A Qualitative Study of BME Mental Health and Wellbeing

in Brighton and Hove

BME Mental Health / Wellbeing Study Group

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February 2012

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Introduction

It has been widely reported that Black and Minority Ethnic (BME) groups in England have a poorer experience of mental health services compared to the rest of the population.[1-3] Studies in the UK and elsewhere have suggested that the risk of adverse mental health outcomes is amplified when ethnic minority populations reside in areas where they comprise a very small segment of the population, commonly referred to as the "ethnic density effect".[4] In an attempt to explain this effect, the authors identified "...perceived exclusion from local networks, a need to rely on geographically-dispersed culturally-specific services and facilities, perceived risk of physical and psychological intimidation and damaging effects of everyday racism" as potential factors behind this increased risk. A qualitative interview study in Birmingham showed that while there did not seem to be ethnic differences in therapeutic relationships, care pathways or in the role of family and friends, negative experiences in in-patient care appeared to be mediated by ethnicity.[5]

Although most mental health care in England is delivered in community settings,[6] a number of published papers on ethnicity and mental health focus on the experience of those in in-patient care.[5] Among those who are already in-patients in mental health services, both racism and a lack of cultural awareness have both been cited as contributors to the discrimination experienced within these settings.[7] The limited cultural awareness of the staff experienced by the service users in this study was highlighted when their expressions of illness and perceptions of causes were ignored or misinterpreted, preventing the formation of a therapeutic relationship with positive patient experiences.[7]

In addition, while some studies have found a greater use of compulsory detention,[8,9] coercion involving the police and criminal justice system,[10] and higher rates of treatment consent refusal among BME in-patients[11], others have argued this may also be confounded by economic deprivation.[12] The use of coercion seems to be prevalent among involuntarily detained psychiatric in-patients both Black and White from deprived areas,[12] is potentially related to fear of contact and less satisfaction with services[8] and is also a significant barrier to the establishment of a therapeutic relationship crucial for positive patient experience.[7] On the other hand, a large community survey noted that while individuals from BME groups were no more likely to have mentioned receiving medication for mental health problems in the past 12 months than those from a White British background, they were less likely to have said they received talking therapy sessions from the NHS during the same time period.[3]

Stigma may also play an important role not only in seeking care and adhering to treatment, but also to lowering self-esteem, reducing social opportunities[13] and even negatively affecting the course of the mental illness itself.[14] Stigma has a complex characterization, and includes discrimination, rejection and loss of personal power.[15] The concept of "Double Stigma" has also been hypothesized in the literature, wherein members of ethnic minorities with mental disorders suffer discrimination not only because of their ethnic background but also because of their mental health problems.[16] Thus individuals with mental health problems, and especially those from BME backgrounds, may delay or avoid treatment with consequent deleterious effects to their health in an effort to avoid public and self-stigma, as well as interactions with a mental health system which does not understand or communicate effectively with them.[16]

The issue of communication between culturally diverse clients and carers poses barriers not only related to language itself, but also to difficulties which may arise in the patient's ability to disclose the problems they are facing.[17] In some Asian populations, open disagreement with health service providers is avoided, and even if a patient nods his or her head, this may mean that he or she is hearing but not necessarily agreeing with what is being said.[18] In addition non-verbal cues and expressions which are meaningful within certain cultural contexts but not when directly translated can be missed.[17] Stigma related to mental health problems can also lead to the expression of culturally-unacceptable emotional problems in physical symptoms, leading to misdiagnosis.[17]

Other studies have suggested that while people from Asian background had the highest community rates of mental disorder,[19] they were the most frequent consulters in primary care, but were less likely than White people to have their mental disorder recognised or to be referred to specialist care.[20] The large survey of community mental health services in England in 2004-05 provided further evidence that Asian patients had significantly poorer access to a range of community mental health services than those who were White British.[3]

In summary, many factors are highlighted in the literature which need to be considered in identifying and addressing the mental health needs of BME populations, including racism, lack of cultural awareness, mistrust, stigma and poor communication.

Context within Brighton and Hove

The information in this section is abstracted from the Brighton & Hove Joint Strategic Needs Assessment (JSNA) Summary 2011,[21] the State of the City Report 2011[22], BME Community Partnership (BMECP) report of the BME mental health project 2003[23] and data provided by the Sussex Partnership Foundation Trust. More detailed breakdowns are provided in Appendix 1.

BME groups in Brighton & Hove

At the time of the 2001 Census, 88% of the Brighton & Hove population were from White British groups compared with 87% in England. More recent estimates produced for 2007 suggest that the local picture is changing.

In 2007, using the Office for National Statistics (ONS) mid-year estimates by ethnic group,[24] people from BME groups (all ethnic groups except White British) made up 16% of the population of Brighton & Hove (40,900 people), an increase from 12% in 2001.

