drug and the behaviour pattern when they come out [of a psychiatric hospital] is not normal. So they get very aggressive and when you look at those who are stabbing or those who are beating people up or things like that, when you look at the history of them and they have had drugs under the Mental Health Act. It is really bad.

Although this is the view of only one person, this comment highlights the suspicion of mental health services (even among those who have worked in them) among some ethnic minority communities. Some people may have chosen not to express these views to me since I to some extent am a representative of mental health services. Several Black African young men also comment that mental health services make you worse. These types of beliefs are quite ingrained and they further highlight the genuine need for a large drive to promote positive impressions of mental health services and to demystify treatment to all ethnic communities.

6.9   Spirits

It is regularly acknowledged that ethnic minority groups from non-English cultures may have alternative cultural explanations for mental health problems, such as curses, djinns, spirits or demons. However, these are usually attributed to older generations. I was particularly interested that when I spoke to central African and East African young men, most of them had a predominantly spiritual causal model of mental health problems. All but one of them was born abroad and migrated to England as children. Their vivid and strongly-held accounts of spiritual causes of mental health problems made it clear that their views were at odds with the medical model adopted by UK mental health services and are likely to reflect a similar disparity among their parents' generation. The three extracts point to a serious barrier to engaging with medication and Early Intervention of any kind:

6.91 Congolese men aged 21
> A: It's got to be spirits, it's not normal. I mean I don't see it [the hallucinated object], he don't see it, he don't see it, so it's supernatural or something …It is sprits innit yeah, that's it basically, that's it, there's no other explanations for it […] but that's when people try and go and look for, try and look for things that's not there […] it's not, the answer's not far […] but people go they look for it.

> B: They look too far…

A: Yes it's like something else, not really the doctor but people they research innit […] like "Oh what's wrong with this person?" everything, "What could the cause be?" and everything… they go, they look too far but it's just…

B: I'm trying to find the answer myself like "What is it?" They might not see it as a spirit or -

A: Basically yeah that's what I'm saying, they'll tell you like "Oh it's a mental, it's a, you got something wrong with you or you should go and see the doctor then you should go and take whatever". We know people that's on medication and everything… Talk to people and everything, you need help but at the same time like you said before, church, […] that's really like the shortest way to, that's the shortcut, you understand, to everything, to all your problems and everything so when it comes to spiritual like we said before like that's the best, the best place to go to. When you're seeing things and everything.

B: I've seen it bruv, someone like yeah badly was gone and that, fully come back, like fully come back.

A: That's the church.

6.92 East African men aged 16-17
C: It could be something like a ghost or something like that, somebody getting their revenge, like you probably done something.

D: Yeah, and so they're cursing you, like to get you back. They're trying to make you do things that will get you in trouble… I believe in magic…

E: Yeah, yeah, some countries it's religion, in some countries black magic.

C: Some of them [at the Mosque] yeah if you don't pray and that yeah, that's what they say, if you don't pray and that, God makes you do things… Not God but the Satan like basically you'll be misguided yeah and if you get misguided yeah you'll be in the hands of the Satan. And that Satan tells you to do things that you don't want to do and see things that you don't want to see and that will make you feel worse and for example you could get into drugs and different things.

6.93 East African men aged 15 and 16
F: My country is Africa, Kenya, you see that some people go to a Guru or something and the Guru's actually real and if the devil comes up to you he will help you. And if you see the devil he'll make you see it again and then once you see it he will tell the devil to go away, like. And we don't believe in Gurus, Gurus to us are like devils, we don't go to them we just read the Qu'ran, like a bible we just read that, yeah. I saw one and I ran home because they're like demons, if you go near the house it'll curse you, it's true and I run for my life.

Researcher: So you obviously believe that they can curse you, but your Mum doesn't?

F: My Mum she doesn't but she knows, she says don't go near them, she knows it's true… I prefer doctors. Cos if you do, they're like things yeah that if you don't do what they tell you, those things will keep coming to you and worse. Cos it's like this yeah, a Guru will help you but if you do the thing wrong and if you told the devil to go away and he didn't like it and you did something wrong to the Guru, the Guru will make the devil go worse on you. It'll come true, all the time and you'll probably die.

G: Voodoo stuff man.

Despite their strongly held cultural beliefs these young men remained interested to hear from me what is provided by local mental health services. People will hold on to their

inherited cultural beliefs but young people in particular are likely to be open to hearing about alternative explanations and outreach education will be critical in dispelling misunderstandings about mental health services and making them more accessible to minority groups in the earliest stages of symptoms.

What the range of perceived causes of mental health problems illustrates is that services cannot assume that clients will agree with or even be aware of the explanations assumed by the Western or medical psychiatric model. Once again, clear information and education is required for both services and the community to understand each other's perspective. There is a huge amount of confusion and misinformation which contributes to stigma about mental health and will need to be challenged if we are to expect ethnic minorities to feel comfortable accessing services early on. Furthermore, it needs to be acknowledged that additional social challenges faced by minority groups in Redbridge contribute to their mental state. Many of these can be addressed by greater cooperation and working together by mental health and social services. It is hoped that current plans to merge the management of some mental health and social services will make care for ethnic minority groups more appropriate by being more joined-up.

It is clear from the repeated discussions of spirituality and mental health by ethnic minority groups that this is a critical and highly neglected area of mental health services. This is not a new observation. The National Institute for Mental Health in England and the Mental Health Foundation both have projects around the role of spirituality. Despite high profile discussions of this issue, however, such as Nigel Copsey's report, *Keeping Faith*, for the Sainsbury Centre for Mental Health, the North East London (Mental Health) NHS Foundation Trust boasts woefully inadequate provision for religious and spiritual needs. This report investigated the spiritual needs of ethnic minority groups in the neighbouring borough of Newham:

I spoke with many users of day services. In our discussions it was clear that their particular beliefs were very important to them. However, there was a fear regarding talking about those beliefs because it was thought that if they did so, they would either be sectioned, placed on medication, or seen as exhibiting psychotic symptoms. Many mental health workers with whom I spoke saw the whole complexity of religious beliefs as being far too complicated to engage with, and many saw religious belief as contributing to mental health problems… In all these situations, those who sought help went first to their Faith Community. One very deeply religious man to whom I spoke, who was severely depressed, went once to the day hospital but 'God was never mentioned'. He didn't return.

The commonly reported view that faith may contribute to mental health problems is a worrying one since there is a growing body of evidence to suggest that spirituality is beneficial for mental health and recovery (e.g. Pardini et al. 2000).

Many people to whom I spoke, drawn from all religions, said they dreaded going into a hospital or day centre because there was nothing in those buildings which enabled them to express their faith. When I asked what they wanted, many said they wanted a place for prayer, contact with their religious community, and staff who wanted to talk to them about their faith. One person told me that having been to a day centre once, she refused to return as she felt so cut off from the things that mattered most to her. This difference cannot be overstated as it constitutes what I believe to be the fundamental reason as to why there is so little integration between the community mental health services and the new communities. The belief system underpinning nearly half the population of Newham is grounded in non-western culture. This culture has a long history of integration between the body, mind and spirit. Spiritual values are an essential part of life. There is no dichotomy between the secular and the spiritual. Life is sacred. The transcendent is part of life. Such a belief system permeates the *whole of life.* This is very hard for those with a western world view to understand. The history of both psychiatry and most psychotherapy is based on a world view that has excluded the transcendent. If this fact were to be taken seriously, then we would attempt to initiate a *dialogue*

between the two belief systems. My research over the past two years shows that there is no real attempt at dialogue on this crucial issue.

Mental health teams and psychotherapeutic services need to change their paradigm. Instead of working with a model that focuses on the individual, there is a need for a truly holistic approach, which sees the individual as part of an extended family and a Faith Community, and recognises the culture from which that person comes. Such an approach would involve shaping services according to the context. For example, the spiritual and cultural norms of the environment would need to be reflected on ward areas, at day hospitals and at day centres. In order to discover the most appropriate provision, people from the various communities would need to be asked!

Learning from this excellent project in Newham, Redbridge mental health services must acknowledge the critical role of spirituality in the recovery and general wellbeing of many ethnic minority communities if they are to *Deliver Race Equality*.

7.0 Barriers to using Primary Care

It is essential that all communities perceive primary care as a reliable, rapid and appropriate first contact for all their health problems. An important factor in the over-representation of ethnic minority groups in mental health services is the fact that White British people are more likely to see their GP first, and ethnic minorities are more likely to follow more coercive routes such as the criminal justice system or attend Accident & Emergency services (Morgan et al. 2005). It was therefore of great interest to me that without any prompting, representatives from South Asian, Black Caribbean, Black African and Jewish communities complained time and again of a host of problems accessing and talking to their GPs about mental health problems. This implicates a critical area for community development work. It seemed the vast majority of ethnic minority groups I spoke to did not see primary care in a particularly positive light. An important project in response would be to work on raising the profile and improving the image of the GP surgery as most communities know it, as well as working with groups of primary care practitioners to make them more aware of the beliefs that make people less likely to seek help from them in future crises. All of the comments below focus on General Practitioners since most people seem to see them as the embodiment of primary care services but it is important to acknowledge that many of these comments really relate to the accessibility of primary care services generally

7.1 Summary

- Ethnic minority groups were deterred from seeking help from their GP because they perceived them to be too busy to listen to what they felt would be a long explanation of how they were feeling.

- They also assumed that their GP would prescribe them anti-depressants as a default solution, which most people did not think would have any effect. Two recent media stories about anti-depressants seemed to have had a serious effect on some people's faith in and willingness to take medication for mental health problems and some of them were concerned that it would be addictive.

- Some people had had bad experiences of primary care and dismissed practitioners as inflexible or even rude. Greater numbers commented that their concerns would not be taken seriously and they would be told that 'there's nothing wrong with you', deterring them from seeking help from primary care.

- A number of people from ethnic minority groups viewed mental health problems as being manifestations from their own social problems and not as medical problems at all. Since they did not think there was anything primary care could do about their social problems, they did not consider seeking help there.

- Other people worried that primary care practitioners did not know about or understand mental health problems and that they needed more training.

- Some people from ethnic minorities did not feel able to explain their mental health problems to a primary care practitioner because they did not know their previous history.

- A number of people were deterred from seeking help at the primary care level because they expected that waiting lists would be too long. This may contribute to some groups waiting and then attending A&E since they perceive this as a more immediate way to be treated.

- Given their concerns about the time constraints imposed upon GPs in particular, several people expressed the wish to have someone to talk to in the primary care setting; this presents a great opportunity for low-intensity therapy under the Improving Access to Psychological Therapies agenda to have an impact.

7.2 "They don't have enough time"

The average GP consultation time in 2006/07 was 11.7 minutes, up from 8.4 minutes in 1992/3 (Information Centre for Health and Social Care, 2007). South Asian and Black Caribbean people I spoke to were highly aware of the time limits imposed on their GPs, estimating them to have from 6 to 10 minutes to see each patient. While most people acknowledged that GPs are in a difficult position, there simply are things which they would like to talk about but do not raise because of the perceived lack of time available.
I think what GP needs is time. I think that's what no-one seems to have these days. I'm not sort of blaming them entirely, blaming GPs entirely, it's just it's so easy to get in a doctor's surgery and he starts sort of writing down, you know.

People would like their GPs to make another appointment for them to explore mental health issues in more depth but most people suggested that it would be so difficult to bring up in such a short space of time that they would prefer not to talk about it at all.

7.3 "They immediately prescribe anti-depressants"

Once again, a range of South Asian groups and one Caribbean group that I spoke to were in agreement that if they did raise a problem such as depression or anxiety with their primary care practitioner, they would immediately be prescribed tablets. For some this was a way of 'fobbing them off', to get rid of them quickly, whilst for others this was perceived to indicate a lack of interest on their clinician's part in hearing about their problems. For example:

> *They just give people the drug – no-one is trying to cure their actual problems, asking why these problems happen… Here at the group the first thing we talk to the ladies about is their problem, one on one.*

> *I told my GP what was wrong with me but he put me on tablets before getting to know me. Repeat prescriptions are very bad: they haven't seen us face to face for a long time. They don't want to listen to you, they cut you short. You expect to be offered something in addition to the tablet.*

> *Like you hear, half of the time sometimes people go to the doctors with depression and they get Prozac or whatever and all they probably needed was someone to listen. Because if you give someone a tablet or put them in a mental institution, it's the quicker way out, isn't it?*

7.4 "Medication is addictive, or doesn't work"

Several people talked about fears that any medication they would be prescribed for a mental health problem would be highly addictive. This contrasted with people's fears raised by two recent news stories. In one, research found that new generation anti-depressants are no more effective than a placebo for people with mild to moderate depression (Kirsch et al. 2008). In another the television programme *Panorama* revealed that GlaxoSmithKline tried to show that Seroxat works for depressed children despite failed clinical trials and evidence that it trebles suicidal thoughts in under-18s. The corresponding suspicion of the evidence base for medication only adds to the mistrust and confusion ethnic minorities already feel about mental health treatments. Combined

with the belief that their GP will prescribe an anti-depressant as a default option, some people feel that they would rather not seek any treatment for mental health problems. This is another example of the power of the media to affect help-seeking behaviour.

7.5 "They can be rude or inflexible"

Some people had had bad experiences with primary care practitioners and seemed to have been put off generally from seeking their help. Several people wanted primary care and hospital services to be more flexible, opening on weekends, being less rigid with their appointment times, contacting you by more than just a letter which may not arrive or may be difficult for them to read, and felt that ambulance services were unreliable.

> *The doctors give appointments that suit them, not me.*

These problems frequently extended to the more worrying complaint that:

7.6 "They don't take you seriously"

Quite a number of ethnic minority groups commented that primary care practitioners are unhelpful or are not understanding. Some felt that they will just be told that 'there's nothing wrong with you'.

> *When I look back at my own life I feel that it would have been more helpful if someone had actually had the courage to say "Well, maybe you do have a problem somewhere, but we can help you with it."*

Not feeling listened to or taken seriously clearly impacted upon ethnic minority groups' levels of trust and sense that they could talk to their clinician about anything and in some cases meant that people chose to suffer in silence rather than to seek help.

7.7 "They're not there to help with 'social problems'"

There was a strong sense from some ethnic minority groups that if they were struggling to cope with life this would be a 'social problem' and since primary care practitioners deal with biological, medical needs, mental health would not be an appropriate thing to discuss. This may be related to the observation that some ethnic groups 'somatise' their feelings (Rack, 1982), perhaps seeking treatment for headaches or stomach pains when it is depression or anxiety that is troubling them. Aspects of this may be part of a cultural perception of what doctors are for, but there were certainly people who had been told first hand that something wasn't their doctor's problem. One Indian woman said:

> *I was overcharged £3,000 council tax and was receiving threatening letters. My doctor said money things were nothing to do with him but I wanted him to understand that it affected my mental health. He scolded me like an irresponsible child. When my next appointment approached it worked me up, I didn't want to go.*

7.8 "They don't understand mental health"

On the other hand, other groups suggested that primary care practitioners simply did not know about or understand mental health problems, and needed better training on how to recognise and deal with mental health problems. Although surprising, this finding is not new. A group of service users in England cited GPs (more than any other group of people, including the police) as needing targeted educational sessions to reduce mental health discrimination (Pinfold et al. 2003). This is of particular concern given that between a quarter and a third of GP consultations are estimated to be about mental health (South West Yorkshire NHS Trust). A group of mental health service users

agreed that they had experienced the same stigmatised views about mental health problems in primary care as they encountered in the wider community. A group of Jewish mental health service users discussed their perception that primary care practitioners lack the empathy required to treat mental health problems:

A: GP surgeries are frightening places [inaudible], there's nowhere… where you can just…

Researcher: What is it about them that you think are frightening?

A: I think a lot of the issue is that the person with a mental health problem almost knows instantly if the person they're speaking to has any inkling, any understanding. Most doctors are not understanding. Most doctors are not understanding people… It's about education. And communication as well. The communication isn't right…

B: My point is do they understand it, doctors, because they've never experienced it for themselves?

7.9 "They don't know my previous history"

Another unexpected problem for several people was that they felt that, having moved to a new general practice, that nothing would be known about their previous history. While it is true that many primary care practitioners would not have time to read a person's notes prior to their appointment it is revealing that several people did not recap the critical aspects of their history that affected them now:

My mental health problem came after my falling down the stairs, I had a head injury. The doctor doesn't know I fell down the stairs because I moved here from X.

I needed somebody to pick up on some issues and I don't even know whether they had any idea how ill my husband was because I changed surgeries but the other surgery should have passed that information on… I know the GP can't solve all your problems but I think it's important to look at every person holistically.

My GP is new, I moved here from another borough so he doesn't know my history of depression, I can't talk to him.

Primary care practitioners understandably assume that patients will mention any critical history such as a serious head injury or the terminal illness of their spouse. Yet a number of people from ethnic minorities felt unable to do this. There can be cultural and other reasons why a person will not mention serious life events but whether their worker hears about them will have critical bearing on whether they receive appropriate treatment.

7.10 "Waiting lists are too long"

Many people assume that waiting lists for services are so long that it is not worth bothering to seek them out:

NHS waiting lists were so long and his health deteriorated while waiting… Twenty years ago the waiting list for psychoanalysis was two years; I don't get the sense that there has been a great improvement.

As part of programmes raising awareness about mental health services it will be important to publicise their accessibility. Service users commented that the current wait for appointments with psychological services was far too long. Experiences like these will be shared with their communities and contribute to perceptions that it will take too long to get help, impacting on whether people seek primary care or wait until crisis point.

Staff at the King George Hospital Accident and Emergency Psychiatric Liaison commented that they noted many Eastern European and South Asian people came to A&E for a range of different health needs that could be treated in primary care. This is further evidence that some minority groups avoid using primary care, for many reasons, one of which may be the perception that A&E will treat you quickly and take you seriously whereas primary care will tell you that nothing is wrong. Providing large scale A&E services is expensive, a less efficient use of resources, and this further motivates a revamp of the public image of primary care as an approachable, accessible community service for physical and mental health needs.

7.11 "More primary care talking therapies are needed"

Several people felt that the general practice is the right venue for low-level counselling and talking therapies but that the GP him- or her-self is not the appropriate person for this, having limited time. This is where greater use of graduate primary care mental health workers and therapists as part of the Improving Access to Psychological Therapies agenda would be very valuable for people who need a lower level of support, to prevent their problem from escalating. This is also a more approachable arena than attending an assessment with a psychiatrist, which many people will have very negative preconceptions about. A group of African Caribbean women said this:

> A: Well I've never had counselling but I know some people who have had it, because I used to sort of criticise counselling, but people say it does work, you know. I used to sort of pooh-pooh it, but people say they had counselling and it works.
>
> B: Because the counselling is sharing.
>
> A: Yes, yes, the people say a problem shared is a problem halved.
>
> B: But you just have to make ready for it and be willing to do it because a lot of people don't want someone they call nosy parker coming and getting involved in their things.

Taken together, all of the beliefs about GPs and primary care that abound constitute one enormous barrier to ethnic minorities accessing services. The evidence that ethnic minorities seek help from primary care less and reach services more through more coercive routes such as the criminal justice system and A&E, often in crisis, are quite unsurprising, considered in this light. As well as being less equipped to deal with mental health cases, coercive routes are more costly to provide and a longer duration of untreated psychosis is associated with a poorer outcome (de Haan et al. 2003). A major aspect of community development work to encourage Early Intervention and help seeking among ethnic minorities must therefore be to work to improve the profile of primary care and to work with practitioners to highlight the barriers minority groups face in accessing them.

8.0 Barriers to Accessing Services

8.1 Summary

- A group of Jewish service users talked about wanting mental health services to be delivered holistically in 'one-stop' locations in which all of the relevant departments could be centrally located. These principles could be applied to new developments like polyclinics and relocations of community mental health services.

- The need for holistic healthcare extended to ethnic minority groups asking for complementary and alternative therapies to be available. Although this is a somewhat contentious issue, the NHS does currently provide some of these therapies and they may be a crucial way of engaging BME groups by illustrating that services go beyond the Eurocentric medical model. These could be delivered to people who want them via direct payments and could present an opportunity for health services to commission therapies by the voluntary sector.

- Black Caribbean women commented on how much they appreciated being asked about their mental health during their diabetes appointments.

- Mental health service users found that their physical health needs were not taken seriously. Engaging service users in voluntary sector partnership projects like *Fit For Fun* will be an important way to involve the community in holistic healthcare.

- People from ethnic minority groups who have multiple needs requiring support from several different departments or agencies struggle with being repeatedly referred from one to the other. They comment that better partnership working between different agencies is necessary.

- Ethnic minority service users commented that they appreciate the diverse ethnic mix of Redbridge services.

- Cultural competence training is being disseminated across Redbridge NELFT services but it may not be enough to radically change staff clinical practice. The fact that its efficacy is only evaluated once, at the end of one year, makes it somewhat tokenistic. The training must be evaluated by service users from a range of ethnicities and their comments considered.

- The context of Islamophobia and fear of terrorism today and the heritage of colonial occupation and the slave trade must be acknowledged. There are profound reasons why ethnic minority groups will be suspicious of and reluctant to seek help from large scale institutions such as the mental health service, which are perceived to be White-dominated and therefore threatening.

- Ethnic minority groups commented on the fact that medication could not be prescribed in isolation since talking therapies were needed to get to the root of the problem. Others struggled with the model of psychological therapy they received and felt it jarred with their cultural beliefs. Inter-cultural and systemic family therapy may be more appropriate for some ethnic minority clients.

- Ethnic minority groups not using services wanted more information in their own languages and located in community venues about the help available. Those who were using services wanted more accessible and translated information about their medication and their treatment. The information may well be there but it may not be made available to service users as a matter of course.

- Ethnic minority service users felt that their views were not routinely consulted but only occasionally through tokenistic gestures.

- Ethnic minority service users commented that fear of their benefits being cut off when they entered hospital deterred them from seeking help as soon as they began to feel unwell. Support to re-arrange these types of services should form part of everyone's discharge summary; this may need to be Equality Impact Assessed.

8.2   Holistic Healthcare

A central theme raised by a range of ethnic minority groups was that healthcare needs to be holistic. Services currently compartmentalise people into parts and individual problems. Trusts are divided according to whether they provide physical or mental healthcare, and this jars with people's conceptions of themselves as a whole person, whose physical health is interrelated to his or her mental health.

8.21 A Holistic centre for wellbeing

A group of Jewish mental health service users talked about wanting a holistic centre for wellbeing which would provide information and mental health promotion and prevention, in which people could receive physical health services, mental health services, attend activity groups and voluntary sector services, take exercise and get involved with faith activities. This would work along the lines of a polyclinic but would have a holistic ethos, and should be the kind of place that all people feel happy to attend, rather than having the stigmatised label of a 'mental hospital' around it. Benefits advice, help with housing and Freedom Passes and support for other disabilities could be located there as well as lower-level counselling. This type of building would of course be very expensive but given that North East London NHS Foundation Trust is considering moving community services from Goodmayes to a building in Gants Hill or another community location, these ideas could be incorporated into existing plans. This could ensure that costly new buildings provide a fresh start, for people to approach community mental health services with a new outlook to combat fear and stigma in the community. This ethos could also be incorporated into the five polyclinics which are due to be built in Redbridge, the first of which, to be located in Loxford, is currently being constructed.

8.22 Alternative and complementary therapies

Several South Asian women talked about wanting services which improved both their physical and mental health, and a range of ethnic groups talked about wanting more options for alternative and complementary therapies.

> *I would like to be offered therapy in a group to share your feelings: different people might have the same problems. Group talking, massage, reflexology, supervised exercise to help your physical problems as well, you need encouragement so you aren't afraid of injury, so you feel confident to exercise.*

> *Healing is viewed [in our culture] as a holistic process: you must look at the whole picture of the person and heal the whole.*

> *People miss out on a lot of herbal remedies. I would like to be able to take herbal medication like 5HTP, it's natural, herbal. I want more choice about what to take, there should be more involvement in choice of medication. Herbal medications have been brilliant for me.*

Ensuring that health services work in a more holistic way, more in keeping with ethnic minorities' own conceptions of their health is likely to make it easier to engage them with services. There is of course an ongoing debate about the scientific efficacy of complementary and alternative therapies and commissioners might question their

responsibility to fund them. It is not, however, a radical idea for these therapies to be provided by the NHS, as illustrated by this quotation from the NHS Direct website:

There are five NHS homeopathic hospitals in the UK… Most hospital clinics offer some form of complementary therapy. Acupuncture is often used in pain clinics, and aromatherapy and massage may be used in the treatment of cancer. Osteopathy and chiropractic are commonly used to treat bone and joint problems such as back pain, often alongside physiotherapy and heat treatment. Lots of GPs have completed further training in complementary therapies, and may be able to provide treatments such as acupuncture, homeopathy and osteopathy directly from the surgery.

Furthermore, offering alternative therapies to people who want them will be pivotal in demonstrating that services are able to look beyond the Eurocentric world view and embrace some non-medical explanatory models of mental health. This type of therapy will be critical in engaging certain communities with mental health services. In the same way that services do not place value judgments on the different faiths (but are expected to provide chaplaincy as standard), so services must acknowledge that if alternative therapies make people feel better and make them more likely to engage with other forms of treatment, then they are essentially valuable.

The new advent of direct payments and personal budgets should also make provision of alternative therapies and greater choice easier, but it will be necessary to ensure that ethnic minorities, particularly those with English language difficulties, are actively encouraged to take them up and understand how they work. The voluntary sector is well-placed to provide alternative and complementary support and therapies in culturally sensitive community settings. For this to work well it will require a genuine commitment by commissioners to develop the capacity of the third sector by offering small grants to groups to fund this type of holistic treatment to improve wellbeing. A good example of how this can work is 'Fit For Fun': Redbridge Primary Care Trust has funded RedbridgeCVS to distribute small grants to voluntary sector groups to provide programmes of exercise of their choice to the community.

8.23 Feeling they are interested in you as a whole person
The value of feeling like your clinician has an interest in you as a whole person was captured by the following comments from some Black Caribbean women. The simple question 'Do you feel depressed?' from a diabetic nurse really made a difference to them:

> *A: But myself I didn't even know that I was classed as depressed… and then I went to the doctor and we have a diabetic nurse and she said to me one day when me and my husband went for a blood test… 'Do you think you're depressed?' and I said well "What is depression? Everybody is depressed. Well, I might be…" And then I went to see the doctor and she said 'I think you are depressed…' and she gave me some tablets… so I tried it and I must say at the end of about three weeks I felt marvellous and I said "Well I must have been depressed!"*

> *B: But you know, I don't know if it's a standard thing, that, but when I had a diabetic review in November, you have a review and then you have to go for your results, my doctor did ask and say "are you depressed?" and he said to me they have to ask patients that.*

> *C: It's because of the stress in society today.*

This group talked about how it was nice to feel that someone had asked. Even if they didn't feel depressed, it made them feel as though their clinician cared about more than just their blood test results. These kinds of simple changes to clinical practice make a big difference to how they are perceived, and is likely to make them more approachable if the same person needs help with a mental health problem in future.

8.24 Service users' physical health needs are often ignored
A very common complaint from mental health service users of all ethnicities was that their physical health needs are ignored or not taken seriously:

> *Many doctors see your physical problems as symptoms of mental health, or they see you as a hypochondriac, or they just don't address them. They should look at you as the whole person.*

> *It [my mental health problem] started in 1989 but I only found out in 2001 that I had an unreactive thyroid; they should have noticed it. It makes me wonder whether my problem is due to my thyroid because the symptoms are very similar. I'm still not sure. The doctors are more aware now.*

Although physical illnesses and poor dental health are much more common in people with severe mental illnesses than in the general population (Jones et al. 2004), there is strong academic evidence that they have less access to quality medical care (Druss et al. 2001). People with all types of mental health problems have also been found to have an increased risk of dying prematurely (Harris & Barraclough, 1998).

This problem commonly reported by Redbridge service users is very serious, with people feeling that their physical health needs are ignored because they do not concern mental health services and are frequently attributed to symptoms of their diagnosed condition. Given the additional health problems many mental health service users face, for example as a side effect of medication or of a less healthy diet or lifestyle including smoking, there is a clear demand for services to acknowledge that working to improve users' physical health will improve their mental health. This might be through more partnership projects with the Primary Care Trust or through endorsing more physical health activities such as Air Football (a highly successful local project promoting recovery through football). However it works, it is in the interest of mental health services to make the physical health of its patients a priority.

One Indian man who had lost a lot of weight through deciding to walk for one hour every day extolled the virtues of fresh air and moderate exercise, and wondered why it hadn't been suggested to him before:

> *I used to be overweight but I decided to do walking and so I'm saving the NHS lots of money with all the complications I no longer have. People could follow my example. People think the doctor is God, he will save me. But he can't always save you. People need more willpower to exercise – people don't realise the value of fresh air – it would save the NHS money.*

Again the voluntary sector must be a key partner in this agenda. The current Primary Care Trust funded project, 'Fit for Fun', enables third sector groups to deliver exercise projects. That is, there is already extensive funding to improve the physical health of communities, it only requires engagement with groups of mental health service users to make use of this type of mainstream exercise provision. Community Development Workers can be instrumental in encouraging this type of partnership between the voluntary sector and users of mental health services. Such projects could also combat stigma by engaging service users in exercise activities with non-service using members of their community. This could attempt to both challenge community preconceptions about service users and improve the social inclusion of the service users themselves.

8.25 Services working together
One Pakistani woman did not understand why services could not work together to help her with problems that affect her mental state such as housing, asylum applications and benefits:

They are good when they ask questions, listen properly, they are very caring but afterwards they are not helpful. They should help you to resolve problems like housing

and benefits because that is the reason you are suffering… They need more working together, not just thinking "This area is nothing to do with me". People always pass me on to another agency, another phone number.

In teams such as the Early Intervention Team care coordinators have smaller case loads and are able to provide this kind of more intensive support for a more holistic package of care. This should be considered a model of good practice to illustrate how successfully the different agencies can work together to support an individual. Greater merging of health and social care services should also make this type of collaborative working more feasible.

This point about healthcare needing to be holistic is more than just a preference people have for services 'in an ideal world'. It signifies a fundamental mismatch between how ethnic groups view their health and how the organisational structure of health services looks at their health. It is likely to be a critical aspect of why minority groups do not seek help for mental health problems early on: they just don't feel that they will be understood or taken seriously. Mental health services need to work more holistically if the range of ethnic minority groups is expected to perceive them as approachable.

8.3   "Services are not culturally sensitive"

Several people talked about wanting staff of all ethnicities to work with greater cultural sensitivity.

8.31 Staff ethnic diversity

While they did not mind if nurses and care workers were not of their own ethnicity they would still appreciate people of their own ethnicity working on the ward where they were treated. One South Asian woman said:

People from different countries have different needs… I would have liked people from my own country working there. There was one Asian woman, they were mostly Black and English. We really don't mind who it is, the colour of the person giving our care, so long as we get the care we deserve with respect. They should experiment. Do things work better with more diverse staff? Try it out.

Redbridge services in the North East London NHS Foundation Trust does have an ethnically diverse workforce, although these numbers are not broken down into teams. See Figure 1 for the comparison of staff ethnicity in the Redbridge Directorate versus user and population ethnicity.

Figure 1: Ethnicity Comparison for Redbridge in 2007
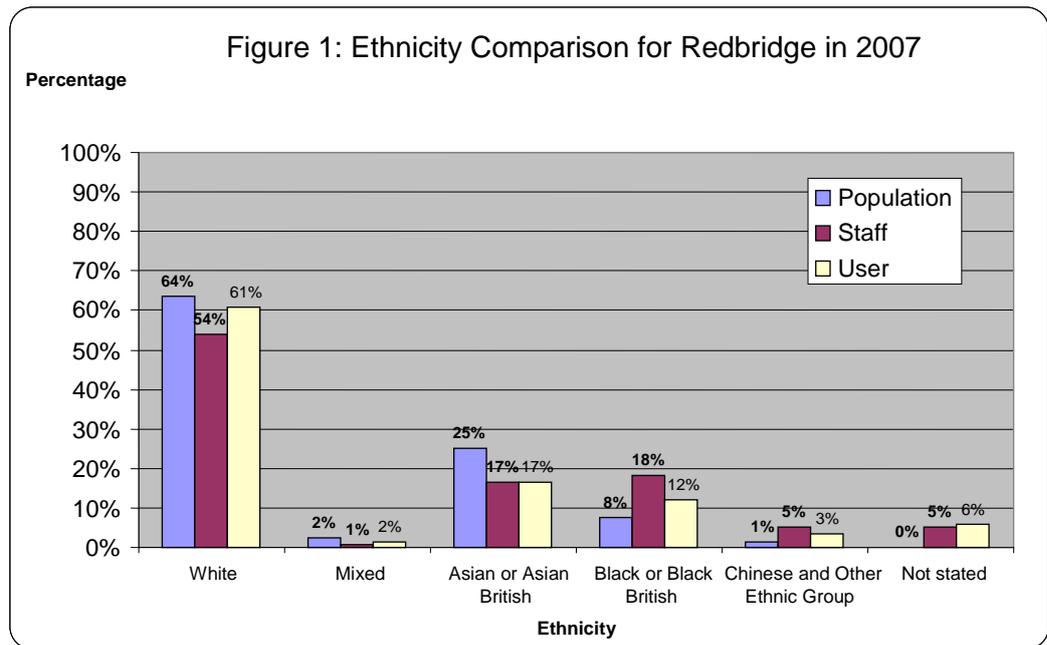
8.32 Cultural competence training

NELFT has begun implementing one-day sessions of Cultural Competence training which forms part of the Delivering Race Equality agenda, but it must be questioned whether one day's training is sufficient to imbed new approaches to different cultures within the entire work practice of staff. This training has not yet been tested by groups of service users from different ethnic groups and this will be an important step in evaluating whether the current training provision is sufficient. In addition the current one day training is only followed up once, one year later. A more comprehensive, less tokenistic plan of follow-up and evaluation of the impact of cultural competence training is required if it is to constitute anything more than a meaningless tick-box exercise.

Many doctors have trained abroad and induction training should include cultural competence… You need sensitivity to people's contextual and cultural views and expectations.

8.33 "Services are inflexible to cultural needs"

One Asian Muslim woman with two relatives who were inpatients at Goodmayes hospital at the same time commented that:

The inpatient units are not aware of Ramadan and it was difficult to visit them during Ramadan because I need to be able to visit them before sunrise and after sunset and they don't allow it.

Basic needs of ethnic minorities such as these must be catered for in order to ensure that they receive the same levels of care as the White British majority, and it is quite shocking that the needs surrounding such an important cultural event are not supported by the current organisation of wards.

8.34 The heritage of relations between White groups and ethnic minority groups

Minority groups' experiences of ethnic discrimination contribute to greater sensitivity and heightened awareness, and services need to be alert to this. A member of Accident and Emergency Psychiatric Liaison staff commented:

A lot of our Muslim presenters are quite cagey about saying they're Muslim [we have to ask for monitoring purposes]. "Why do you need to know?" I assume that means that they have met with hostility about it before. It is pure ignorance about Islam.

There is emerging evidence that Islamaphobia may have significant negative effects on the mental health and healthcare of Muslim families and children (Leard et al. 2007). The significant Muslim population in Redbridge means involving faith leaders in mental health services now could ensure this community's needs are addressed before they escalate into more serious illnesses.

Within the African Caribbean community as well as other ethnic minorities it is important to remember that relatively recent experiences of explicit racism and current day-to-day experiences of implicit racism remain very salient. Given the historical treatment of African and Caribbean people in the UK it is unsurprising that many communities retain a deep suspicion of services and what they will 'do to you' if you seek help from them.

In the 1970s Black people were put in institutions… White people saw Black behaviour as completely different: singing loudly in your garden, making noise, shouting, singing. They were not considered normal by White social workers… they just assumed that there was something wrong with her. How dare you do that to a Black person? Once in [a psychiatric hospital], they start the drugs [medication] straight away. Then the drugs start to make people start to act funny – rocking, screaming, they start to pick up the actions of people who are mental. Then it is very difficult to get them out. Some Black people died in there under the Mental Health Act. Then I decided not to work there anymore, it was so frustrating, especially the youngsters and so many drugs. Eventually you hear he stabbed someone, beat someone up.

This group of Caribbean women, some of whom had been nurses in Goodmayes Hospital from the 1970's onwards, held the belief that mental health services make you worse rather than better.