These changes are important as different ethnic groups experience different disease patterns but can also experience differing levels of access to services. We also know that BME groups experience some of the following issues which impact upon mental health and wellbeing:

- Nationally, pupils from the following ethnic groups have lower GCSE attainment: Traveller of Irish Heritage and Gypsy/Roma; Black Caribbean; Pakistani; Other Black and; Mixed White and Black Caribbean.
- Nationally, prevalence of obesity is significantly higher in children who are Asian or Asian British, Black or Black British.
- National evidence shows that families from certain BME groups are at a significantly increased risk of experiencing child poverty.
- Locally, BME groups are more likely to feel that local public services do not treat all people fairly and that these services do not treat them with respect. But, they are also more likely to report that local services act on the concerns of residents.
- BME people are at an increased risk of racist or religiously motivated hate crime.
- BME people are more likely to experience housing need in the city.

According to 2007 Brighton & Hove population estimates:

- 1.4% (3,600) of the city's population were White Irish
- There was higher than average proportion of residents who were White, but not British or Irish, around 6% (14,000 people) compared to the national figure of 4%.
- About 2% (5,800 people) of residents were described as mixed race.
- 1% (2,600 people) were Chinese.
- We had a lower than average proportion of Asian/Asian British residents at 3% (8,200 people) compared to the national proportion of about 6%.
- We also had a lower than average proportion of Black residents, about 2% (4,300 people) compared with nearly 3% nationally.

Brighton & Hove Ethnicity Profile
Source:
2001 data: UK Population Census
2007 data: ONS Resident Population Estimates by Ethnic Group

Ethnic Group	Brighton & Hove						South East		England	
	Census 2001		2007 Estimate		Percent increase / decrease 2007 - 2001		2007 Estimate	Percent increase / decrease 2007 - 2001	2007 Estimate	Percent increase / decrease 2007 - 2001
	Number	Percent	Number	Percent	Number	Percent	Percent	Percent	Percent	Percent
All Persons	247,814		253,500		5,686	2.3%		3.9%		4.0%
White: British / Irish	222,099	89.6%	216,200	85.3%	-5,899	-2.7%	88.2%	-0.8%	84.8%	-0.1%
Other White	11,483	4.6%	14,000	5.5%	2,517	21.9%	3.8%	43.5%	3.5%	35.8%
Mixed	4,799	1.9%	5,800	2.3%	1,001	20.9%	1.5%	47.7%	1.7%	35.2%
Asian or Asian British	4,539	1.8%	8,200	3.2%	3,661	80.7%	3.5%	54.4%	5.7%	29.6%
Black or Black British	1,989	0.8%	4,300	1.7%	2,311	116.2%	1.6%	128.6%	2.8%	27.8%
Chinese	1,305	0.5%	2,600	1.0%	1,295	99.2%	0.7%	78.0%	0.8%	81.4%
Other Ethnic Group	1,600	0.6%	2,400	0.9%	800	50.0%	0.7%	94.8%	0.7%	75.2%

The age structure of the BME population in the city is considerably younger than the White British population; 26% of the BME population in Brighton and Hove is aged 0-19 years compared to 21% of the White British population.

Migration

Brighton & Hove is also a destination for migrants with 15% of the city's population born outside England, higher than for the region and for England.

Data on estimated population and mental health service utilisation by broad ethnic group

Service utilisation data for the calendar year 2008 from the Sussex Partnership Foundation Trust suggest over-representation of BME people in acute mental health services, which is consistent with reports from mental health services in other areas. Our data suggest that it is individuals from mixed ethnic backgrounds who are somewhat under-represented in terms of access to adult mental health services, and not those of Black backgrounds; although a cautionary note must be made due to the small number of individuals within each ethnic group category for whom the data were available. It has been suggested in the literature that individuals from these communities may be at a higher risk for psychotic illness due to social and economic disadvantage and the experience of racism,[4] and that they may not be offered a wider range of alternatives by health professionals due to discrimination.[3] They may also delay seeking help for mental health conditions until they have worsened considerably due to stigma, fear and mistrust[9] or chose not to be remain in contact with community mental health services due to dissatisfaction with previous experiences.[3]

Our data also suggested that there was some under-representation of individuals of Asian or Chinese background in the use of mental health service. It has been suggested that this may not be due to a lack of need, but rather because of social isolation, stigma, or ignorance of the ability of health professionals to be able to help with emotional problems.[19] One the other hand, the over-representation of those of other ethnic backgrounds in the use of adult mental health services has also been identified in previous reports of health equity in mental health services elsewhere in the country. This is something that still needs to be clarified, as it is not possible to ascertain the homogeneity or heterogeneity of this group. What is apparent is that these individuals are identifying themselves as a non-White minority, who seem to be making greater use of the adult mental health services available, in contrast to many of the other ethnic minorities identified. The characteristics that distinguish this group, however, need to be further examined and determined.