> *One thing I reckon you should not do is have your relatives sectioned straight away. Because I think sectioning is one of them things, they give them electrical stimulation and thing and they never come back out how they were when they went in. They always come back changed, it's horrific. It's very hard to get them back over.*

> *If say someone has depression and they refer them to Goodmayes and then they mix with the other ones who are worse, then they tend to believe that they are really mad.*

This echoes the views of the young Black African men who said that services would only make you worse. The relationship between African and Caribbean communities and mental health services in particular is extremely complex and interacts with the memory of colonial enslavement of Black people. The emotions surrounding the oppression of one's people are very strong for many and have no remedy. However it is important for services to acknowledge that a deep suspicion remains within some Caribbean and African communities about mental health services as a tool for further oppression and this will have a massive impact upon people's readiness to seek Early Intervention for decades to come.

One Caribbean carer whose relative has been using mental health services for almost twenty years said:

> *We did notice that White people got better quicker in hospital… I think they gave different medication to the White people and the Black people. Then they gave him two tiny tablets and suddenly he got better and no-one would tell me what the medication was.*

The disproportionate representation of Black African and African Caribbean people in mental health services and compulsorily detained under the Mental Health Act only adds to communities' suspicions of mental health services. There is a significant number of people, including many psychiatrists, who believe that the reason for this over-representation is that psychiatry itself is institutionally racist and thousands of Black

people are incorrectly diagnosed with mental illnesses. This debate is emotive and very complex but no matter what the reason, the fact remains that large numbers of people believe that mental health services as a whole are malicious and to be avoided. Only long-term commitment by services to spend time engaging in dialogue with ethnic minority groups can begin to address these complex historical issues. Community Development Workers play a key role in this but ultimately they remain just one or two workers in a borough of over one hundred thousand ethnic minority citizens. The PCT and mental health Trust must acknowledge that more than two workers' efforts are required to make over the public image of mental health services.

8.4   Greater access to a range of talking therapies

This South Asian woman's comment highlights the importance for ethnic minority groups that medication be prescribed not in isolation but in conjunction with talking therapies:

> *About eight years ago my friend asked the doctor whether there was any such person who could help take these thoughts out of my mind. Because of that [not having access to talking therapies] that's why my problems have lasted as long as they have. Even though I'm taking medication I have no-one to talk to. The medication helps because before I couldn't even get out of bed. So it helps practically. Before I would never say anything about anyone because I've always been brought up to believe that you shouldn't talk about anyone… Now my attitude has changed… Because even my friends say if you keep everything inside then how are you going to look after your kids?… Even by expressing how I'm feeling I've been able to find out a lot more about what medication could help me. Before I would worry about going to my GP and showing him what medication I was taking from India because my GP turned around and said to me people go to India and take medication even though it's no good… Now I'm much more open about telling him what medication I'm taking and how it's helping me… And sometimes my doctor prescribes me the same medication.*

The specific psychological needs of ethnic minorities generally and refugees and asylum seekers in particular remain insufficiently supported in Redbridge. One example, of placing a mental health worker within the community has been proposed in a (thus-far unsuccessful) bid for funding by RICHNEL [Refugee Integration Community Health (North East London], a group of voluntary sector and statutory sector providers with a mutual interest in refugee and asylum seeker needs. They suggest funding a joint post between the Redbridge Psychology service and the voluntary sector Refugee And Migrant Forum for East London, able to provide counselling services to ethnic minority communities from both sectors.

One Congolese woman struggled to engage with the approach taken by her psychiatrist:

> *Sometimes you want to talk about your problem, for example with a psychiatrist and they may say the problem is in your mind. The psychiatrist's approach was not very helpful. I tried another and had the same problem, so I thought that I would stop. They offered me to try a third psychiatrist but he will only say the same thing. They give you antidepressants and say that you should take them forever but I don't want to. I want the psychiatrist to let me speak, empty myself, I want the psychiatrist to put himself in my shoes. You talk to the psychiatrist but you get no feedback so it feels pointless. You want feedback, for them to tell you what they think. You want to empty yourself, you want them to give you advice. In Congo I wouldn't talk to anyone about these problems. I want more direction from the psychiatrist. She doesn't give me anything and then the time is up and it's "Oh, we've finished".*

This problem seems partly about the clinician not having a sense of what the client wanted to get out of the encounter, and not considering what the person would want

based on their own culture. Some people may feel hesitant about the process of talking therapies. One Iraqi man summed it up:

There is a cultural gap with counselling. You have to summarise a long tale of sadness in a few words, you have to share many of your secrets and then suddenly the time is up and you have to go. You want to stay just ten minutes more but he can't. It is so mechanical.

For this man there was a problem, culturally, with the way counselling or psychiatric therapy are delivered in Britain for ethnic minorities. The actual method used jars with cultural norms around sharing private information, giving time and expecting something to be given back by the therapist beyond listening.

> *Nafsiyat Intercultural Therapy Centre on Holloway Road, London, is a psychotherapy and counselling service, based on psychodynamic principles, focusing on therapy sensitive to the cultural needs and circumstances of the client and their family. Nafsiyat was set up to address the difficulties experienced by people from diverse cultural backgrounds in obtaining high quality, financially accessible psychotherapy.*
>
> *In intercultural work clients from diverse cultural, racial, linguistic, religious and ethnic backgrounds are offered psychodynamic therapy that is appropriate to their mental health needs in the context of their cultural background. Intercultural therapy, as practiced at Nafsiyat, recognises that adaptation of traditional psychodynamic/ psychoanalytical theory and practice is necessary for some minority patients because of their life experiences as well as current problems. Wherever possible, therapy is delivered in the client's first language unless the client prefers another language. Services are provided free to London residents and referrals are accepted from clients as well as professionals. It is funded by Camden PCT, Islington PCT, Haringey PCT, Enfield PCT and has a grant from London Councils.*

Inter-cultural therapy provided by organisations such as Nafsiyat focuses on these issues. It can be costly to provide but a one-size-fits-all approach to talking therapies will not work for all ethnic minorities and in some cases something more culturally appropriate will be necessary. Since the organisation provides services free to London residents, a cost effective measure would be for Redbridge Psychology services to establish a clear set of criteria for referring clients whose needs are acknowledged as requiring specialist skills. However, the ethnic diversity in Redbridge implicates the need for at least one full-time psychologist with specialist skills in working with ethnic minorities.

A group of service users raised concerns that there is too much emphasis on Cognitive Behavioural Therapy when they felt that it isn't always the most appropriate treatment. People wanted a choice of talking therapies, if not a choice for them at least a selection being offered by services:

You want a range of options to suit the person, including one-to-one and group options.

In particular, systemic family therapy may be more beneficial for some ethnic minority service users for whom their family plays a critical role in their recovery. While Redbridge Child and Adolescent Mental Health Services offer systemic family therapy, the Redbridge adult services provision is very limited.

8.5   Better information

Many South Asian people commented that their communities were unaware of the services available. They suggested that while there was a lot of information available it needed to be translated into South Asian languages and distributed in more appropriate locations, for example in temples, social halls and GP surgeries.

People using mental health services also pointed to insufficient information. One South Asian woman caring for her son did not feel that services involved her enough:

I need more information. I want to have someone to ask about the tablets but the GP doesn't listen and you can't force him [my son] to see a psychiatrist. I want to know the long-term results of this medication.

There is evidence of a need in Redbridge for services such as those provided by Barking and Dagenham's Advice and Brief Intervention Team, which offers advice, assessment and signposting. Such a team, if located in an approachable part of a Redbridge community, for example Ilford Lane, could ensure that people feel more informed and can drop in for information if they have questions.

Medication and side effects are a particular problem for service users of all ethnicities. While these effects cannot always be avoided, there was a strong sense that many people did not have their medication or its side effects explained to them, leaving them feeling misinformed and more likely to stop taking it:

> *Even when medication is prescribed to you, you don't always know what you're taking it for. I noticed that even when I asked my doctor a couple of times even he ignored me and didn't tell me what it was for. Sometimes when you do tell your family, a family member says, "This medication helped me, why don't you try this?" And you try it and you take it to the doctor, he will tell you off for taking something that's not been prescribed to you. You are ignorant about what you're taking and if you haven't got knowledge, how can you ask the right questions?*

> *The many tablets were all different, very bad side effects from the medicine. I used to be very slim, the medicine changed my body so I don't like tablets. No-one explained the different tablets to me.*

> *They neglect you a lot, give you a lot of pills, leave you alone. There are bad side effects from drugs like Olanzapine.*

> *There is so much medication and you're not sure of all the side effects, you feel like a guinea pig.*

> *A: I haven't been able to read about other people's mental health problems.*

> *B: There are websites though.*

> *A: I've looked in the pharmacy, doctor, dentist, I find information on physical health but not mental health.*

> *B: There's lots of information in the library.*

> *A: Then it needs to be more easily available. I couldn't find any information on schizophrenia. I didn't even know what the word was. No-one told us what he was going through or how to relate to him.*

While a lot of information has been produced it seems that for some people it isn't being provided in the appropriate locations. Work needs to be conducted to ensure that information of the appropriate level is available in places where people will actually see it

and feel able to pick it up, such as in shop changing rooms (by Drugsline) or community centres and places of worship, as suggested above. Buses, while expensive to advertise on, are also a very effective way of ensuring information is communicated to a wide range of people.

People using services felt that there was not enough information communicated to them, for example about how long they could expect to stay in an inpatient unit. This echoes the findings of the service user-led Roots to Routes project (2007):

They don't seem to let you know you're going to be in there another couple of months. I wanted to know more about their plans.

All service users should be involved in and have access to their care plan. Ensuring that this is done forms part of ongoing audits of Care Planning Standards in NELFT. However, it will be very important that cultural needs are considered within this, for example inviting an interpreter to the CPA meeting and ensuring a translated copy is provided to the service user if necessary and if they cannot read in their first language, an audio copy where appropriate.

8.6   Insufficient Consultation

While quite a lot of consultation is undertaken with members of the public about physical health services such as hospitals and polyclinics, there was a strong sense that consultation with mental health service users has been tokenistic and most people feel they have never been consulted. In addition the ethnic diversity of service users represented in consultations tends to be quite low, meaning that ethnic minorities are not sufficiently involved in the planning and development of services. There needs to be greater emphasis on involving minority groups and in supporting service user organisations such as RUN-UP to do more to engage minorities. While the new structure of the North East London NHS Foundation Trust allows more levels at which service users are involved, including representation on the Trust board, there should also be more events which allow minority groups which do not want to take on formal roles, to be consulted and have their say.

Several people mentioned that they appreciated that I was asking their views, that it was positive that some effort was being made to find out people's opinions. A greater effort by mental health services to come across like they are listening to their users, and evidence that they make the changes suggested to them, would make people feel they had greater ownership of services and in turn be more likely to talk positively about them in their communities.

8.7   Discharge to outpatients

Several service users and carers were very concerned about people being discharged from wards direct to outpatient services without any support from a community care worker after leaving hospital. One man had been promised a key worker but a year later still didn't have one. People wanted more support on discharge. One Indian man said:

[After discharge from the inpatient ward] it's a few weeks until your CPN [Community Psychiatric Nurse] gets back in touch. I would prefer every couple of days after you leave to have a phone call to see how you are… or they could come over to your house to see if you're taking your medication. When you're in hospital your DLA [Disability Living Allowance] and benefits are stopped and you are then left to contact the DLA again. A social worker should make those phone calls, fill in those forms. You're left penniless but needing to pay all those bills that have mounted up while you were in hospital. You then go home to an empty fridge. People might need help getting back into life, back into reality.

Several mental health service users agreed that the fear of one's benefits being cut off made people afraid to go into hospital to stay on an inpatient ward and actually encourages them to wait until crisis point before seeking help. The way inpatient admission processes work actively deters people from seeking help that they know they need: this is a real failure. A clear procedure to help service users who live alone return home, for example assistance with buying the first week's shop or an advance on their benefits so they can pay their bills does not seem too much to ask. In fact this should be part of any effective discharge strategy but clearly this does not always happen. It should not be up to the service user to have to ask for this kind of help: it should be provided to all as standard. The procedures in place for discharge should be Equality Impact Assessed to ensure they meet the needs of ethnic minority and refugee and asylum seeker service users.

9.0   Service user views

A range of service users I spoke to agreed broadly on the improvements to mental health services which they felt would have the greatest impact.

9.1   Summary

- Ethnic minority service users emphasised the importance of community services (both statutory and voluntary) in their recovery and suggested their capacity to be built so that they could expand, for example to ethnicity-specific befriending and more frequent social outings.

- A group of Jewish service users were enthusiastic about wanting to get involved in more mental health promotion initiatives and forums in which they could share their experiences.

- Ethnic minority service users recommended that services have a more holistic focus on their overall health, assisting them with health eating and lifestyle, nutrition and more activities. This type of service is ideally suited to voluntary sector partnership projects.

- Service users commented that they wanted the ward environment to have a more therapeutic ethos to it, although they acknowledged that with increasing numbers treated in the community and ward patients being more unwell, this would be more difficult.

- Carers commented on how they felt very alone at night and at weekends when their loved ones had a crisis and they felt that A&E was often to difficult or traumatic to attend. They recommended a 24-hour telephone line with an on-call Approved Social Worker who could assess the need for an inpatient admission over the telephone to minimise the stress to both carer and loved one. Since something like this may have been poorly used in the past, CDWs should undertake work to more widely consult ethnic minority carers on their views and needs.

- Ethnic minority service users have struggled with the many changes in providers of employment support in Redbridge in recent years and asked for greater stability, more capacity in the service and more specialist service to meet their needs.

- Many ethnic minority service users and carers have been extremely happy with the mental health services they have received.

- Almost every service user was unaware of how they could complain about their treatment and care. In order to ensure that services develop and improve in line with what clients want, some effort should be made to ensure that a simple, accessible and responsive complaints system is developed.

9.2   More community support

South Asian men using a mental health support group emphasised the impact it had on their lives. Many people using day services provided by both statutory and voluntary sectors wanted them to be better funded to provide recreational activities to encourage them to go out, such as day trips. One good suggestion was a specific befriending service for the South Asian (or any other minority) community to combat social isolation and work towards greater understanding and acceptance of mental health problems. A befriending service is already being run out of Redbridge Concern for Mental Health so running a pilot project specifically targeting an ethnic minority such as the South Asian

or Black Caribbean community for example, could be an interesting low-cost way to determine whether there is sufficient demand for such a service. Jewish Care already runs a very successful befriending scheme for their community, supporting people in activities such as attending their synagogue, which can be very daunting after a period of ill-health.

9.3   More publicity and media coverage

This conversation at a meeting of Jewish mental health service users shows how much passion service users have for changing perceptions of mental health problems. Committed, individuals should be involved in work to challenge negative stereotypes of mental health problems.

> A: Advertising, more advertising. You know like, television, newspapers… so that everybody knows, it's everybody's problem… They say you're [people with a mental health problem] all poor, slow, you're a bit downtrodden, you're bad news, you've been abused… once you see them more on a regular basis, people will see what's it's all about and understand it more.

> B: What I think personally is that if we could get that message across, that it's part of someone's life but it's not the whole person, it doesn't explain who you are, as people or what you can achieve and expect in life… that that would change people's ideas a bit.

One group of service users commented that they had enjoyed discussing their views on mental health and suggested that if there were more public events and forums in which people could talk about mental health the general public would start to understand it better.

9.4   More emphasis on overall health

An extension of the comment that service users want their healthcare to be holistic is that they would like to see services encouraging their overall health and wellbeing. People wanted education about healthy eating, healthy lifestyle, more activities such as gardening and exercise. While one might argue that this is not part of the 'job' of a mental health service, what people are clearly stating is that mental health problems affect the whole person and those who are struggling won't necessarily learn about healthy eating or arrange to play sport if left to do so themselves. Voluntary sector projects such as Forest Farm Peace Garden could be better supported by and integrated into the mental health service and promoted more to service users.

9.5   More therapeutic ward environment

The challenges faced by ward staff were summed up by one service user:

> The atmosphere on the wards used to be much more therapeutic, now there is much more crisis management.

One service user felt that nursing staff distanced themselves from patients, spending too much time in the office and not being supportive enough. This may be related to the increasing demands on ward staff to document patient's needs using the RiO computer database. 'Protected time' should ensure that staff have enough time to spend with patients but it should be noted that service users have felt this change.

9.6   Intermediate options between community care and inpatient admission

Service users and carers felt there were no options intermediate between dealing with a mental health problem at home or going to hospital as an inpatient. A service user suggested that:

They ought to have a triage or admissions ward for up to seven days; you would then be moved either to the community or inpatient wards. It would make them more therapeutic.

A group of carers agreed that this kind of service would give them some respite when a loved one was going through a 'bad patch'. They felt that out of hours there were simply no options apart from attending Accident and Emergency to provide support during a crisis. They wanted a telephone number they could call for support which in an emergency could send someone to their home to de-escalate a crisis and to assess whether a loved one needed to go to hospital. They felt this would be much less traumatic for all concerned than trying to go to A&E in the middle of the night.

However, one person commented that a previous local service of this kind was not well-used. It will be a useful project, therefore, for the Community Development Workers in Redbridge to investigate more broadly what a range of mental health carers of different ethnicities want to see from services to support them. There are also several 24 hour helplines nationally, for example run by NHS Direct, and so it may be more economical for CDWs to work in partnership with local carers groups to put together detailed information packages in different languages which could be distributed to mental health carers across the borough.

It was suggested by the service user organisation, RUN-UP that hotels with the support of the Home Treatment Team or a fostering placement with a family to give both the service user and his or her carers respite and time to reflect is needed. The fostering model is used very successfully by Crossroads with dementia sufferers, using trained families.

9.7   Consistent employment support

Ethnic minority service users and carers noted that the frequent changes in providers of employment support services (currently newly contracted to REED) have been a major problem. It has meant very little continuity with no provider settling in long enough to work professionally and has been very disheartening for service users who desperately want to return to work. It has also been acknowledged nationally that people from Black and minority ethnic communities are less likely to use employment support services and less likely to succeed in gaining employment than their White British peers (Sainsbury Centre for Mental Health, 2008).

Most people with mental health problems very much want to be involved in purposeful activity but are very concerned about how their benefits will be affected by working. Although services exist to advise them around this many people do not know how much work they can do. The Supported Volunteering Service run by Redbridge Concern for Mental Health is a very positive service, but without greater funding it is struggling to meet the demand of people who want to volunteer. With the equivalent of only 1.4 workers, the number of people who can be supported through the process of volunteering and the number of placements that can be set up is restricted. Furthermore, with funding extended often on a yearly basis the sustainability of the service is constantly in jeopardy. An important piece of work could be to provide mental health awareness training for local businesses and organisations and assistance in developing systems to work with volunteers. This could have the dual benefits of

targeting stigma and ignorance in workplaces whilst creating new opportunities for volunteering for users of mental health services.

9.8   Many people say they are happy with services

While there are numerous obstacles to ethnic minorities accessing services, when asked, many ethnic minority service users reported being happy with what was provided. One aspect of this may be that people who have migrated to Britain are very thankful because the service is better that what they might have received in their country of origin, and culturally, people may not feel it appropriate to criticise:

> *I haven't reduced my medication for a long time but you must take it, don't blame the doctor. You make a big fuss and waste money by going to court. Some people are always complaining, they want NHS money, to get richer. Doctors work very long hours, I don't blame them, some don't sleep at all.*

> *Nothing is perfect but I've got no complaint. I'm not dependent on other people or the government providing for me. Because of my background I don't expect something for nothing but I'm very glad that there is something there for me when I need it.*

> *Mental health services at Goodmayes were very good, I have no complaints. Inpatient food was good, spicy food like what I want. Nurses asked my food preferences. I am very happy with the service.*

> *The mental health service is very, very good. There's a lot of help out there, there's a lot of phone numbers like the Samaritans. So far I'm quite pleased with the help.*

> *It's been good. It has been good. Everyone's been very supportive, I like the fact that they trust me with my medication.*

> *A: Six or seven nurses were tying me down and forced medication on me several times.*

> *B: He got very aggressive, they had to, they couldn't talk him into it. The services did well, they had no alternative. I know it helped him not to go off and kill himself.*

One Caribbean carer noted that mental health services were much better in Redbridge than they were in Newham:

> *We moved to X from Y and she was right. Up here NHS services, quality of medicine and treatment was much better. It's discrimination. Beds, food, carpets, were better in the Redbridge wards.*

9.9   More accessible complaints procedures

No service user that I spoke to knew how they could complain about their care, and only one had a clear idea of how they could find out how to complain. This makes it less surprising that in 2007/08 the North East London Mental Health Foundation Trust received just 39 complaints. In order for services to be responsive to user feedback and for people to feel more involved, seeing changes made to services, the complaints procedure needs to be much better publicised, understood and more user-friendly. A Caribbean carer said:

We know the system but it is sometimes difficult to know who to speak to. We've made complaints and they take it very personally. We were unhappy so we went to our MP so things changed. We felt we had to complain before we got the service we wanted.

For many people complaining seems futile, like too much hassle since nothing will change. Several people were also afraid that their care would be compromised if they complained.

I don't have anything but if I did have a complaint I'm not sure who I'd do that with: I need more information. I would worry about the outcome of how I was treated if I complained about somebody.

It will therefore be necessary for the Trust to demonstrate how valuable service user feedback is, illustrating how complaints and comments are used to improve and modify services. Having become a Foundation Trust, a move towards a more business-orientated model should extend to a greater emphasis on client satisfaction

10.0   The role of the community sector

The 'third sector' of community, voluntary and faith groups plays an underrated, key role in supporting ethnic minorities and their mental health. The benefits for social inclusion and wellbeing of voluntary sector groups providing day services as well as other forms of support to people who are isolated cannot be overstated. However, each of these groups faces a daily struggle for funding and many remain restricted in their capacity at quite a low level because of difficulties in securing long-term and more substantial financial resources.

A central objective of the Delivering Race Equality agenda is to better showcase and value the innovative and vital services provided by the third sector, particularly to groups of people who never fully engage with more formal statutory services. While statutory funding for the voluntary sector is not limitless, there is certainly room in Redbridge for greater partnership work and more contracts to be tendered to voluntary sector providers. Acknowledgment of the role the sector has to play as an interface between at times 'hard-to-reach' communities and statutory services, as well as capacity building are key objectives to encourage early help seeking by ethnic minorities.

10.1   Summary

- Ethnic minority groups discussed the importance of ethnicity-focused groups delivered by the voluntary sector for their wellbeing and recovery. Facilitators noted that groups needed to have an active focus as their members were unlikely to come just for a discussion group. Having a group run in members' first language where that is not English was identified as valuable although some members prefer to confide in people from a different ethnic group.

- Groups found that their members wanted them to be open on every day of the week but they were restricted in their capacity by funding constraints. Many hoped that they could expand to providing a regular day centre. However, funders considered them to be replicating each other's work since they provide similar services to distinct communities. Partnership bids for funding may be a solution to this problem. A lack of appropriate day services for young people with mental health problems was another issue.

- The competitive funding market has meant that groups providing similar services within similar sectors, for example the same ethnic minority group, have built up rivalries which get in the way of partnership work. Gradually developing a network of these groups could ameliorate this.

- Service users and group leaders argued that some groups received funds which were improperly spent or did not deliver the services they advertised. They wanted more transparency of how funds are spent and better monitoring of contract delivery; this could encourage more trust between groups in the same sector.

- Voluntary sector groups had actively tried to initiate partnership work with the statutory sector and had been ignored; the potential for capacity building key groups to deliver services needs to be capitalised upon.

- Community sector groups, including faith leaders, have highlighted their ability to contribute to mental health promotion, sign-posting and referrals.

10.2   Benefits of ethnicity-focused groups

Among a range of voluntary sector groups providing services for ethnic minority groups, it clearly emerged that the services they provide are absolutely imperative for the wellbeing of many of their members. In quite close communities in which significant numbers of women are home-makers and do not go out to work, having a regular place to go for social interaction, emotional support and activities was pivotal. The same was true for the men I questioned. They strongly identified the group leader and fellow members as sources of support and often as the only people they could talk to who would understand.

Providing activities for ethnic minority members, such as art, healthy eating workshops, singing, eating a meal or exercise were unanimously identified as critical to ensure regular attendance at community groups. Despite the demonstrable benefits to mental health of having such groups to go to, it seemed that culturally, members would not attend groups without a practical focus. A talk delivered by representatives of the mental health service to raise awareness of depression was rejected as 'too depressing'. This is one example of the way voluntary sector services tailor themselves to community need in a way that statutory services struggle to. Far more innovative and creative ways of communicating with ethnic minority groups are required if mental health promotion is to be meaningful rather than tokenistic. In this a lot can be learned by the statutory sector from the voluntary sector.

The value of services run by people who speak the mother tongue of the members of the group cannot be overstated, particularly in communities in which large numbers speak limited English. For people extremely afraid of what statutory services will be like, due to the beliefs discussed in previous chapters, a facility which communicates in your first language, run by people who look like you and dress like you makes a huge difference to a service seeming approachable. Contrast this with the intimidating prospect of visiting Goodmayes Hospital, a large old asylum building, speaking to someone in an unfamiliar and difficult language who looks and behaves in a way that is foreign to you, in a brightly-lit formal office or meeting room, and you begin to understand why some people choose not to persevere with statutory services.

However, many people would like to see a clinician from a different community to their own since it assures them that their secrets will remain confidential. It is also completely unfeasible to provide mental health services specifically tailored to every one of the diverse cultures represented in Redbridge. The comparison is, however, useful in considering why many ethnic minority groups fail to engage with the mental health system, and some of the lessons that could be learnt from the voluntary sector.

It was reported by one community group that even Asian-focused services with most of their funding from the statutory sector were perceived as too intimidating for many women. This shows that there will always be a need for community-led organisations which remain at the heart of a local population, to act as a first port of call for those people who do not feel anywhere else will understand. These groups in particular represent important contacts for mental health services to develop referral pathways with, and improved channels of communication. In addition these groups should be far more involved with training and planning of services to ensure that the wealth of community expertise in the voluntary sector is shared and harnessed by the statutory sector.

The following conversation between Jewish mental health service users gives a flavour of the impact community groups have on the mental health of its members:

>   *A: Coming to a centre… the staff are so supportive, and helpful for people with mental health.*

>   *B: I think this is a centre where there's no mental stigma, you're in a safe haven here…*

> *C: I don't actually live in Redbridge, I come all the way from X to integrate in something Jewish, but it isn't just that, it's about maybe trying to be able to go to different places and not being quite so anonymous and that's very difficult, very hard to explain… there really isn't anything like that down in X.*
>
> *B: I think there should be more mental health facilities spread all over England… There could be more day centres for every religion for ethnic minorities…*
>
> *C: Being understood. It's a reflection on society isn't it? …It's very complicated to understand but I do know that I don't run away from something Jewish whereas I do run away from something else… when it comes to mental health issues, it's confusing… but after Thursdays I go back to X and I'm on my own.*
>
> *B: We have a drama group, we have a keep fit class a week, other activities as well, a film society on a Wednesday, a singing group as well, so many I can't think of the others, but so many things to do.*
>
> *B: Yes, the outings as well. Over the last ten years we've gone a long way, you know.*
>
> *D: One thing that wasn't mentioned was the self-confidence group, now we never had that before, it's recent and it's become very popular, and people have come out of their shells, getting the confidence to do things they never thought they'd be able to do…*
>
> *E: There's much more activities to do, I always look forward to coming here, I like coming here. […] I feel I've achieved something during the day, there's more than one activity to do.*
>
> *E: Kosher food, festivals.*
>
> *F: Friendly atmosphere.*
>
> *D: Intercommunity spirit…*
>
> *E: Something in common.*
>
> *G: My first time here, I was welcomed. I felt wanted…*

It is important to acknowledge that an ethnicity-specific service is not what every person from an ethnic minority wants. The quotation below is from an Indian mental health service user talking about the impact of the statutory mental health day services on his recovery:

> *It plays a great part in my recovery. I can mingle with people with similar problems, illnesses. I feel part of the family, I don't feel left out. They should have more resource centres like this across the boroughs. Some people treat it like a café but I come in every day, Monday to Friday, 9.15 to 4.30. It would be nice to have access to a resource centre on weekends. I go to Outlook at Mellmead House Saturdays 1pm-7pm but it is a bit of a journey. Sundays I go to Mansfield Road. It would be great for Ley Street to be open on weekends. You use your time up. At home you're always thinking about the bad things that might happen to you. I need something to distract me from the voices I hear.*

However, a significant number of people from ethnic minorities simply would not use mixed, statutory services in this way, and for these people the ethnicity-specific options in the voluntary sector are invaluable.

10.3   Need for a day centre

Many of these groups, often providing services for one or two days per week, hear regularly from their members that they need to be open five days per week. Many of the people using community daytime groups have no other source of support and on other days of the week struggle to cope with the levels of isolation they face:

> *I would like a centre that is impartial, all religions welcome, all cultures. It shouldn't be explicitly mental health, people can just come for their 'health' and don't have to acknowledge their mental health problems.*

> *Members want us open more days and to go on more outings to get out of the house and keep active. They are advised to socialise and communicate but who with? How should they get there? They need stimulation and activity… They need light-hearted things, entertainment, keep them occupied and active. For depression there is nothing, no day centres… I would want a drop-in centre which could be open every day for even just a cup of tea. There would be someone who could do a one-to-one with people. Dial-a-ride and taxi cards are a great help for transport.*

> *A: If I could go every day I would go…*

> *B: What I would have liked if we had more money is to set up a proper centre here where the different activities could be going on and they could drop in and go in the corner and do some craft work and do some music, read some books and we could buy a sandwich and bring it for them or whatever, is what I would really envision, I would like to go on later on… But at the moment, I mean, she will benefit from it because her choice will be, I am coming out, even if it's three days a week, stretch my limbs, meet people, rather than being isolated at home, she has no-one else to converse with more than when she goes to church. When we wanted to close for Easter, I remember she was saying "What am I going to do?" and I was thinking "Oh no, what can we do?" And you're worried about her being indoors with the daughter and these young children that she's got.*

However, from a funder's perspective, there is a certain amount of duplication of work in the ethnic minority sector, insofar as different groups often provide similar services to *different* groups of people. This means it is easy for funders to say 'Why do you need this group when people could just go to group X?' There is huge potential for greater collaboration between daytime groups which provide similar services. Unfortunately the competitive nature of the funding situation and other factors mean there is a significant amount of rivalry between different groups within certain ethnic minorities. This fosters distrust and splintering of groups into smaller factions, reducing the capacity of the whole: see below.

These comments do point to a genuine need for voluntary sector community services provided on every day of the week, including weekends for some people, to combat isolation and encourage social interaction. This comes back to the idea proposed by the Jewish group of having a Wellbeing Centre which encompasses a holistic range of mental health support services.

In addition several people have pointed to the lack of services provided for young people with mental health problems to socialise and combat isolation. Many of the services available are excellent but are used predominantly by people in their forties and over, and so are off-putting to younger age groups. There are examples of good practice such as the Friday Club for people with a dual diagnosis of substance misuse and mental health problems, and occupational therapy initiatives such as the climbing group and social group run out of the Redbridge Early Intervention Team. However there is a clear need for more social activities provided for younger people with mental health problems and those who may no longer be formally using services.

10.4   Rivalry between groups in the same sector

Many ethnic minority groups are engaged in important and innovative work supporting the mental health of their community, although the term 'mental health' is almost never used because of its stigmatised connotations. However there are historical rivalries among groups working within the same community (as one would find between individuals anywhere) which have stopped those groups from uniting more and working together. A vital piece of work for Community Development Workers in future will be bringing together those groups within a minority such as the South Asian community that are prepared to collaborate, for example in partnership bids for funding for similar work. There is a Black and Minority Ethnic network in Redbridge but it has lost its funding so will be continuing on a voluntary basis. A smaller network of ethnic minority groups working with people with mental health problems could be piloted to try to encourage greater skill sharing and communication. Given the long history of distrust between some groups this would not be easy but several groups that I spoke to said they would be interested in the idea. These problems were frequently brought up by South Asian groups but were also raised by Caribbean and Jewish groups. Examples of the frustrations small groups competing with others face are:

> *I had a really successful project, had 150 people involved. One woman from my community got our contacts and took my idea and got a large grant and all the people involved stopped coming here. Half of them had some kind of depression although they don't admit it. In Asian communities people can be jealous of your success. I have made enemies because I will not support corruption. Most people use others' hard work as a ladder to climb up… Other people gather the crowd for the power.*

> *The council can bargain with us: "if you can't provide what we want for £3000 then [group X] can".*

> *I want to get letters out to the churches and to call a meeting from all the ministers from the church to get together to find out exactly why they are not actually plugging it [our group] because they say charity begins at home… and a lot of Black people they attend the churches and a lot have problems… The problem is… we had a massive function together at the town hall, after that I went and had a meeting with all the members… The next thing, they didn't want to know… and I thought "You should know better. Get your butt out here to the… meeting to find out what's going on here, all sorts of health issues and things like that, but don't cut me off and then ask me to come down."*

> *We thought they [the council] were going to help us at one time but only on the condition that the other group that had folded up, that I would take them under my wings, and work with them… we had to work together to get a lump sum of funding but they [the other group] didn't want to know, but you can't force somebody to do something they don't want to do.*

10.5   Greater monitoring of how funding is spent

An extension of this inter-group rivalry is a sense among South Asian communities that some groups are mismanaged and do not always provide the services which they are funded to. Both service users and people working in the voluntary sector wanted grants to be better monitored:

Some groups don't follow you up or call you if you haven't attended their group for a while. One woman killed herself and they didn't even know… They provide transport to some people but not others, these services need to be properly run. Who follows up on the funding, checks if the services are delivered well, asks members if they are satisfied? They don't check if they are running reflexology, they sit in their office, don't interact with members. Not all groups offer what they say.

Many groups get grants and aren't using them properly to help the community. The council needs to be careful and check how they spend the money, find out who the right person to give the money to is. There must be stricter supervision and regulation of groups. There is too much paperwork [on funding applications] so that you can write anything you like. One group gets so much money… and no-one in the group is doing anything. Many groups are like that. They may say they offer certain activities but they are only interested in the power.

> *I got us a grant and the men [management committee] said it was all because of them, so I didn't apply for the second and third years because I said "I don't need it, they take all the credit" so I don't bother applying any more. Why do the men need to dominate a women's group? In Asian organisations men dominate so you can't do anything. We need more time and staff. This is the first time I have talked about these issues.*

Greater trust and transparency between groups could be encouraged through joint work, partnership bids for funding and more events which bring the whole sector together to showcase their work. However these levels of mistrust are likely to be difficult to eradicate and it seems wise that local funding bodies better monitor the spending of their grants so that the whole community feels financial resources are being fairly spent. This must be done in a practical way, such as surprise visits by officers to monitor which projects are running. Many small groups struggle under the weight of the paperwork demanded by bureaucratic funders, so spot checks on those in receipt of grants or anonymous surveys of group members would be a more achievable measure.

10.6   Lack of statutory partnership

One group commented that when they actively tried to engage the statutory sector in partnership work they were met with disinterest.

> *A: We're going to be doing some work with GPs, we've started up some one-to-one talking therapies, counselling… I'm trying to link in with Redbridge, for example health professionals to say this is our idea… we would like you to work with us, and I'm just getting passed from one to the other to the other, no-one is willing to say 'This is the person you need to speak to, that's a brilliant idea'.*
>
> *Researcher: Is this at the PCT [Primary Care Trust]?*
>
> *A: Yeah, and it feels very much "Like this is our bit, that's your bit" and it seems a bit silly really considering that this is a way, a new way forward and a new way of working and I think all these conversations need to be had because if you're working with people who come from a medical model, way of attitudes and ways of thinking and then you talk to groups with more holistic attitudes and approaches, you're just going to collide, it's about the best thing for our members and our services.*
>
> *F: It's about education.*

There are excellent examples of partnership work between mental health services and the voluntary sector in neighbouring boroughs which illustrate how valuable this type of work is, such as Derman and Newham Asian Women's Project. Successful work from other parts of London could form the inspiration for a new plan of initiatives for services engaging better with local communities in Redbridge.

Newham Asian Women's Project, established in 1987, was set up initially to provide advice and support for Asian women and children experiencing domestic violence. They now provide a refuge, a second stage hostel and a resource centre delivering legal advice, training, mental health support, counselling, Zindaagi: a self harm project and young women's and other support groups. All of their services are developed in consultation with Asian women who have used the refuge service. Funded by London Borough of Newham, Newham PCT, City and Hackney PCT, East London and the City Mental Health NHS Trust and a range of charitable trusts, it is another example of how the statutory sector can invest in and capacity build the ethnic minority voluntary sector to deliver services in more community-friendly formats and locations.