Aim of the study

The aim of the study was to examine the level and quality of mental health services being accessed by people from BME groups in Brighton & Hove, with the goal of improving access to these services and the quality of treatment within them.

Methods

A qualitative study of mental health and wellbeing of BME groups residing in Brighton & Hove was conducted from April to June 2010 by the Public Health Directorate and Mental Health Team at the NHS Brighton & Hove in collaboration BME Community Partnership (BMECP) and Sussex Partnership Foundation Trust (SPFT). Community development workers (CDWs), whose role is to improve services for black and minority ethnic (BME) communities, identified local residents to participate in the study. The study was organised in focus groups and a community survey. The methods for each of these are described in the relevant section of this report.

DH - Delivering Race Equality in Mental Health (DRE) 2005-2010

Delivering Race Equality' (DRE) was set up to reduce inequalities in mental health service for people who experience discrimination and disadvantage such as Black and ethnic minorities, Irish origin, Mediterranean origin, East European migrants. In addition, specific populations include refugees and asylum seekers, older people, and children and young people (DRE action plan, 2005, p.9) The employment of community development workers (CDWs) nationally, was to develop more culturally appropriate services. Two CDWs are based in Brighton & Hove with Peter Koroma in BME Community Partnership (BMECP) and Eleanor Hope in Sussex Partnership Foundation Trust (SPFT).

Overall summary findings from the study

The study highlighted key areas of improvement in mental health service provision for BME groups in the city. Qualitative and quantitative data collection methods in addition to local population statistics and information on mental health service use provide a more complete picture of the reality being experienced by these populations in Brighton & Hove.

Demand for services

Survey respondents and focus group participants were likely not representative of the entire BME population in Brighton & Hove, although their perception and experience of mental health issues, either personal or from within their communities, provided valuable information from an insider perspective. Thus, while the need for mental health services in the wider community might be lower than the 72% identified among this sample of survey participants, the obstacles to maintaining good mental health that were identified in the focus groups, such as the experience of racism, poverty, poor education and acculturation difficulties, are prevalent throughout BME populations in UK.

Sources of help

The most popular source of help identified in the community survey of those requiring assistance in the past 12 months was the Sussex Partnership Foundation Trust – mental health / wellbeing services (61%), with other professional and lay sources also being mentioned, such as psychological therapy, complementary services and the support of friends and family. Comments from the questionnaire survey, in addition to focus group discussions, suggested a general dissatisfaction with the mental health services being provided by GPs and mental health specialists, and more positive comments emerging in from complementary services and peer support groups, although only one-third to one-quarter of survey respondents mentioned having sought these sources of help. This may also have been due to barriers related to these alternatives, such as long-waiting lists, costs and lack of information on the availability of these alternative sources of help.

Barriers

The experience of barriers was also prevalent among those who needed help (81%) according to the community survey, the most common of which appeared to be related to not wanting to be seen entering mental health services because of stigma. This also emerged as a barrier in focus group discussions, especially among less acculturated members of the BME community and those with strong community ties.

Isolation was also a common barrier in relation to those who don't have a community to belong to, but also in relation to men, who, because of the perception that they are 'strong', are unwilling or unable to ask for help with their problems and often turn to drugs and alcohol for comfort.

The main barrier, however, in obtaining help from existing health and mental health services that emerged both in the community survey and focus group discussions was the relationship between service providers and users. While some felt that they were being given second-class treatment because of their BME status, there was a consensus that service providers were not listening to them, understanding them, or allowing them to participate in decisions related to their care. Thus, the needs of the BME community are not being met by the present services, which are viewed as providing them with unwanted forms and tablets.

Recommendations

Increasing dissemination of information

Open discussions need to be held in a variety of settings on mental health and wellbeing to dispel widespread stigma. This is helpful in letting people know what it is, the strength and courage required to live with mental health issues, that these conditions can be treated and managed, and that misconceptions related to violence and mental incapacity are not accurate (www.rethink.org). These discussions might also be useful in informing people that help is available in different forms from different sources, including voluntary organizations and peer support groups. This can be done through a variety of ways, many of which were suggested by participants themselves, including:

- Open meetings at the BMECP, such as the present focus group.
- Specialists mental health promoters to come to community meetings to talk about mental health issues and possible solutions.
- A list of voluntary organizations, alternative therapies, and peer support groups could be available at GP surgeries (including leaflets in different languages), BMECP, and in the BME community newsletters.

Improving user-provider relationship / communication

GPs and other mental health service providers could be given further training in interpersonal skills, such as listening and trying to understand another person's perspective of mental health, what they are experiencing and what they believe to be the

issues behind it and their expectations for treatment (i.e. cultural awareness). This must also necessarily address stereotypes and misconceptions, potentially held by service providers including those which are race-related in order to broaden their views, increase their ability to empathize and allow them to understand the user's perspective. They can then use this information to recommend different treatment modalities most suitable to the users' expectations, and carefully explain the expected/desirable outcomes of these treatments.[17] In this way, the service provider and the user can avoid power imbalances often experienced by those with mental health issues and agree on a joint treatment plan which will insure a more positive user experience and better compliance.