Derman has provided holistic health and social care services for the Kurdish, Turkish and Cypriot communities of Hackney and Haringey for 17 years. It aims to improve the quality of life of these communities and support their continued wellbeing. This organisation represents an excellent partnership between the grassroots expertise of the voluntary sector and the healthcare expertise of the statutory sector. Funded by City & Hackney Teaching Primary Care Trust, Haringey Teaching PCT, the London Borough of Hackney safer communities partnership, the London Borough of Hackney, Hackney Children's fund and a range of charitable trusts, Derman delivers mental health advocacy, short-term counselling in GP surgeries, mental health support, welfare, rights and benefits advice, education advocacy and probation support. They have delivered training to NHS mental health professionals including community psychiatric nurses. Derman shows how successfully the voluntary and statutory sectors can work together in partnership.

10.7 Promotional Role

In response to the problems the groups I spoke to outlined, many of them highlighted the valuable role members of their community had to play in mental health promotion work.

> A: Groups like this one, clubs and schools could promote… mental stigma, plays to show you're not alone when you're really unwell like that.
> B: Systems that could help people integrate better. Not just in the synagogues…
>
> C: Yes, adult education, [in] the synagogue, health clubs.

The Redbridge Faith Forum's recent application for funding to provide mental health awareness education for faith leaders is an example of how outreach work could engage the faith sector. As people's comments about the role of spirituality in mental health reveal, faith leaders have a critical role to play in signposting ethnic minority groups to services early on in a mental illness. This project should form a pilot to investigate the impact this type of training has on the views of minority groups about their mental health.

However, it should not be assumed that staff in the voluntary sector, by virtue of being engaged in social work, are immune to the stigma and prejudice towards mental health found everywhere. A meaningful programme of mental health education in the community must target everyone.

11.0   Recommendations

This review of the barriers to accessing mental health services faced by a sample of ethnic minority groups in Redbridge implicates a range of recommendations. Many of these can be undertaken on a small scale by the two Community Development Workers (CDWs) for ethnic minority mental health employed in Redbridge. Later, I outline these projects in the form of two proposed work plans for two CDWs and for statutory services. Several recommendations have greater financial implications and are large scale projects which require long-term planning. However, they are realistic ambitions and do fit in with future plans for change and expansion of mental health services in the Redbridge Directorate of the North East London (Mental Health) Foundation Trust (NELFT). They should be considered options to explore with larger samples of ethnic minority groups.

11.1   Summary

Education and Promotion

- High profile community events which appeal to ethnic minority communities in their own right but have an underlying emphasis on raising awareness and understanding of mental health.

- Long-term programmes of community mental health education with a focus on myth-busting and raising the profile and accessibility of primary care.

- Mental health outreach education to children and young people using creative media such as film, drama and music to communicate information.

- Information leaflets translated into community languages and distributed in key community locations outlining how and where to seek help.

- CDWs to reach out to ethnic minority groups less well represented by the voluntary sector through local businesses and faith groups, for example.

- CDWs to work with local media on more positive reporting of mental health and suicide stories. Develop a speakers' bureau through RUN-UP so that local service users from diverse ethnicities can be consulted by local media.

- Foster more public dialogue around mental health through regular forum discussions where service users can have their say but members of the public can also ask questions.

Within the Voluntary Sector

- Genuine commitment by the statutory sector to acknowledge the important role of the sector, to financially invest in it through tendering long-term contracts and to undertake meaningful partnership work to build its capacity.

- CDWs to develop a network of ethnic minority groups involved with mental health who wish to work together and explore partnership bids for funding and to collaborate.

- This network to map a coordinated programme of voluntary sector community mental health services to identify gaps in services and needs for development.

- Events to showcase the work of the voluntary sector to the community and statutory services and to facilitate better networking across sectors.

- Develop communication channels between statutory and voluntary sectors to enable better signposting and referral as well as partnership working and greater involvement of the community sector in the planning and design of services.

- Mental health awareness training delivered formally and informally to the voluntary sector.

- More visible regulation and monitoring of voluntary sector contracts by statutory sector commissioners to encourage transparency and eliminate distrust between voluntary sector organisations competing for funds.

- Pilot befriending between members of specific ethnic minority groups to promote social inclusion and better community understanding of mental health problems.

Holistic Healthcare

- An emphasis on low-intensity talking therapies delivered by ethnically diverse therapists, not just in primary care settings but also other ethnic minority community centres to reach out to individuals who will not seek help themselves.

- Greater provision of therapies more suited to ethnic minority clients unlikely to engage with other forms, such as inter-cultural and systemic family therapy in Redbridge Adult Psychological services.

- A worker in Redbridge Adult Psychological services with a specialism in ethnic minority communities or cross-cultural work with at least one day per week dedicated to outreach work in the community.

- Future healthcare developments such as polyclinics and relocations of community mental health services to take on the suggestions of service users for a more holistic approach to mental health and wellbeing, incorporating faith, physical and mental health services, exercise, nutrition and voluntary sector services.

- The physical health needs of service users to be better supported through more exercise and healthy eating initiatives and more focus on inpatient wards on clients' physical health and wellbeing.

- Mental health and social services to work in a more joined-up way to minimise the referral of service users with multiple needs from one agency to another.

- The inpatient discharge support process to be Equality Impact Assessed to ensure ethnic minority service users' needs are addressed and greater focus on ensuring clients are not deterred from going in to hospital by the fear of losing their benefits and the hassle of re-arranging them.

- For clients for whom access by direct payments to complementary and alternative therapies is deemed beneficial to their overall mental health, wellbeing and engagement with services, this should be a choice made available.

- Statutory services to acknowledge approaches to mental health outside of the Eurocentric medical model, for example through events to showcase its best practice initiatives under the banner of 'Holistic Healthcare'.

Accessibility

- High quality publicity campaigns aimed at different ethnic groups in prominent community locations to dispel misconceptions about the nature of mental health services and raise positive awareness of the services available.

- Work to raise the profile of primary care as an approachable first port of call for mental health services and support, depicting it as welcoming to all ethnicities.

- Greater involvement of ethnic minority service users in RUN-UP and NELFT committees as well as holding one-off events to consult service users and carers from specific ethnic minority communities in service planning and design.

- NELFT to better publicise to service users the changes made in response to user feedback and complaints, to give clients more ownership of services.

Improvements for service users

- Employment support services to be Equality Impact Assessed and a focus on continuity and stability of providers.

- Investigation into need for day services for young people with mental health problems, involving service users of a range of ethnicities in discussion.

- Translated medication leaflets to be widely available in waiting rooms and offices in statutory and voluntary sector mental health service locations across the borough.

- CDW to work with local carers' groups to investigate ethnic minority carers' needs and determine gaps in the service; work on an information pack in several languages to make carers aware of all of the respite and support networks available to them.

- Cultural competence training to be delivered to a group of ethnically diverse service users. Developments to be made to expand the training into a more extensive programme for clinicians and for evaluation of progress to be part of staff personal development plans.

- More visible publicity for all staff about how and when to use translators and interpreters and for training in use to be made widely available to staff. Mental health training to be compulsory for translators and interpreters.

Acknowledgment and support for the role of spirituality

- Chaplaincy provision to be appropriate to the ethnic diversity and breadth of faiths as well as the population size of the region covered by the four NELFT boroughs.

- Mental health awareness training to be piloted by Redbridge Faith Forum and evaluated; consider whether it could be delivered borough-wide if successful.

- Statutory services to develop meaningful working relationships with local community and faith leaders to ensure channels of communication and skill sharing as well as development of signposting services and enhanced referral pathways.

11.2   Education and Promotion

The most obvious and least surprising recommendation regards the fact that levels of ignorance about mental health among ethnic minority *and* White British communities

are extremely high. This is the case across the world (e.g. Jorm et al. 1997) but ultimately it is local and national campaigns of promotion and education which affect the beliefs and attitudes of individuals and their communities. A key part of this is to engage the existing ethnic minority third sector in education and promotion.

This objective embraces the third Delivering Race Equality building block of 'Better Information' and the second, 'Community Engagement'. More specifically, education and promotion are key to working to foster:

1.   Less fear of mental health services among BME communities and service users;

Taking a long-term perspective, high levels of community mental health awareness should also ultimately affect the following DRE objectives for 2010:

2.   A reduction in the rate of admission of people from BME communities to psychiatric inpatient units;

3.   A reduction in the disproportionate rates of compulsory detention of BME service users in inpatient units;

4.   More BME service users reaching self-reported states of recovery;

5.   A reduction in the ethnic disparities found in prison populations;

In line with the Early Intervention agenda, we can expect that if services were able to reach many of the ethnic minority service users who wait to seek help until they reach crisis point, many of them should be able to maintain or recover from their mental health problem without any recourse to inpatient admission. By extension, if Early Intervention is working well we should see a reduction in ethnic minority groups with mental health problems represented in the criminal justice system long-term.

11.21 Creative, innovative community mental health education and promotion
A focused programme of education and promotion, aimed specifically at individual ethnic minority groups and their own unique beliefs, myths, explanations, stigmas, traditions and taboos should be designed and delivered. Talks and leaflets simply do not capture communities' imaginations or affect their behaviours. A big part of this should be interesting, appealing events which minority groups will want to attend, which increase knowledge and encourage dialogue in communities with especially high levels of fear of mental health problems. Populations to be targeted must include individual South Asian, Black Caribbean and Black African communities, refugees and asylum seekers and Muslim and Jewish faith communities. It will be important to promote an open-minded approach to different people's explanatory models of mental health problems but it seems likely that greater understanding of a biological model of mental health problems could reduce stigma by emphasising the fact that the illness is beyond the control of the service user.

11.211 High Profile events

Examples of good practice in this area are projects that have used mass media to their advantage. One excellent project is the Happy Soul Film and Arts Festival, run in South West London and St. George's Mental Health NHS Trust. It celebrates Black and minority ethnic creative achievement while promoting mental health awareness through film and the arts. The festival has focused on attracting minority groups by inviting well-known community members such as writer Meera Syal and bollywood actress Konkona Sen Sharma to speak about their experiences of mental health problems. This ensures high attendance while normalising mental health problems, highlighting their universality and making them less stigmatised. A survey of those who attended found that 53% said their attitudes to mental health had changed as a result of attending and 98% said they would like to see another festival take place. Happy Soul attracted extensive media coverage (this links to another key objective: working with the media), including a debate on BBC Radio Four's Women's Hour about mental health in South Asian women featuring Indian actress Nandita Das. The festival has been nominated for a Health and Social Care award for work in equality and diversity.
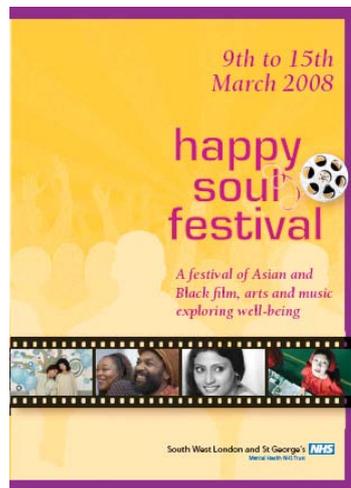
Events of this kind can be organised by Community Development Workers in Redbridge. As part of World Mental Health Week 2008, I have worked in partnership with Redbridge Concern for Mental Health and the council's Arts Development Worker to organise:

- A screening of the Indian film *15 Park Avenue* which addresses the impact of Schizophrenia on a South Asian family, followed by a discussion about mental health with South Asian service users.

- A talk delivered by Sathnam Sanghera, author of If You Don't Know Me By Now: A Memoir of Love, Secrets and Lies in Wolverhampton, to speak about his experiences of serious mental illness in his own South Asian community.

- A workshop run by the local Asian women writers' group and invited speaker Anna C. Young to talk about writing a book about her experiences of services published by mental health publisher Chipmunka.

We have focused on the South Asian community in the first instance because it is the largest ethnic minority in Redbridge but we view these events as a pilot for future projects which can be targeted at different groups. For example, we have discussed an event for young Black African and Caribbean people in the borough where a musician

such as Dizzee Rascal or Roots Manuva speaks about their experiences. Dizzee Rascal recently wrote a song, *Dean*, about a friend who committed suicide and Roots Manuva has spoken candidly through his music about his experience of mental health inpatient admission.

High profile events which appeal in their own right to minority groups but address the scary, stigmatised and uncomfortable issue of mental health problems are absolutely critical to normalising them. As indicated above they also attract *positive* media attention (see below) about mental health problems, which is another key objective for challenging stigma and ignorance.

11.212 Long-term education

One-off, high profile events which bring mental health problems into the spotlight are essential but more sustained types of mental health education and promotion are required to reach larger numbers of people and give them a more meaningful understanding of mental health.

The range of misconceptions ethnic minority communities have about mental health and services needs to be addressed before fear of seeking help will diminish. Passionate service users from these minority groups could be instrumental in education interventions for their own community. For example, the charity *Jewish Care* provides mental health education to Jewish and non-Jewish secondary schools, employers, synagogues, community groups and businesses. It is planned and delivered by service users, carers, volunteers and mental health professionals using drama, life stories, art, audio visuals and music.

A significant goal of community education programmes for minority groups will be myth-busting: addressing the common misconceptions covered in this report, such as:

> *"All mental health services do is lock you up"*
> *"Mental health problems can't be treated because they are caused by life difficulties"*
> *"Medication and services themselves cause you to have mental health problems"*
> *"Asking for help is a sign of failure"*

Hand in hand with education about mental health problems will be a clear focus on changing communities' perceptions of primary care and working on the public image and understanding of what practitioners are like and what they are there for.

Importantly, however, projects of this nature cannot be achieved without collaborative work with the practitioners themselves. A vital aspect will therefore be to present the findings of how ethnic minority groups perceive primary care to the clinicians in Redbridge and work with them on ideas about how to increase their accessibility. They are busy people with many decades of experience between them but nonetheless, they need to be more aware of the significant barriers to accessing them, as gate-keepers of all health services, for minority groups.

11.213 Mental Health outreach education for young people

Much of the problem of mental health ignorance in ethnic minority groups stems from entrenched beliefs passed from one generation to another. Working with young people therefore represents a fantastic opportunity to raise awareness in the new generation. Mental health education in schools in an obvious project currently lacking in school Personal, Social and Health Education programmes.

There has not yet been a focused, coordinated initiative to raise awareness about mental health among school-aged children themselves and this is notable by its absence. A pilot initiative which involves service users and carers in its design, perhaps of using the model mentioned above, implemented by Jewish Care, could be worked on in future by

Community Development Workers initially in several schools with the greatest ethnic diversity.

But there are other, more creative and equally necessary ways to reach out to Redbridge youth. Many examples of good practice are already in place and can be used by Community Development Workers to specifically focus on the breadth of mental health problems that affect young people, from eating disorders, bullying, stress, anxiety, drug abuse, to the extreme of psychotic illness. Well-established services such as Ilfomation, Connexions, the youth bus, sexual health services, youth offending teams and the youth panel run by Redbridge Council are perfect opportunities to raise the profile and level of dialogue about mental health problems within ethnic minority youth. This work will be a critical part of the placement of the Community Development Worker located in the Early Intervention in Psychosis team.

> *Youth culture such as Facebook and MySpace could be harnessed for these uses too. A particularly impressive piece of work was run by the Redbridge Young People's Project. Young people who conceived children whilst teenagers were given the opportunity to devise a script and make a film about their experiences. The actors and film-makers now take the film to local schools to talk about their experiences of teenage parenthood.*

This would be a highly transferable model for providing mental health education in schools. The films also might not need to be made exclusively by service users (since many young people with mental health problems might prefer to remain anonymous). Asking young people not using services, or using youth offending teams, for example, to make films about the topic could also be an interesting project. With young people more than any other group it will be critical to use aspects of their own culture to communicate mental health promotion messages.

Mental health promotion with young people must also address the confusion surrounding the role cannabis plays in mental health problems since different sources currently communicate very different messages. For young people to be able to make sensible choices about drug use they need first to have accurate information, rather than anything vague or exaggerated.

11.22 More accessible information
Whilst leaflets should never be the main focus of any education campaign, the stigma surrounding mental health problems is such that some people simply will not attend promotional events of any kind. Many groups commented that members of their community are unaware of what help is available. Brief, clear information about the steps that should be taken to seek help for mental health problems must be available in every important community language. These should include key South Asian languages (Hindi, Urdu, Gujarati, Panjabi, Tamil, Bengali) and African languages (such as Somali, Swahili) and other widely spoken languages such as Arabic. A concerted campaign must then be undertaken by Community Development Workers to ensure that this information is available in the most appropriate locations. Borrowing from Drugsline, the changing rooms of sari shops on Ilford Lane are discrete places where people can pick up accessible information without being seen. Places of worship, local businesses, police stations, social centres, English language schools, restaurants (as well as the obvious GP surgeries, family planning clinics, etc.) are all examples of community settings where people might feel more comfortable picking up information.

11.23 Outreach to less represented minorities
There are growing ethnic minority communities in Redbridge such as Eastern European people, who are not well represented by specific voluntary sector organisations in the borough whose mental health should not be overlooked. It is therefore important that Community Development Workers spend time reaching out to the less obvious but still significant minorities, for example through churches like St. Cedd's which has a Polish

order of priests and a large Polish congregation. There are also limited numbers of community groups specifically for the African Caribbean community and again churches will be a key point of contact for outreach work with this significant ethnic minority group. Education and promotion messages must be tailored to the needs of each individual minority if they are to be meaningful and taken seriously.

11.24 Engagement with local media
The vast majority of information communities receive about mental health comes from the media. Enhancing the accuracy and positivity of national media depictions of mental health problems is a project being delivered by the Care Services Improvement Partnership's project called SHiFT (www.shift.org.uk). However, a large and significant role can be played by Community Development Workers (CDWs) in encouraging positive and accurate portrayals in local media.

For example, CDWs could work with the highly-read local newspaper The Ilford Recorder as well as other important community publications around changing how mental health problems are reported and indeed how ethnicity is documented in articles. Resources already exist such as SHiFT's media handbook, 'What's the story?', on reporting mental health and suicide. CDWs could give presentations to staff at local newspapers and radio stations about the importance of accuracy and reducing sensationalism in relation to mental health reporting. Forster, the social marketing company commissioned by Delivering Race Equality, provides free training for CDWs in communication and working with the media, which would support this work. They could distribute copies of 'What's the Story?' and contribute articles to publications and give talks on local radio.

> *The CDW working for Heart of Birmingham PCT presents a half hour mental health show on New Style Radio, a local African Caribbean community radio station. "We use the radio programmes to talk about how to spot if someone has a mental health problem. It's about self-awareness and knowing who you are as a person. If someone hears something on a radio programme it can really give them a wake-up call" George believes.*

However, far more powerful than the voice of the CDW is the voice of the service user. In partnership with the service user group, RUN-UP, a speakers' bureau could be set up, a group of service users of all ethnicities who are happy to give their comment when views are sought about a mental health-related issue by the media. CDWs can work to promote the role of these speakers, and ensure that there is regular, positive reporting in local media about mental health. Media in foreign languages will be a particularly powerful means of promoting mental health information in some of the most difficult to reach groups of people.

11.25 Fostering public dialogue
Service users and carers identified the lack of public forums about mental health as a factor in supporting secrecy and shame. People wanted open places where members of the public could take part in discussion and ask questions about mental health problems. It seems that the first step should be for CDWs to bring together all of the third sector groups who are involved in supporting mental health. Having done so, such a group could explore how best to set up this type of discussion forum. For example, a programme of monthly or fortnightly lunchtime events could be developed in which service users and carers involved with different groups have the chance to talk about mental health and things they do to promote mental health in their community. These should be held in a prominent and accessible location such as the public library and should be publicised widely to the general public rather than focusing solely on those currently using services. Interested statutory sector staff must also be involved to ensure that there is partnership between the sectors for this project.

11.3   Within the Voluntary Sector

This objective is central to fulfilling the second Delivering Race Equality building block of 'Community Engagement'. It is central to the aims of the DRE agenda and will target seven of the twelve specific characteristics which services must aim for by 2010. Greater involvement of the voluntary sector in mental health service provision will target objectives 1) and 2). DRE acknowledges that "the BME independent sector has continued to develop innovative services and has higher patient satisfaction ratings than statutory services".

6.   Less fear of mental health services among BME communities and service users;

7.   Increased satisfaction with services;

Taking a long-term perspective, greater voluntary sector involvement should foster earlier intervention and maintenance of mental health problems in the community rather than through inpatient services, and should be able to offer a more therapeutic and more recovery-focused environment for some clients:

8.   A reduction in the rate of admission of people from BME communities to psychiatric inpatient units;

9.   A reduction in the disproportionate rates of compulsory detention of BME service users in inpatient units;

8.   More BME service users reaching self-reported states of recovery;

10.   A more balanced range of effective therapies, such as peer support services and psychotherapeutic and counselling treatments as well as pharmacological interventions that are culturally appropriate and effective;
11.   A more active role for BME communities and BME service users in the training of professionals, in the development of mental health policy, and in the planning and provision of services;

This objective also relates to the World Class Commissioning (2007) competencies of:

2.   Work collaboratively with community partners to commission services that optimise health gains and reductions in health inequalities.

10.   Effectively manage systems and work in partnership with providers to ensure contract compliance and continuous improvements in quality and outcomes.

11.   Make sound financial investments to ensure sustainable development and value for money.

11.31 Capacity building the voluntary sector for mental health
It is clear that the voluntary sector is a critical and currently under-used forum through which certain so-called 'hard-to-reach' ethnic groups can be contacted. It is equally clear that its powerful role in community mental health is rarely acknowledged and it often lacks the capacity to deliver more formal services or to signpost people to the statutory sector. It is here that Community Development Workers in their role as capacity builders can be very powerful.

The voluntary sector could be the primary interface between these ethnic minority groups and the statutory sector. However, for this to occur there needs to be genuine commitment by commissioners and mental health managers to acknowledge this important role, to financially invest in the sector and to undertake meaningful partnership work.

11.32 A network of ethnic minority groups working for mental health
The first step will be for CDWs to reach out to the breadth of voluntary sector groups working with ethnic minorities and to identify those with a genuine interest in mental health. Bearing in mind the tensions and politics which may prevent some groups from wanting to work together, the aim initially should be to pilot a 'BME mental health network' or (if deemed more feasible and/or appropriate), a minority-specific network such as a 'South Asian Mental Health Network'. If the latter is envisaged it will be important to recruit a CDW with a grasp of the relevant community languages such as Hindi/Urdu, Panjabi or Gujarati.

Initially the network could meet in order to learn what each group does and to encourage skill sharing. The network could then move on to identifying member groups' needs in terms of training, development and funding. An initial project could be to collaboratively put together a proposal for statutory sector commissioners about the network's vision of the role of the voluntary sector in the mental health of Redbridge communities over the next five years, and what needs to be delivered for that vision to be realised. Out of this could come partnership bids for funding for similar projects delivered to different communities.

In theory this type of network sounds like an excellent start but it will not be easy, given the long history between certain voluntary sector partners. However, even if the group starts small, with just three or four member groups who are prepared to work together, this will be a start to demonstrate how a larger network could operate in future.

Bringing together the relevant members of the voluntary sector is a crucial first step in giving these groups a voice with which to lobby the statutory sector for support and commitment to partnership.

11.33 A coordinated programme of voluntary sector mental health services
One valuable way in which such a network could showcase the important work delivered by the voluntary sector in mental health would be to find out exactly what day services it provides in Redbridge on which days, in which locations and bring it together into a coordinated programme of services. This could be very helpful in lobbying for more funding for some groups, for example being able to show that there is no supportive day service for Black African communities with mental health problems, or that there is nothing provided on a Sunday for South Asian women, or in the evenings for young Caribbean men.

This type of mapping exercise would be valuable in highlighting the important and rarely acknowledged services provided by the voluntary sector and would give commissioners a better idea of the gaps in provision. It has anecdotally been observed that there is nowhere for people to go very late at night when they can't sleep, or nowhere for young people with mental health problems to socialise on evenings, but this could be categorically illustrated if the full spectrum of provision were mapped. Currently most day services are delivered in isolation with little knowledge of what else is being provided elsewhere. Having an accurate picture of voluntary sector mental health services and the gaps within them will be a compelling tool for proposing improvements and developments.

For example, many different minority groups currently provide informal community mental health support, with little or no statutory funding or official recognition. Mapping what is being provided will enable these groups to show commissioners how indispensable their services are, and ensure that statutory sector staff are aware of what is available so that they can refer clients to their community groups.

11.34 Showcasing the work of the voluntary sector
An extension of this project is that CDWs must be ambassadors for the work of the voluntary sector in mental health, highlighting it wherever possible. It will be important

to have regular events which showcase the work being done. One example could be allowing each group to have a stall in a community centre to represent their work, for example in an event to engage ethnic minority groups in dialogue about the elevated levels of mental health problems in their community. Both voluntary and statutory sector partners should be present at such events in order to foster the networking and communication between sectors which so rarely takes place and is so necessary for meaningful cultural competence. In between events, valuable work could be showcased through a biannual or quarterly newsletter sent to the voluntary and statutory sectors to make both aware of the success of each other's work.

11.35 Develop communication channels between the statutory and voluntary sectors
A network such as this could also be instrumental in fostering greater dialogue between the voluntary and statutory aspects of mental health services since it can act as a single body and represent the views of its members. Encouraging networking between these quite polarised sectors could take a number of forms, for example inviting key staff from Redbridge mental health services to speak to the BME mental health network, or arranging networking meetings over lunch where staff can interact and higher managers can learn about the work of the voluntary sector in mental health. The involvement of higher management will be crucial in developing clear referral pathways so that key voluntary sector groups can refer their members direct to community mental health teams and mental health teams can refer their clients to the most appropriate group for community support. Building the capacity of these voluntary groups to be seen in the statutory sector as key partners in the package of community mental health support provided in Redbridge must be a central goal of community development work.

In addition, voluntary groups delivering mental health support must be far more involved in the planning of statutory services and the training of staff than they currently are. The cultural competence training being delivered in Redbridge by NELFT is an example of training where local ethnic minority groups' expertise could have been invaluable and yet no effort was made at all to involve the voluntary sector in its planning. There are several new levels within NELFT's new management structure for service user involvement but there is no explicit way in which the voluntary sector working for mental health in the community can input into services. This is one area which should be explored in future by CDWs.

11.36 Mental health awareness training in the voluntary sector
Mental health awareness training for faith leaders is discussed separately because these individuals are considered to have a particularly pivotal role in the referral process. However, all sectors of society are vulnerable to the stigmatised media depictions of mental ill-health. Simply because the voluntary sector is engaged in 'charitable' work it should not be assumed that its staff are any better informed about mental health than the general public. As mentioned above, when one worker was trying to arrange volunteering opportunities within the third sector for people with mental health problems, they met with a surprising amount of resistance and ignorance, as well as fear of the stereotypical dangerousness of such individuals.

It will be important, therefore, for CDWs to engage in both formal and informal community education about mental health in the voluntary sector. This must start from RedbridgeCVS, where one post is based, and expand to other key organisations. In some cases this may be a formal day or half-day of training; in others it may take the form of regular one-hour discussions or question and answer sessions. We must remember the comment from one group that "talks about depression are depressing" and so be prepared to adapt training methods according to the needs and wishes of the individual group.

What form this training takes can be debated. Mental health first aid training (provided free to CDWs by the London Development Centre) is one option that should be explored but it may be better for this to form a starting point which is adapted to the context of

each voluntary sector group. Such training must deal with myths and preconceptions and discuss the different and equally valid explanatory models of mental ill-health, including the medical model adopted by statutory services, and explaining how mental health services operate. Encouraging everyone to know how to signpost themselves and others to seek help as early as possible should be an over-arching theme, supporting the Early Intervention agenda.

Working to eradicate stigma in the voluntary sector workplace will be the first step, with reaching out to local businesses and other key partners to follow. This work could be done in partnership with the mental health Supported Volunteering Service run out of Redbridge Concern for Mental Health. Raising awareness about mental health problems in local workplaces could be done in conjunction with developing volunteering opportunities in those same organisations.

11.37 Better monitoring of grant spending and contracts
In order to encourage greater trust between ethnic minority community groups in competition with one another for funding, it is recommended that local funders such as Redbridge Council and the Primary Care Trust make an effort to more visibly monitor delivery of contracts and grant spending. This will ensure that service users feel confident that they can access all of the services advertised and reduce feelings of resentment in other voluntary organisations about groups receiving funds which are improperly spent. Encouragement for groups providing similar services to put in partnership bids together should also reduce such mistrust, in time.

11.38 Befriending within ethnic minority groups
One interesting suggestion was to create opportunities for befriending for people with mental health problems within an ethnic minority group. This would combat the social isolation that emerged as being all too common and could promote inclusion and understanding within that person's ethnic community. There is already a befriending service being run by Redbridge Concern for Mental Health so it would be quite easy to trial a pilot project targeting befriending to a specific group such as the South Asian community, and to monitor its impact over six months or a year. This is an example of a small scale piece of work (putting together a proposal, applying for additional funding, monitoring and evaluating its impact) which a CDW could be engaged with, aiming to improve mental health in ethnic minority communities.

11.4   Holistic Healthcare

Holistic healthcare, accessibility, improvement to services and acknowledgment and support for the role of spirituality all constitute ways of fulfilling the first Delivering Race Equality building block of 'More appropriate and responsive services'.

In particular, an offer of more holistic healthcare can help fulfil several DRE objectives:

1)   Less fear of mental health services among BME communities and service users;

2)   Increased satisfaction with services;

8)   More BME service users reaching self-reported states of recovery;

10) A more balanced range of effective therapies, such as peer support services and psychotherapeutic and counselling treatments, as well as pharmacological interventions that are culturally appropriate and effective;

The Enhanced Pathways Into Care project for the Pakistani community run by Sheffield Care Trust is discussed later under work with spirituality. It is a joint partnership with the Pakistani voluntary sector, working with Imams to deliver mental health home treatment. It will soon start work with a breast cancer nurse so that women with other health concerns can discuss mental health at the same time. The consultant nurse running the project says "I want a one-stop shop so that if Mrs Khan comes in for her diabetes she can also mention that she's been having problems sleeping. I want to mobilise health professionals to come together in a holistic, whole system way".

11.41 Talking Therapies

Talking therapies are a priority for ethnic minority groups. Their availability is crucial for people to feel their problems are being considered, as an individual, and that they are not simply being given the default, 'one size fits all' treatment of antidepressants. Provision must be developed if services are to be responsive to community need. Talking therapies need not be expensive, as in many cases they will not need to be delivered by a psychologist. For a significant number of people, what they need to talk about may simply be their life circumstances, and will not actually want psychological treatment so much as someone independent of their intimate circle to talk to. Graduate primary care mental health workers and low intensity therapists (as part of Improving Access to Psychological Therapies) will be critical here in widening access to talking therapies while keeping within budget constraints. It will also be important to recruit mental health workers for this low-level talking therapy from a representative range of ethnicities so that clients have some choice over who they see. Some will only feel able to open up to someone from an ethnic group which they identify with, while others may be suspicious that their words will not be confidential when spoken to someone from their own community.

The GP practice is one key location in which people want to receive talking therapies, since the hospital building is perceived as intimidating. For some people however, as we have seen, even the general practice is a frightening and intimidating place to seek help. It will therefore be very important to explore providing low-level talking therapies within alternative community settings. One example would be providing a drop-in service for one day per week from a Muslim cultural centre adjacent to a mosque, or in a local temple. For services to be meaningfully accessible and culturally competent, this flexibility for outreach will be critical. When setting up this type of service it will be important to select a location somewhere which is considered appropriate for women to attend alone.

At the higher end, however, there remains a shortage of psychological service provision in Redbridge and this is likely to impact upon the engagement levels of ethnic minority clients. Greater options within the psychology service of therapies which will meet the needs of ethnic minority groups such as inter-cultural therapy and systemic family therapy are needed. There must also be at least one staff member in Redbridge adult services with some responsibility for cross-cultural specialism, such as the refugee specialist employed in Waltham Forest. This worker must have the opportunity for outreach work in the community for at least one day per week.

11.42 A Holistic Centre for Wellbeing

An ambitious but not unfeasible aim for Redbridge is to have a holistic centre for wellbeing. The first steps are already being taken towards this type of model by the development of the first of five Polyclinic health centres in Loxford. Myself and others have been pushing for as much voluntary sector presence in the centre as possible, and this first clinic should be a good illustration of how well voluntary and statutory services can coexist in a community setting. The provision of some mental health services alongside physical health services is another big step towards reducing the ostracising of mental health problems into their own special category.

The potential for community mental health services to be relocated in future to premises in Gants Hill or elsewhere in the community would also present an opportunity for mental health services to be provided in a holistic setting, where voluntary sector groups, exercise facilities, faith groups and alternative therapies might work alongside one another. This is also compatible with the drive to support local communities to have 'community anchors' which form hubs of local initiative and capacity building (Home Office, 2004).

This ideal cannot be achieved independently and would have to develop as part of another, well-funded agenda such as polyclinics or community mental health services. It is nonetheless important to acknowledge that this is something both service users and voluntary sector groups have asked for and if it can be accommodated when making other major changes to the face of Redbridge's health services then this should be explored.

> *One example of this type of holistic community centre is the Qalb Centre in Waltham Forest. Established in 1993, a group of local professionals including social workers, counsellors and psychiatrists felt that mainstream services were not fully meeting the needs of South Asian communities. The centre provides counselling, alternative therapies, support services, a domestic violence project, a drug and alcohol project, mental health day services and on a different site, a short-stay residential centre for respite for carers of people with mental health problems. They are funded by both statutory providers and charitable trusts and present an example of best practice in how statutory services can be delivered by the voluntary sector in a community setting.*

11.43 Services to support physical health
As part of a movement towards a more holistic approach to healthcare, ethnic minority groups want their physical health needs to be addressed in order to improve their mental health. The Department of Health stipulates that every client on an Enhanced CPA have a physical health Care Plan and NELFT has a physical health policy. However, current service users did not seem to have felt the benefits of these policies yet.

One way in which the voluntary sector can be involved in this is via Primary Care Trust-funded projects such as 'Fit For Fun'. The PCT has provided funding for twenty-week bespoke programmes of exercise to be delivered within voluntary sector community groups at no cost to community members as part of a drive to improve health and wellbeing. The CDW based at RedbridgeCVS (which is delivering the Fit For Fun programme) is well-placed to ensure that groups working with ethnic minorities and mental health take advantage of this project. The intention is that after twenty weeks of exercise the group will be motivated to organise the continuation of their chosen activity.

Direct payments also present an excellent opportunity for mental health service users to be able to choose physical health as an important part of their treatment programme. However, there will need to be concerted publicity initiatives to ensure all relevant staff are aware of their clients' entitlements and actively encourage service users to take up opportunities to exercise.

Physical health must extend beyond exercise, however. Services need to acknowledge their responsibility to care for clients' overall mental and physical health, including awareness of the physical health implications of medical side effects and providing information and education about healthy eating and lifestyle including smoking cessation.

One example of how mental health services can work through improving physical health is Air Football. It is a programme run in Redbridge and Newham that provides specialist five and seven-a-side football training for adults with substance misuse and mental health problems and those involved with the probation service. It provides an opportunity to increase fitness, confidence and self-esteem while looking to assist people's progression through treatment. Members have access to a gym, banking advice, health and nutrition advice, drug and alcohol education, IT and further education, training and courses as well as regular tournaments and competitions. The vision of this project lays out the real benefits of physical health initiatives for mental health:

The overall vision of the Air Football projects is to support vulnerable people to improve physical and mental health, enhance their quality of life, confidence and self esteem and work toward a healthier lifestyle…
- *To provide structured activities which are a safe and positive alternative to substance misuse.*
- *To promote social inclusion through participation in a team sport and integration with the wider community via regular inner/outer London friendly/league/tournament matches.*
- *To enable participants to explore their capabilities and potential, find productive outlets for anger/frustration, increase their motivation/self esteem, develop social links and improve their communication and team working skills.*
- *To support participants in developing more productive lifestyles throug*h signposting to treatment services (mental health/substance misuse) and support with access to training through the provision of free courses, employment support, advice and in-house employment opportunities through our trainee coaching scheme. This enables them to move through the "system" and regain independence.

This model could be successfully applied to activities that might appeal to other groups, such as dance or music for South Asian women as an example.

11.44 Greater partnership working between mental health and social services
Greater partnership will therefore be needed between mental health services and physical health services such as a client's general practitioner. Furthermore, a key need for ethnic minority groups is for mental health services to work more in partnership with social services where social problems and deprivation are factors in a person's mental health. All too often people reported being told "that's not my job, you need to go to X about that" which for individuals unfamiliar with the organisational structure of services is very disheartening, especially when a social problem clearly impacts upon their mental health. Mergers between some parts of social care and mental health services should improve matters but for ethnic minorities in particular it is critical that services assist people to navigate the minefield of different departments or they are likely to simply get lost in the maze of referrals.