The NHS may also wish to consider specific campaigns to recruit and retain more mental health service providers from BME backgrounds.

Issues related to BME men in seeking help

New approaches to reach (engage with) BME men in particular must be explored, as the focus groups suggested that particularly men from BME backgrounds are under a lot of pressure to be 'strong' and find it particularly difficult in asking for help. Some suggestions were made during focus group discussions as to approaches which men may find more acceptable, including a peer support group for men (perhaps connected with sports activities) and availability of a 'stress' specialist (which is associated with less stigma than 'mental health' specialist). It has also been suggested in the literature that the forms of treatment offered to men might be more effective if focused on cognitive problem-solving rather than on emotions.[20]

Talking therapy / alternative therapies

It is also important to ensure that people from BME groups have equal access to talking therapies within the NHS, as this has been shown not to be the case in a large survey in England.[3] This issue could be considered in B&H, with sufficient resources in place (i.e. available therapists) and guidelines to GPs and other mental health service providers to ensure that different treatment modalities are offered and available to all patients.

If resources allow, there may also exist the opportunity for a small pilot programme to be implemented in which individuals experiencing mental health difficulties could be offered a complementary therapy (such as homeopathy or acupuncture) with a close evaluation of uptake and prognosis.

Partnership with voluntary organisations

In partnership with voluntary organizations and BME community groups, the NHS may also wish to promote the formation of additional peer support groups.

Other issues

It is important to ensure that members of the BME community who are refugees are aware of existing services. These services may be periodically evaluated and improved in order to better meet the needs of those they serve. Additional services may also need to be added to that portfolio, including specialised support in dealing with traumatic events they may have experienced in their native countries, and relationship/family counselling, to assist them in addressing different norms related to gender roles and/or child rearing they encounter in this country.

Focus groups

Overview and aims

The aim of the focus groups was to examine the level and quality of mental health services being accessed by people from BME groups in Brighton & Hove, with the goal of improving access to these services and the quality of treatment within them.

Methods

As part of this assessment, two focus groups were conducted at the BMECP centre on 4 June, 2010. Participants were recruited by the two community **development** BME mental health workers (PK, EH). Members of the BME community, aged 18+ years, who were resident in Brighton & Hove were eligible for participation in the study. Individuals were invited to attend a 2-hour session in the morning or afternoon at the BMECP centre. Light refreshments were provided, and a £25 supermarket voucher was given as an honorarium to each participant.

The focus group sessions were facilitated by a female researcher trained and experienced in working cross-culturally and in the use of qualitative methods (LM). At the beginning of the session, the aims of the assessment were explained (MC). Permission was obtained from the participants to tape-record the sessions. The focus group discussions were guided by questions developed by the Mental Health / Wellbeing Needs Assessment Group (AM, LM, MC, EH, PK, DN).

Each participant was encouraged to speak and express their own views and often conversations among participants enriched the discussion. Beside the recording of the discussion, written notes were also taken (MC, VC), using flipcharts, to allow for a review of the process and to ensure that participants' views were clearly documented.

Data management and analyses

The audio-taped recording of each focus group interview was transcribed verbatim by one of the researchers (VC). Thematic analysis was used to extract information from the data as follows: two researchers present during the focus group sessions as facilitator and

note-taker (LM and VC, respectively) familiarized themselves with the contents of the notes and transcripts and began developing an iterative coding scheme using QSR's NVivo 8 software. This process involved the identification of common words and phrases which were coded and later grouped into sub-themes and themes. As revision of the data continued, new themes and sub-themes emerged and others were adapted in an iterative process. Themes identified by this analysis are illustrated by quotations from focus group participants. All data management were conducted using the NVivo software.

Participants

There were a total of 23 participants in both focus group interview sessions: 13 in the morning session and 10 in the afternoon session. Characteristics of the participants are given in Table 1.

Focus group interview questions

1. Tell me about what mental health / wellbeing means to you? How can someone maintain good mental health?
2. How can someone who is experiencing worry or difficult emotions or thoughts deal with them, or find help to deal with them?
3. What are some of the things that might prevent someone who feels like they need help to deal with worry or difficult emotions or thoughts, but are unable to get it? How might this be different for men and women?
4. How can the current mental health / wellbeing services provided be improved?