11.45 Improved discharge support
One example of services working in isolation rather than in partnership was illustrated by the complaint that people are frequently discharged without any help in getting their benefits reinstated or in dealing with the bills that have piled up during an inpatient admission. All of this is part of a good discharge plan. All inpatients who require social support should be referred for care coordination before discharge and a seven day follow up is mandatory, but this clearly does not happen for every individual. Particularly for service users who struggle to speak English it seems likely that they will be particularly disadvantaged by this process. It therefore seems necessary that clear information about important processes like discharge be provided to all service users, and be translated into foreign languages for those individuals who would benefit from it. Services must be more proactive in providing this type of necessary support for all discharged clients, regardless of whether they ask for it or not. The process should also

be Equality Impact Assessed to ensure it is not discriminatory in how it supports ethnic minority groups.

11.46 Alternative and Complementary Therapies

In keeping with the recurring theme that ethnic minority groups want their mental health to be treated holistically, with greater appreciation for the needs of the whole person, it will be important for the choice of alternative and complementary therapies for mental health to be a real option for people who want it, as part of direct payments.

The voluntary sector is one field in which there is likely to be a wealth of expertise in alternative and complementary therapy, and commissioning voluntary groups, where appropriately equipped and qualified, to provide this type of service presents an excellent opportunity to build capacity in the sector and develop partnership working.

It may be easy enough to make complementary therapies available as part of mental health treatment but whether ethnic minority communities are aware of this is quite another matter. Large-scale campaigns to ensure minorities are aware of what can be incorporated into treatment packages will be needed, but CDWs can also be instrumental in going out into communities and raising awareness about services and how much choice patients can have.

11.47 Acknowledgment of other explanatory models

The exclusive focus by statutory mental health services on a Western or biological explanatory model of mental health problems has been identified as a key barrier to ethnic minority communities accessing care.

It will be important that services actively, openly and publicly embrace a holistic view of mental health and highlight that medical treatment is only one part of a broad package of care which is provided by both voluntary and statutory sector services. Developing partnerships and dialogue between services and faith and voluntary groups will be an important start but other events should also be considered. Events could be organised in which service users and clinicians share the different explanations they have for mental ill-health, for example. In addition, Redbridge mental health services could organise a large-scale event in partnership with the voluntary sector under the theme of 'holistic mental health care' in an effort to illustrate its acceptance and open-mindedness about a range of sources of help, support and treatment. This type of large-scale event may be beyond the scope of a CDW's work but they could certainly be involved in the planning and delivery of this type of community event.

11.5   Accessibility

For services to be more accessible they need first and foremost to have a better public image among ethnic minorities and also among the general public. This fulfils the DRE objectives for 2010 that services should be characterised by:

(1) Less fear of mental health services among BME communities and service users;

(2) Increased satisfaction with services;

(3) A reduction in the rate of admission of people from BME communities to psychiatric inpatient units;

(4) A reduction in the disproportionate rates of compulsory detention of BME service users in inpatient units;

(11) A more active role for BME communities and BME service users in the training of professionals, in the development of mental health policy, and in the planning and provision of services;

This objective is also related to the World Class Commissioning (2007) competency to:

(1) Proactively seek and build continuous and meaningful engagement with the public and patients, to shape services and improve health.

11.51 Positive promotion about mental health services
This report has outlined the breadth of misconceptions about mental health and about services which abound in ethnic minority communities. Whilst CDWs can be instrumental in providing informal promotion of services with community groups, Redbridge mental health services need to start actively publicising themselves in a positive light to counteract the decades of ignorance and confusion which exist in the community.

This type of publicity must be professional and carefully thought out, for example glossy posters in GP practices and on local buses. It must be accepted that one type of publicity may not reach out to all groups.

Services should actively involve voluntary sector representatives of prominent ethnic minorities in the design of publicity campaigns about services. Using positive personal testimonies from mental health service users from ethnic minorities to challenge perceptions of mental health problems and of services will be a crucial step. Letting quotations such as these speak for themselves should be an effective challenge to the classic myths about services.

In the ward I was pleasantly surprised, it was much better than my impression… It was an airy ward, I was treated like a human being, was listened to, treated like an individual with a problem, not a problem. I needed it more than anything…

These posters would of course presume that the viewer speaks and reads English and so campaigns like these should form only one aspect of a publicity campaign, with radio adverts in English and community languages also being important. Events in which service users from specific ethnic minorities speak out to their community about their experience and answer people's questions will also be very important in demystifying mental health services. It is in everyone's interest for the general public (those who need and do not need to access mental health services) to perceive services in a more positive light, since better understanding should foster decreases in ignorance and eventually in the associated stigma and discrimination which result from ignorance. More knowledge, for example that there are no mixed wards in Goodmayes hospital, should hopefully also make mental health services somewhat less intimidating for those approaching them for help for the first time. This objective may overlap successfully with the remit of the Redbridge public health team.

11.52 Improving the image of primary care
As this report has detailed, ethnic minority groups have significant beliefs, some of which are based on personal experience and some of which are inaccurate, which prevent them from seeking help from primary care. It will be important for these findings to be relayed to the central body in Redbridge which represents primary care practitioners for their information and to ask them in turn what they think could be done by CDWs and through public health messages to rectify these views.

One piece of work will be to raise awareness of the general practice as the first port of call for mental health problems particularly among communities who often present to A&E in crisis, such as Black African and Black Caribbean groups, or who present to A&E because they perceive it as a more immediate way of getting help (anecdotally, Eastern European and South Asian groups). However, other pieces of work discussed here which create alternative care pathways, for example through faith leaders, for people who will not access health services for a mental health problem, will also be crucial. An interesting piece of work for CDWs would be to work with primary care practitioners to find out

what their experience of treating mental health problems in ethnic minority communities is like, and develop a work plan for improving these groups' seeking of help from primary care.

11.53 Greater ethnic minority service user involvement

Service users from ethnic minorities remain under-represented in service user involvement opportunities across the North East London NHS Foundation Trust. The service user group, RUN-UP, has identified this as an important problem which needs to be addressed, and CDWs could work with RUN-UP to attract more active members from minority groups. NELFT should also make a more concerted effort to involve a representative sample of service users in the User Quality Action Team and other areas of involvement. For example, South Asian communities have been very active on the Redbridge Patient and Public Involvement Forum (for physical health), so this community should be in principle likely to have interested members, although of course the stigma of mental health services could be a factor.

> *Where there is little take up from ethnic minority service users it may be necessary to hold one-off events to consult with specific groups. For example, in the DRE Focused Implementation Site of Central and North-West London Mental Health NHS Trust a successful event was held in Harrow called 'Listening to the Views of the Asian Community'. This could be a valuable way to start consulting with ethnic minority service users and carers around mental health services and encourage future involvement. A broader event could be held for ethnic minorities in general, or several events aimed at specific communities could be held. It will be important for such events to be attended by higher management staff to indicate the value which is placed upon these communities' views by the Trust.*

The recently published report by NELFT on its performance on the National mental health service Ethnicity Census 2008 acknowledges the continuing over-representation of Black people detained under the mental health act by services in all four boroughs, including Redbridge. The report, yet to be signed off by the relevant committees, recommends that the Trust as a whole attempt to build up Black user involvement on both a borough and Trust-wide basis. Making the effort to engage key minority groups with the Trust and its work to reduce the over-representation of ethnic minority groups detained on inpatient units will be an important step.

One clear barrier to service users having their say about mental health treatment they have received is the accessibility and transparency of the complaints procedure. Nobody I spoke to knew how to complain and many people suggested that it would be too much hassle or they would be concerned about possible negative impacts of complaining on the quality of their future care. RUN-UP has identified this as a key problem, based on feedback from their members and have an event planned which will involve service users in designing an easier, more accessible process for giving feedback about their care, be that positive or negative. However, at a higher Trust level, user feedback should be sought more proactively, to gain a better idea of what could be improved. Why not have people discharged from inpatient units complete a brief form, with assistance if needed, to comment on all aspects of their treatment, much as you might when leaving a hotel? A large-scale piece of work surveying service users and carers is due to take place soon but evaluation of the experiences of users should be undertaken as part of standard practice.

11.54 Evidence of what has improved

If services are to expect their users to be actively involved in the planning process then much more effort needs to be made to communicate to clients exactly what is being done by the Trust in response to user feedback. This also applies to complaints procedures. Much more needs to be done in response to complaints for service users to feel that making a complaint is worthwhile and not a pointless exercise (or even counter-productive). This might be achieved, for example, through the production of a quarterly

bulletin to be distributed in wards and team waiting rooms (in different languages), which updates clients on improvements and changes and how these have been a result of user involvement.

11.6   Improvements for service users

Many improvements to services have already been discussed but the more specific recommendations outlined below target the following DRE outcomes:

(1)   Less fear of mental health services among BME communities and service users;

(2)   Increased satisfaction with services;

(11)   A more active role for BME communities and BME service users in the training of professionals, in the development of mental health policy, and in the planning and provision of services; and

(12)   A workforce and organisation capable of delivering appropriate and responsive mental health services to BME communities.

11.61 Stable, Reliable Employment Support Services
Support back into work, education or training was identified by service users as a key aim for their recovery. Many people had tried hard to engage with Redbridge's frequently-changing providers of employment support but failed to receive a consistent service. This is currently being provided by Reed and Richmond Fellowship. A key recommendation for commissioners must be that greater stability of employment support services is required. Given the important target in the Local Area Agreement for Redbridge to have 8% of all people using Tier 2 mental health services in employment, we may hope that greater importance will be attached to the quality of employment support services over the coming year. It would be useful for the service to be Equality Impact Assessed to ensure it equally meets the needs of all ethnic groups.

11.62 More social activities for young people
One factor often considered likely to deter young people from engaging with mental health services was the social isolation attached to diagnosis. Across the UK, engaging young Black men with services in particular has been notoriously difficult.

> *One example of best practice in Redbridge has been the Friday club, designed by and for service users with a dual diagnosis of mental health problems and drug or alcohol problems. This group had been found to be very difficult to engage so the organisers asked clients what type of service would attract them. They asked for a place where they could play pool, listen to music, socialise and have a hot meal; this service was delivered and has been extremely successful in engaging this client group, which has a high proportion of members from ethnic minorities. Other examples are the social group and the carers' group being set up in the Redbridge Early Intervention Team.*

However, there remain large numbers of young people with mental health problems who may or may not be accessing services, who are socially isolated from their peer group. One carer commented that her daughter would just like to spend time with people talking about books and films she liked. The needs of people too young to feel comfortable among traditional day services is a neglected area, one which could be investigated further by the CDW based in the Redbridge Early Intervention team.

> *One initiative from South-West London which has successfully engaged large numbers of people from ethnic minority communities who did not otherwise connect with mental health services is Sound Minds. Beginning with setting up a band using musical equipment in a church basement, Sound Minds, based in Battersea, has expanded to fine art, theatre and film work, managed by service users and supported by the South West London and St. George's Mental Health Trust. In Redbridge, the day centre at 19 Mansfield Road has good musical equipment and could be used to bring together young people from ethnic minority groups who do not otherwise engage with services. The CDW based at Family Mosaic on this site is well-placed to work on a project like this.*

11.63 Better information about medication

A number of people I spoke to were taking medications which they did not understand and about whose side effects they knew very little. Detailed information about medication is available to clinicians in Redbridge mental health services on the 'ELF' intranet service for staff of the North East London NHS Foundation Trust in many community languages including Arabic, Bengali, Farsi, French, Gujarati, Somali, Tamil, Turkish, and Urdu (although Hindi is one written language that is notably absent). However, it seems that these leaflets may not be routinely shared with service users. CDWs can be involved with ensuring this excellent resource is printed and made available to ethnic minority service users in all teams in Redbridge, for example placed in waiting rooms or distributed to all psychiatrists.

11.64 The needs of carers

Overall it emerged that the roles of carers and ethnic minority families more generally in recovery could be better appreciated and supported by mental health services, where accepted by the service user. While there is a stereotype which is often inaccurate that ethnic minority families are over-involved and perhaps even 'the cause' of mental health problems, some families are closer-knit than the average White British family. Many carers wanted more information and time to be spent explaining diagnoses and treatments and services must be flexible enough to deliver this where desired.

A key gap in service provision identified was after-hours support for carers, particularly during crises, in the middle of the night or during weekends. Psychiatric liaison at A&E is expensive . It is also traumatic and difficult for the carer and the loved one to attend. A 24 hour crisis telephone line with a corresponding approved social worker for example, available to go out to people's homes in a crisis to assess whether they need to be admitted to a ward, was considered to be an important and potentially money-saving service if it reduced the number of presentations at A&E. This suggestion should be considered by the sub-group of the Redbridge Mental Health Local Implementation Team which is already evaluating proposals which have been made for crisis accommodation and respite care for carers.

The type of respite on offer to carers from ethnic minority groups should also be born in mind. One woman said that she would not feel comfortable leaving her loved one with a stranger when she went on holiday, so perhaps she would benefit more from short periods of respite more regularly. Several local voluntary sector groups do excellent work providing respite but receive little or no statutory support. Greater acknowledgment for the importance of this work by the statutory sector is needed.

11.65 Better Staff Training

NELFT has taken an important step towards acknowledging its responsibility to ensure a more culturally competent workforce by implementing a programme of one day mandatory cultural competence training. However, the training itself does not specifically focus on how staff will actively change their own clinical practice in order to improve cultural competence and it will be extremely easy for the day to be forgotten

and for its messages to not be reflected in day-to-day relations with service users from ethnic minorities.

The first step, which has been and must continue to be pushed for by CDWs at the NELFT Equality and Diversity Group, is to have a session of the training delivered to a group of ethnically diverse service users and gain their feedback on what needs to be improved. The training also needs to be extensively evaluated, since anecdotally the current programme has not been well received by all staff members. Thirdly, the training is currently followed up one year later to determine whether staff practice has changed. This is insufficient; training should be followed up perhaps three months later. Since Equality and Diversity forms part of staff members' Knowledge and Skills Framework, cultural competence should form an official part of every staff member's personal development plan and should be considered during annual appraisal. Fourthly the training does not include any work on different cultural explanatory models of mental health and illness, which should be a key factor in helping mental health staff to understand the needs and perspectives of ethnic minority groups. The training should also discuss the different social challenges which affect ethnic minority groups' mental health, to give clinicians a better understanding of some of the inequalities these groups face which can impact on their mental health. The local ethnic minority voluntary sector has a wealth of expertise of working with these groups which thus far has not been utilised in cultural competence training. CDWs can push for greater local involvement and contribution to NELFT staff training and can facilitate voluntary sector involvement. A higher level of cultural competence training which deals explicitly with clinical settings has been proposed at the NELFT Equality and Diversity group so CDWs attending that group should continue to support this proposal.

One small and easily achieved action is for NELFT staff to be more aware of the range of cultural events and festivals which take place throughout the year. For example, the fact that a Muslim carer's needs in the month of Ramadan were not met by inpatient services caring for her husband and son is unacceptable. A bulletin of news and information is emailed to all NELFT staff every week and the CDW based at the Early Intervention Team can easily take responsibility for ensuring that a weekly update on cultural and spiritual festivals is included in it, and in the monthly staff magazine.

Although NELFT has recently negotiated an improved contract for translation and interpreting services for clients whose English is not of a high enough standard, there is a number of problems associated with the use of interpreters. One example is that some staff do not feel confident to use a telephone interpreter because they could not be sure how their words had been translated and so would prefer to resort to a family member if absolutely necessary. Many of these concerns are detailed in the Language Support Strategy put together by Waltham Forest's Refugee Support Psychologist. An obvious point would be that it is not enough to simply have an interpreting service, Trusts must also actively publicise, with clearly displayed information in every team office, exactly what is available. This should be supplemented by training sessions about the protocol for how and when to use interpreters and to answer the fears and questions staff will have about them. The Redbridge Psychological service has previously delivered this type of training session in partnership with interpreters for the Medical Foundation for the Care of Victims of Torture; this type of initiative needs to be rolled out to all teams.

11.7   Acknowledgment and support for the role of spirituality

This objective works towards these DRE outcomes for services in 2010:

(1)   Less fear of mental health services among BME communities and service users;

(2)   Increased satisfaction with services;

(1)   A reduction in the rate of admission of people from BME communities to psychiatric inpatient units;

(2)   A reduction in the disproportionate rates of compulsory detention of BME service users in inpatient units;

(8)   More BME service users reaching self-reported states of recovery;

(11)   A more active role for BME communities and BME service users in the training of professionals, in the development of mental health policy, and in the planning and provision of services; and

(12)   A workforce and organisation capable of delivering appropriate and responsive mental health services to BME communities.

11.71 Enhanced chaplaincy provision
Redbridge mental health services must acknowledge the critical role of spirituality in the recovery and general wellbeing of many ethnic minority communities.

As already discussed, the provision for spiritual and religious support in NELFT is completely inadequate and has been for many years. In wondering where to go from here we can consider the example of good practice delivered in the neighbouring borough of Newham.

> *The Department of Spiritual, Religious and Cultural Care at East London NHS Foundation Trust is run by paid staff representing a breadth of faiths from the local faith and voluntary sectors. Members of the team make one-to-one visits to people on mental health wards who have a religious or spiritual need. They provide ward faith groups, acts of worship, connect service users to faith leaders and faith communities, celebrate festivals, provide religious texts and materials, have monthly liaison meetings with staff and undertake individual spiritual needs assessments linked to a client's Care Programme. The team also provides training to enable mental health staff and faith leaders to holistically support people suffering from mental distress. In addition they offer a one year university certificate in Spiritual, Religious and Cultural Care following completion of an introductory course, jointly delivered with the Psychology department at the University of East London.*

This type of commitment to the spiritual needs of clients of all ethnicities is exactly what service users should be able to expect from a mental health foundation trust in a region with as much ethnic diversity as North East London. With the tokenistic gesture of one Christian chaplain to cover four boroughs plus Whipps Cross, the Trust seems to suggest a complete indifference to the spiritual needs of all ethnic groups.

A strategy for improved chaplaincy will be evaluated at the Operations level in August 2008. Even if it is signed off as supported, it will then take time for the funds to be reallocated from another area to provide for new chaplaincy posts; it is therefore critical that CDWs continue to support this important area of service development and ensure that this strategy is not forgotten.