Table 1. Characteristics of focus group interview participants (n=23)

	All	Morning session	Afternoon session
	n = 23	n = 13	n = 10
	n (%)	n (%)	n (%)
Gender			
Male	11 (47.8)	5 (38.5)	6 (60.0)
Female	12 (52.2)	8 (61.5)	4 (40.0)
Age group (years)			
15-34	11 (47.8)	7 (53.8)	4 (40.0)
35-64	10 (43.5)	6 (46.2)	4 (40.0)
65+	2 (8.7)	0 (0)	2 (20.0)
Ethnicity			
Black or Black British	6 (26.1)	2 (15.4)	4 (40.0)
Asian or Asian British (Indian, Pakistani, Bangladeshi, other Asian)	4 (17.4)	1 (7.7)	3 (30.0)
Mixed (White/Black, White/Asian, other Mixed)	3 (13.0)	3 (23.1)	0 (0)
Not reported	10 (43.5)	7 (53.8)	3 (30.0)
Level of education			
No formal education	1 (4.3)	0 (0)	1 (10.0)
Intermediate (years 7-9)	1 (4.3)	1 (7.7)	0 (0)
Secondary (GCSE/A-level)	4 (17.4)	2 (15.4)	2 (20.0)
University (degree/diploma/technical qualification)	17 (73.9)	10 (76.9)	7 (70.0)
Sexuality			
Heterosexual	17 (73.9)	8 (61.5)	9 (90.0)
Bisexual	2 (8.7)	2 (15.4)	0 (0)
Gay	1 (4.3)	1 (7.7)	0 (0)
Not reported	3 (13.0)	2 (15.4)	1 (10.0)
Marital Status			
Single	8 (34.8)	6 (46.2)	2 (20.0)
Married/living with partner	7 (30.4)	2 (15.4)	5 (50.0)
Separated/Divorced	7 (30.4)	4 (30.8)	3 (30.0)
Widowed	1 (4.3)	1 (7.7)	0 (0)
Residence in Brighton			
1-2 years	1 (4.3)	0 (0)	1 (10.0)
More than 2 years	19 (82.6)	11 (84.6)	8 (80.0)
Not reported	3 (13.0)	2 (15.4)	1 (10.0)

Summary of focus group findings

Focus group participants reported significant obstacles in maintaining good mental health/wellbeing, including issues related to racism, acculturation difficulties and previous traumatic experiences.

The main barrier in obtaining help from existing health and mental health services was the relationship between the service providers and users. While some felt that they were being given second-class treatment because of their BME status, there was a consensus that service providers were not listening to them, understanding them or taking their needs into consideration, but rather providing them with forms and tables which they did not need/ want.

Counselling, alternative therapies, peer support groups and voluntary organisations were viewed as more helpful. However, they were often associated with other barriers, including long-waiting lists, costs, and lack of dissemination of options for alternative therapies by the doctors.

Language difficulties and stigma associated with poor mental health were also significant barriers especially among more recent arrivals to the country. On the other hand, isolation was also a common barrier mentioned by focus group participants, with family and friends being far away or, even if close by, not always being viewed as those most suited to discuss mental health-related issues. There was also consensus that, even though it is beneficial to talk to someone when one is experiencing difficult issues, men often find it harder to do so, potentially leading to substance misuse and suicide.

The solutions proposed by the participants included further and more pro-active dissemination of peer support groups and voluntary organizations by the doctors to their patients; as well as funding for alternative therapies and venues for community meetings.

There was also a proposal and request for more education on mental health within community groups. One focus group participant also suggested that the name of the mental health service be changed because of the stigma associated with it within his

community, suggesting the title ‘mental health specialist’ be substituted by ‘stress specialist’.

Finally, a number of participants found the focus group discussions therapeutic in themselves and suggested that more focus group sessions could be held in the future.

Detailed findings from focus groups

Themes

Three general themes emerged during the focus groups.

1. The first was related to **challenges in maintaining good mental health / well being**.
2. The second was related to **barriers to obtaining help needed from health and mental health services**.
3. The third was related to **suggested improvements to existing services**.

Theme 1. Challenges in maintaining good mental health / wellbeing

Participants identified a number of factors which were significant obstacles to their maintenance of good mental health and well-being. These included stressors faced in everyday life, such as racism, substance misuse, and acculturation issues, as well as previous experiences, including trauma and abuse.

1.1 Concurrent experiences as obstacles to maintaining good mental health

1.1.1. Substance misuse

I was very, I was led into this whole partying circuit, smoking and drinking. It just became really detrimental to my health. (Male J, 35-64 years, Morning Group)

like he had an addiction to Valium and things like that. (Male L, 15-34 years, Morning Group)

1.1.2. Stress

1.1.2.1. Racism

Very much what is important to us is not to have obstacles put in our way to get these things. To, er, stop us getting the education that we deserve. The job we want. We deserve. The house. You know. It’s there but we want a fair chance. And we don’t want when we get that fair chance, people to say we played the race card to get it. (group makes signs of agreement) (Female C, 35-64 years, Morning Group)

A friend of mine who is from Rwanda, he's, he's a British citizen now and he works in a Bank. He's got a good job, finished his university education and so on. But his neighbour for some reason. He was going to, he was feeling unwell and went to the GP and when he came back the neighbour started shouting at him 'you immigrants, you come here to stress our services, you don't pay rent, they are paying for you'. He starts from nowhere because of him being Black. He just assumes in his mind that he is an asylum seeker, yet he's a British citizen, he's paying his full taxes, he's got a very good job in a Bank (laughs) and he just started shouting at him at really he just felt so low that he called the police and, um, the answer got form the police was that he should, um, he should write a complain. Write a complaint against this, file a complaint against him. They did nothing. They didn't come to the place, to the place, to hear what really happened, to talk to him. And he just really feels so stressed. And what we face in our communities is sometimes too much to take, really. (Male Q,15-34, Afternoon Group)

1.1.2.2. General stress

We have a stress and pressure in our lives, we think a lot, we have a lot of problem, family problem, job problem. That all is included in mental health. Some maybe accommodation problem, family problem, or financial problem. It is maybe immigration problem. (Male O, 35-64 years, Afternoon Group)

Of course, what's she saying, the stress, when you come again in this country. Stress. Either you have your immigration status, your problems to do with that, or your accommodation. You've got depression. You've got too much stress. But all that adds up and really it makes somebody go crazy.

When you want people to help you and you go it's never enough, you're expecting more, so when you go back home you just feel down again. I remember I had some problems two years ago when I had my baby and I was feeling really depressed, everything was just going bad. When I went for housing, for accommodation, they didn't give me the help I was looking for so they just made me feel really down again. (Female R, 15-34, Afternoon Group)

1.1.3. Acculturation

1.1.3.1. Gender roles

Back home we have different jobs, husband and wife. The man work outside, they bring money, food, everything to home. The woman just sit at home, look after children, after her husband. But here, the woman, she likes to work. She works. Same as him. The man he works. The same. They bring money at home. It is equal. This is equal. They bring money both of them to pay bill, to bay rent, everything. They share. They looking after children by turn. He look, she look. The woman, they get everything to give to the man, to look after children. This is different. They think they have a power. They think

everything they do. If you speak they call the police.(...) (Male O, 35-64 years, Afternoon Group)

Women are sometimes created stress to their husbands. They think, I mean, having. We were brought up with that sort of pride of a man having a little bit powerful than a woman. When you come in here a woman now tells you, makes you feel as if you are lower than him. Anything you want to tell them. They say, if you touch me, I'll call the police. (laughter form group). You know, it stresses you. You really feel it. You cannot do anything. (Male Q,15-34, Afternoon Group)

So, the men in Sudan never wash dishes and share. (...) And the woman never put forward. The husband should be forward and the woman put back.(...) Now, those people come to this country and, they've found these things here. Their children they are growing up here so it's normal for them. But for these people it's difficult and it makes them, mentally, very hard. (Male S, 35-64, Afternoon Group)

I think, I think, because the man won't accept the changes for the woman to go to work. You know. And bring some money back home. And he won't accept that. Because back home the woman has to stay at home, cooking, cleaning, looking after the children. He brings the money and he will be like a King. She will be like a slave, cooking and do all the things. Once she come here and go to work and bring some money and if she raise her voice a little bit that means she is naughty, she is not listening to him. And they won't accept that. This is why they put themselves, the stress, they become really, the stress level becomes really high. Because they can't really. If they sat down and talked to her I think they'd solve the problem. But they can't really talk. This is why they've kept it to themselves. (Female T, 35-64, Afternoon Group)

1.1.3.2. Raising children

Even your own child. You can't even smack your own child. A few smacks. (Male Q,15-34, Afternoon Group)

And specialist actually said to me 'forget about Japanese mother. Put Japanese mother in a box and put the lid on. Pretend. Do English mother.' I am not British mother. I am the person to lost my children because of such a stupid system. Emotional abuse, physical abuse, neglect and hygiene. My house has no problem with hygiene. Because the Japanese culture we must take shoes off to make clean. Everything we have we must clean up. Every single day we have to change clothes. Every single day we have to shower. Every single day, as a child, have to study. But this kind of thing they don't understand. Those kind of things make feel poor, make me feel down.(...) (Female D, 15-34 years, Morning Group)

1.2 Past experiences as obstacles to maintaining good mental health

1.2.1.Trauma and abuse

I'd been though a car crash that was really serious, it involved seven people and I was, like, on the verge on death. It was very impactive. It was the after trauma. (Female I, 15-34 years, Morning Group)

I grew up in foster care and I have my own whole range of issues that follow me and I'm having to deal with and I studied counselling. (Female E, 15-34 years, Morning Group)

And the mental health as well if anyone has been, he or she, has lost somebody, his feelings are not good. And also if anyone abused from a child or been badly treated it will affect their mental health. (Female P, 35-64 years, Afternoon Group)

For us, we come personally from Congo, where we have been through the trauma of war and we've seen so many things which, a picture that we'll probably never erase from our head. Seeing people being, chopped heads. As small kids seeing things like that will forever remain in your head. And really it's the brain to do with all of this. (Male Q, 15-34, Afternoon Group)

Theme 2. Barriers to obtaining help needed from health and mental health services

2.1 Relationship between the health service providers and the users – Issues related to racism or cultural differences

Among these issues were those related to culture or race, including racism and a perception that the service providers simply did not understand them or their experiences.