11.72 Mental Health awareness training for faith leaders
An important project will be to raise awareness and understanding about mental health problems with faith leaders who can disseminate their knowledge to their communities as well as identifying and referring individuals who would benefit from help from statutory services. A proposal for funding is underway by the Redbridge Faith Forum and Redbridge Concern for Mental Health, with the first stage being a series of focus groups with local faith leaders to identify what their own needs for mental health training are. A pilot programme of mental health awareness training for faith leaders should then be delivered and evaluated, and modified and expanded according to what works well. Community Development Workers can be involved in making connections with faith

leaders and creating opportunities for partnership and dialogue between mental health service managers and policy makers and these community figureheads. This project has received funding from the London Borough of Redbridge but the Redbridge Primary Care Trust and the North East London NHS Foundation Trust (NELFT) should also be key partners in this.

11.73 Developing communication channels and referral pathways with faith leaders

By developing dialogue between mental health services and faith communities, you create opportunities for joint partnership working. It may be important to develop referral pathways from key faith leaders to mental health services for those individuals who would not feel comfortable approaching the statutory sector for help.

It will be important to encourage the representation of interested faith leaders on key committees such as the NELFT Equality and Diversity group, or on the Local Involvement Network, to ensure the views of faith communities are better represented.

Investing time and energy in meaningful and not merely tokenistic relationships between services and faith communities will be a crucial first step in challenging the preconceptions of ethnic minority groups about mental health. Making these connections will reveal much about the ways that mental health services could become more accessible. In future we should aspire to delivering some services in community locations where possible and appropriate, and this cannot be done without first going out into faith communities so that both sectors can learn from each other on a mutual footing.

> *A consultant nurse at Sheffield Care Trust won the DRE More Appropriate and Responsive Service award in 2008 for her Enhanced Pathways Into Care project with the Pakistani community. Partnerships were established with Imams and the local Pakistani Muslim Centre and the chief executive of Sheffield Care Trust now meets regularly with community leaders. "The Imams have been helping us with the delivery of home treatment. Before, when a patient became ill, they might have believed that black magic was responsible and so would have been reluctant to go and see a clinician. But now, the Imams are providing prayer but also advice on where to go for help". BME patients are recovering faster than their white counterparts. Length of inpatient stay has also been reduced for 12.5% of Pakistani patients, as community treatment options have been extended. There is greater satisfaction with services and more people are being referred for treatment as an awareness of mental health conditions has spread through the community. People who experience relapse after leaving hospital are also coming forward for treatment sooner, often via the Pakistani Muslim Centre.*

11.74 Other DRE Outcomes

Nowhere in this report have I detailed how the following DRE objectives for 2010 should be delivered:

1. Fewer violent incidents that are secondary to inadequate treatment of mental illness;

2. A reduction in the use of seclusion in BME groups;

3. The prevention of deaths in mental health services following physical intervention;

Objectives 5, 6 and 7 are key aspects of Delivering Race Equality which must be addressed by NELFT in its provision of inpatient services. The most recent Healthcare Commission report rated the Trust's overall inpatient services as 'weak' and therefore in the weakest eleven Trusts providing mental health inpatient services in the country. Under the criterion that inpatient:

"Services focus on the needs of the individual and provide care that is personalised and promotes recovery and inclusion"

And the question "Is the care and support provided appropriate to individual needs?" NELFT inpatient wards scored just 1 out of 4 for training on diversity and 1 out of 4 for assessment of, and access to staff support for, cultural and spiritual needs (Healthcare Commission (2008). These findings do relate to the year 2006-07 and the Trust has said it has already made progress. However, this is a clear indication that there is room for serious improvement in NELFT inpatient services, including in the area of equality and diversity. Areas 5, 6 and 7 are not aspects of services which Community Development Workers can feasibly have any impact on and must form part of focused service improvements.

It is important to note that outcomes 3 and 4 will require longer term interventions than are possible on a short-term basis such as the five year duration of the Delivering Race Equality programme:

(3) A reduction in the rate of admission of people from BME communities to psychiatric inpatient units;

(4) A reduction in the disproportionate rates of compulsory detention of BME service users in inpatient units;

Clear reasons why there are disproportionate numbers of BME patients on inpatient units and compulsorily detained remain elusive, although there is a range of hypotheses. Therefore, it seems unlikely that over the next two years services can realistically be expected to have significantly lower levels of ethnic minority service users. The complex reasons for disproportionate numbers of mental health problems are likely to take decades to resolve. However, the evidence for Early Intervention shows that prognosis is better the sooner treatment is received and adhered to. This report therefore proposes that it is feasible to gradually reduce the numbers of BME clients needing inpatient services and needing to be compulsorily detained by ensuring that active campaigns are in place to reach out to BME groups as early as possible and therefore to treat mental health problems before they reach crisis point. This report has outlined practical, achievable ways to do just that. With the co-operation of the voluntary sector, the statutory sector, from front-line staff to the highest levels of management and the facilitation of Community Development Workers, there is genuine reason to hope that the mental health of Redbridge citizens of all ethnicities can be dramatically improved.

12.0   Work plans

The recommendations discussed above are intended to be achievable, practical targets which can be implemented across mental health services at a range of levels. They have been broken down here into the actions which can be taken on under the banner of local Community Development Work by the two CDWs and higher-level recommendations which need to come from mental health service managers and staff themselves.

12.1   Suggested Work Plan for two Redbridge Community Development Workers

This work plan outlines suggested work for two Community Development Workers (CDWs) based in Redbridge. The year for implementation is indicated in the far right column but this is only a guideline. The work set out for Year 2 in particular may be too much for two workers to take on but this work plan at least offers suggestions for the types of valuable work they could be engaged i

RECOMMENDATION	DETAILS
High Profile mental health promotion events	Examples include: Film screenings, Mental health talks by community figures and celebrities, Mental health arts festivals, World Mental Health Week and Black History Month events. CDWs should put together a regular programme of mental health promotion events aimed at BME communities.
Long-term community mental health education	These two objectives could form part of one pilot project worked on by CDWs in Redbridge.
Mental health outreach education for young people	CDWs to investigate how Jewish Care delivers its service user-led mental health education programmes to schools and businesses and put together funding bids for a pilot project of mental health education. This could be delivered in one chosen school with high levels of ethnic diversity and also in the community, delivered to specific minority groups such as South Asian communities, Black Caribbean and Black African groups. CDWs to involve the Young People's Project and investigate whether a similar film-making project could be implemented with young people around mental health. CDWs to investigate use of youth culture media such as Facebook and MySpace to reach out to young people, perhaps in partnership with Redbridge Council youth services such as Ilfomation, designing web-based initiatives with the help of young people. Ensure that the role of cannabis is clearly explained.
More accessible information	Key NELFT leaflets to be printed in the most widely spoken community languages (steered by the NELFT Equality and Diversity group). In particular need a basic leaflet explaining exactly what mental health services offer and where to go for help.

	These leaflets to be distributed by CDWs in the most appropriate community locations including places of worship, local businesses, especially shops and shop changing rooms, police stations, social centres, English language schools, restaurants, GP surgeries, family planning clinics, citizen's advice bureau, etc.
Outreach to less represented minorities	CDWs to spend time reaching out to less represented minorities including African Caribbean people and eastern European communities, e.g. through churches and local businesses such as barbershops and hairdressers, food shops and music venues.
Engagement with local media	CDWs to work with local print and radio media using SHIFT media handbook, 'What's the story?', to raise awareness of positive mental health and suicide journalism, e.g. delivering workshops to staff, contribute articles to publications, organise talks on the radio by ethnic minority community members who have experienced mental health problems, disseminate copies of 'What's the Story?' Work with RUN-UP to establish a speakers' bureau of ethnically diverse service users who are happy to be available to give a user perspective when the media wants to write about a mental health issue.
Fostering public dialogue	CDWs to bring together all the third sector groups as well as interested staff from the statutory sector that are involved in supporting mental health. Investigate how to set up a forum for public mental health discussion, e.g. regular lunchtime discussions between members of the public, service users and carers about mental health, held in a prominent location such as Ilford library.
A network of ethnic minority voluntary sector groups working for mental health	CDWs to bring together groups for a 'BME mental health network' run out of Redbridge CVS initially but to be taken over by the groups themselves or if deemed more appropriate, a 'South Asian mental health network' initially. Grasp of community languages could be useful here. Enable groups to network, share expertise and learning and counteract resentment and rivalry which exists in the sector. Collaboratively put together a proposal for commissioners about the network's vision of the role of the voluntary sector in the mental health of Redbridge communities over the next five years and what needs to be delivered for that to be realised. Explore partnership bids for funding and needs in their organisations for training, development and fundraising.
A coordinated programme of voluntary sector mental health services	CDWs to map all of the community mental health services provided by the voluntary sector to create a timetable and identify gaps in provision for different

	ethnic minorities. This could be done in conjunction with the Redbridge Concern for Mental Health mental health directory. Publicise widely in the voluntary and statutory sectors.
Showcasing the work of the voluntary sector	CDWs to be ambassadors for the work of the voluntary sector, highlighting its importance wherever possible. CDWs to organise events which unite voluntary sector providers and showcase work, including that of organisations providing respite for carers. Ensure attendance by statutory sector management and staff. Consider a biannual or quarterly newsletter making the voluntary and statutory sectors aware of each other's work.
Develop communication channels between the statutory and the voluntary sectors	CDWs to use a 'BME mental health network' to encourage dialogue between voluntary sector providers and higher management in Redbridge mental health services and explore more direct referral pathways from key groups to community mental health services where appropriate. CDWs to push for far more involvement of ethnic minority voluntary groups in the planning of services.
Mental health awareness training in the voluntary sector	CDWs to undertake free (from the London Development Centre) Mental Health First Aid training and consult voluntary sector groups on what they would like to know about mental health. Include myths and preconceptions and different and equally valid explanatory models for mental health problems. Deliver awareness training to a sample of voluntary sector groups including RedbridgeCVS. If successful it may be necessary to bid for additional funding so that training can be delivered on a larger scale to a greater number of voluntary sector groups. Ultimately this could be used with local employers in conjunction with Redbridge Concern for Mental Health's Supported Volunteering Service to set up volunteering placements for service users.
Better monitoring of grant spending and contracts	CDWs to lobby local funders such as Redbridge Council and the Redbridge Primary Care Trust to more visibly monitor delivery of contracts and grant spending without creating additional work for voluntary organisations, for example through spot checks and anonymous surveys of service users.
Befriending within ethnic minority groups	CDWs to explore with Redbridge Concern for Mental Health befriending service the possibility of piloting ethnic minority-specific befriending services to enhance social inclusion and understanding of mental health problems within minority communities. CDWs to assist with applications for additional funding where necessary.

A holistic centre for wellbeing	CDWs to push for holistic organisation of new health developments such as the five Redbridge polyclinics and potential new community mental health buildings in Gants Hill, including voluntary and faith sector and physical health service presence. If BME Mental Health Network is successful, CDWs could assist with funding bids for a centre like the Qalb Centre in Waltham Forest if this is something the network wants.
Services to support physical health	CDWs to engage voluntary sector groups working with ethnic minorities and mental health with physical health projects such as Fit For Fun.
Alternative and complementary therapies	CDWs to raise awareness among ethnic minority community groups of the flexibility of choice afforded by direct payments and ensure people know they can choose alternative and complementary therapies as part of this.
Positive promotion about mental health services	CDWs to organise events in which service users from specific ethnic minorities speak out to their community about their experiences and answer questions to demystify mental health services.
Improving the image of primary care	CDWs to relay the feedback in this report to the bodies which represent primary care practitioners in Redbridge and find out what challenges they face when treating ethnic minorities' mental health. Work towards agreeing what work can be done by primary care services, CDWs and the voluntary and community sector to ameliorate this.
More ethnic minority service user involvement	CDWs to work with RUN-UP to attract more members from ethnic minorities.
Better information about medication	CDWs to ensure NHS information leaflets about the most commonly prescribed medications which are translated into key community languages are printed up and distributed widely to Redbridge mental health teams, having them available to pick up in every waiting room or distributed to every psychiatrist. Explore whether it is necessary to have leaflets translated into Hindi and/or Punjabi.
The needs of carers	CDWs to consult ethnic minority carers to investigate their needs. CDWs to work with local carers' groups to put together information packages in a range of languages to ensure that local carers know exactly what support and telephone numbers are there for them, especially out-of-hours.
Better staff training	CDWs to use the NELFT Equality and Diversity group to push for greater involvement of the local ethnic

	minority voluntary sector in planning of cultural competence training and improvements. CDW based in the Redbridge Early Intervention Team to contribute a weekly reminder about cultural and faith holy days and festivals coming up to the News In Brief bulletin circulated to all NELFT staff weekly.
Enhanced chaplaincy provision	CDWs to continue to support the strategy for improved spiritual and cultural care at the NELFT Equality and Diversity group and the Local Implementation Team if necessary.
Mental health awareness training for faith leaders	CDWs to support the Redbridge Faith Forum's proposal for mental health awareness training with faith leaders and assist with the delivery of the training if necessary, e.g. if part of the training incorporates Mental Health First Aid. CDWs can help with the networking aspect of making connections with faith leaders and introducing them to key managers in mental health services.
Developing communication channels and referral pathways with faith leaders	CDWs to encourage the representation of interested faith leaders on key committees such as the NELFT Equality and Diversity group or the Local Involvement Network. CDWs to push for referral pathways to be created between faith leaders and community mental health services.

12.2   Suggested Work Plan for mental health services

This work plan outlines important changes and improvements to be made to mental health services for them to become more approachable and accessible for ethnic minority communities. Community Development Workers can play a pivotal role in lobbying for these changes but the changes themselves must come from higher management, policy-making and commissioning levels, if they are to be taken seriously.

RECOMMENDATION	DETAILS
Talking therapies	Low-level talking therapies to be delivered by ethnically diverse therapists in community settings including GP surgeries and other key locations such as selected community centres or faith buildings – places women will feel able to attend alone. Wider provision of psychological services, including a position for a specialist in ethnic minority and/or refugee community needs. Greater exploration of and publicity for wider options within talking therapies such as greater provision of systemic family therapy and inter-cultural therapy.
Services to support physical health	Services to acknowledge their responsibilities for service users' physical health needs, e.g. medication side effects, health and diet, smoking cessation etc. Publicising direct payments to clinicians and highlighting how they can be used to improve physical health, e.g. gym membership. Explore how models such as Air Football could work for ethnic minorities with mental health problems who would be unlikely to get involved, for example using dance to engage South Asian women.
Greater partnership working between mental health and social services	Better partnership working between different systems and departments to ensure ethnic minorities' holistic mental health needs are supported.
Improved discharge support	Clear information about discharge procedures to be provided to all service users and be translated into key foreign languages. Services need to ensure an equable and proficient discharge procedure is applied to every single client leaving an inpatient ward. Discharge process to be Equality Impact Assessed.
Alternative and complementary therapies	Alternative and complementary therapies to be made available to mental health service users under direct payments and for this option to be clearly publicised to ethnic minority groups including in foreign languages.
Acknowledgment of other explanatory models of mental ill-health	Services to actively, openly and publicly embrace a holistic view of mental health. Publicity about the breadth of treatment options of which medication is only one. Services could organise a large-scale event in partnership with the voluntary sector with the theme of 'holistic mental health care' to illustrate that services

	embrace views about mental health beyond the biological model. CDWs can assist and facilitate with this but this should be organised by the mental health Trust itself.
Positive promotion about mental health services	Redbridge mental health services must be actively publicised in a positive light. Publicity tailored to key communities, e.g. South Asian, Black African and Black Caribbean groups, in public places such as inside buses and at bus stops or in GP practices. Actively involve the ethnic minority voluntary sector in design of advertisements. Include positive personal testimonies from service users from ethnic minorities. Radio adverts in English and community languages on local radio stations are also important. Goal is to ensure people know that services have moved on from the archaic practice of 'lunatic asylums' which many people believe still goes on.
More ethnic minority service user involvement	NELFT to make a concerted effort to have a representative sample of service users on its User Quality Action Team. Explore new opportunities for involvement, for example a group of Black African and Black Caribbean service users to be consulted on the over-representation of this group, men in particular, detained on section in inpatient units. NELFT to hold one-off events to consult with specific groups which may not want to commit to long-term involvement in the Trust such as 'Listening to the views of the Asian community'. It will be important to involve carers as well as service users in such events. Complaints procedure to be revised to make it more user friendly to ethnic minorities and making it possible for people to complain in different languages. NELFT to seek user feedback more proactively, e.g. a standard questionnaire (with assistance if required) completed by all service users discharged from an inpatient unit.
Evidence of what has improved	NELFT to make service users aware of exactly what has changed and improved as a result of user involvement and action. A quarterly bulletin to be distributed in wards and waiting rooms is one obvious example. NELFT complaints procedure to be assessed to ensure that the response to complaints is meaningful and does not leave service users feeling the exercise was pointless.
Stable, reliable employment services	PCT and Redbridge Council commissioners to ensure greater stability and regulation of employment support services; provision to be Equality Impact Assessed.
More social activities for young people	NELFT and PCT to consider ways in which innovative, creative provision for day and evening services can be commissioned (potentially from the voluntary sector, e.g. the Bridge project) to engage young people with mental health problems in purposeful social activity.
The needs of carers	Redbridge Local Implementation Team to explore options for a 24 hour crisis line for carers in an emergency and 24 hour available approved social

	worker who can attend homes if needed to assess whether inpatient admission is necessary. Mental health services to acknowledge the valuable respite care provided for ethnic minority carers by the voluntary sector, e.g. as part of events to showcase local work.
Better staff training	NELFT to deliver a session of cultural competence training to a group of ethnically diverse service users to gain their feedback and make appropriate adjustments to the training programme. Cultural competence training to be clearly evaluated and modified in response to staff feedback. Training to include alternative cultural explanatory models of mental health and illness and consideration of the social challenges faced by ethnic minorities in predominantly White society. Include the local ethnic minority voluntary sector in evaluation and planning of training; CDWs can be involved in this. Completion of cultural competence training to form part of staff members' personal development plans during their annual appraisal. NELFT and PCT services including GPs to actively publicise translation and interpreting services, with clearly displayed information in every team office about exactly what is available. Training sessions to be implemented about how and when to use interpreters and to answer fears and questions staff have about them.
Developing communication channels and referral pathways with faith leaders	Services to develop referral pathways from key faith leaders direct to community mental health services for selected communities who are less likely to access services via a GP. Service managers to invest time developing meaningful working relationships with key figures from faith communities by actually going out into those communities to meet people.
Enhanced chaplaincy provision	Commitment at the operations level for chaplaincy and spiritual care provision appropriate to the size and ethnic diversity of the population served by NELFT, the equivalent of four full-time chaplain posts, divided among qualified representatives from a range of faiths.

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