I was talking to a friend, and she's from Spain. She was using an English surname as she's married to an English guy. And since she changed her surname she had the feeling that, I don't know, that she's not being treated like before. Anyway, with her GP. (Female A, 35-64 years, Morning Group)

And so people don't trust psychiatrists particularly. I'm not saying this is general for everyone but from my own experience in my own community there trust is about the same as for the police. And that's not a great deal of trust. (Male B, 15-34 years, Morning Group)

Later I hear my son speaking to his white father and the father is saying 'what is happening?' and my son says 'I think the doctor thinks she did her Jamaican bit'. (...) Well, I tried to find a therapist, someone who could understand my experience. I go to an acupuncturist and you are a life saver because you look a bit like me, you look a bit like my son. (Female C, 35-64 years, Morning Group)

And I've also found that when you, for instance, talk about racism that actually a lot of them (therapists) can't deal with it...So you find that actually, although you are supposed to receive the counselling or the therapy, explaining to them the Black experience. 'Cos there's one thing – I'd like to see more Black therapists. (Female D, 35-64 years, Morning Group)

And again, I had to explain, as loads of this stuff came up, about my mum and her experience of racism, and again I had to explain. And I'm, like, I'm not going to explain my flipping experience to you. You know, this is crap. (...)I want to see someone like me, someone who understands my culture who, when I walk through the door, is going to welcome me with open arms and is going to get what I'm saying. (Group makes noises of agreement) (Female E, 15-34 years, Morning Group)

I was required to see a specialist called a psychiatrist and I think the psychiatrist could understand what I was talking about because he come from outside the country. He's not British, not white British. So he understood what's different between here and outside the country. (Female D, 15-34 years, Morning Group)

You know, I got an English friend and she say to me she's got the same problem. And, er, she said she went to her GP and her GP transferred her to her consultant to see her problem and her problem was solved. Why shouldn't my GP transfer me to consultant instead of giving me different tablet every time? It gives me more stress and makes my pain all the time. It's not on and I just feel like I'm really angry and really frustrated because they transferred her because she's English and I'm not English. Transfer her. And I just feel like there's a compare because I'm not English and she's English she's better than me and that makes me really stressed.(...) They will transfer you after your illness has become really worse. (Female T, 35-64 years, Afternoon Group)

Because we pay the same as English people. I mean, that's not fair. We need to, we need equality. (Female R, 15-34 years, Afternoon Group)

They say that if you are foreigner they (doctors) will stress you more and more and more (group laughs). (Female V, 15-34 years, Afternoon Group)

2.2 General dissatisfaction with health service provider's response to their needs

There were also a number of instances in which the main barrier was not related to racial or cultural differences, but to the more general way in which service providers were responding to them and their needs (i.e., brushing aside their concerns, not 'connecting' with them, providing them with forms and tablets rather than the support they really need, maintaining a stance of authority).

She's, she's a doctor so she's very professional, however, she learnt what she learnt from books or from university but she never sample reality. She never knew about reality life. Especially specialists who are actually educated, degree or whatever. For me they are ignorant. They don't see. They put you in a category. So even though something just happens, for them it seems to be something wrong. They are not thinking. They try to tell us what's right. (Female F, 35-64 years, Morning Group)

I tried a counsellor, but at the first session I realised that I was uncomfortable as I didn't want to talk to this person. Yet when I went to the homeopath...I think it depends who you connect with. It's who you feel, there's no barriers there. That person who you meet and you can talk to. (...)So I went to this guy and said, all these years of doctoring, and you treat everybody with the same brush, you know, everybody's different. I'm telling you something's wrong. Why don't you listen? And then there was, like, this clunk. And from then on he wasn't so nice. Because you've challenged them. Because basically you go in and they just want to, you know, you are just like the next person. They don't take time to listen to you. And I don't think it's because of colour or anything like that. In talking to a lot of people, including white people, they encounter the same thing, so. (Female I, 15-34 years, Morning Group)

Can I just feed into that because this is something that, I sometimes experience that when I wanted to use a therapist. I found myself humouring the therapist so that they can actually give me the help that I really need. (Female D, 35-64 years, Morning Group)

Yeah 'cos I couldn't get any help. (...)And I asked for a change of CPN and they crossed me off and said that, you know. She wasn't able to give me what I needed. I got made an appointment to see a psychiatrist and the psychiatrist said that we can no longer offer you any services or help. I was just left to get on with it. (Male J, 35-64 years, Morning Group)

I where to go to find help is really hard because when you do get to a doctor's surgery then tend to be really hostile 'cos the people on reception are always like, brushing you aside, I know there, like, they've got loads of people and they've got a hard job but I actually found it much more rewarding to go to talk to the chemist at Boots. (Group laughs). It tends to be the people at the ground level who you can actually interact with. When I was talking to my doctor it felt like there was this big window between us. (Female K, 15-34 years, Morning Group)

We go to the osteopaths, we go to the acupuncturists. And what is in common with all these is that we are trying to access people who will listen to us, who will allow us to talk.(...). So, you know, do you sleep worse, do you eat badly? He'd make the easiest answers. They're lies. What is wrong with the doctors? But you see they absolve themselves of responsibility because they have given a form. (Female C, 35-64 years, Morning Group)

And mum had to get him to have appointments to get him to talk about stuff, like he had an addiction to Valium and things like that. The way it was dealt with, I think he needed a lot of support. You could tell. Seeing the situation with my mum and that you could tell but looking at him at an administrative level the GPs and the psychiatrists were saying there's nothing wrong with him. That was when they were finally getting back involved in his life, the day that he died. What I was thinking has come up quite a lot is this clash between experiential knowledge of yourself, of your body, of your health and professional knowledge. And how there's this clash between the professional expertise that the doctor has and is often given privilege over someone's knowledge about their own mental state and mental health and experiences. Because of the lack of this kind of experiential knowledge amongst those people who are clinically trained, because they've not had to face a lot of the things that we've talked about the this room today it means that they don't have an understanding of where the person going to see them is coming from. (Male L, 15-34 years, Morning Group)

I was depressed and I went to see my doctor and I was expecting her to tell me about the services out there but unfortunately she just said to me, oh just fill this form in and say how your mood is and I'll give you some antidepressants. You know, I just felt like there's no point in me coming here. You know. I'm trying to get help form you but I'm not getting it. You're giving me pills that I don't want. (Female G, 15-34 years, Morning Group)

She went to the health clinic in the University and the immediate offer that she was given was a prescription of mood normalising drugs. She made the judgement not to take them. (...) She had the choice between medication and down the line when her situation declined then you've got the opportunity to be sectioned, which isn't really an opportunity. (...)They (doctors) have the power. They have the power simply with the stroke of a pen to decide whether you are going to be sectioned or whether you are going to be sent away for some counselling. Or whether you are going to be administered some really, really high doses of whatever kind of medicine, do you know what I mean? (...) Or option two, which I think is what needs to happen, which is a shift in the way that mental health practitioners are trained. So they do have a bit more awareness of the kind of experiential knowledge and of the experiences that people go through so that they can begin to understand why people might be coming to them or so that they begin to ask more questions of themselves about the person coming to them so that they had begin to form a more balanced relationship. So it's more of a dialog rather than being talked down to in a patient or client relationship. That's what I think. (Male B, 15-34 years, Morning Group)

I would wish that there is a suggestion box in, um, the clinic or something. Which, because, sometimes you are not satisfied with the services the GP provides and if you had a option that you can write which you think is confidential, you can write it and put it in there I just felt, I went there and I didn't really see that there was any help what so ever. And when I went home I expected a letter or something asking how did that help at all? Or if there were suggestions I would say how I felt. (Male Q,15-34 years, Afternoon Group)

And they always give you Paracetamol as well. (group laughs) (...)So, I went to my GP and he just tried giving me medicine(for post-natal depression). It didn't help. When you have three kids, or something like that, you don't need to take that all the time. You are just feeling tired and tired. It didn't really, really make a difference. (Female R, 15-34 years, Afternoon Group)

Then, the last 10 minutes he say, it's better to give you an injection. I told him no I don't want injection in my spine. And then the 30 minutes finished. I didn't get anything. So I keep it for myself. I get stress and depression. He send a letter to my GP. This letter saying we discussed with him and told him everything. But they told me nothing. (Male S, 35-64 years, Afternoon Group)

The second option, you have to go to your doctor. Your doctor, like he mentioned, he is going to find your problem form your blood or from your kidney or urine or something, he not venture into your mind, mental problem. (Male O, 35-64 years, Afternoon Group)

If they are sending many times, 2 or 3 times, to specialist, then when they go to specialist they can't mention their problem. They can't properly talk to the doctor. So, the doctor do a physical and say, oh, you don't have any problems. When they go home, that's when they still have illness, still have problem. Then, you don't want to go back again to GP because you don't want more to explain their problems. Then they remain with their stress. They don't know how to explain their problems. That's why they don't want to go to GP many times. So they remain with their illness. That is our big problem. (Male W, 15-35 years, Afternoon Group)

... if you've got problem and you go the first time and the GP gives you some tablet and it's not really helping and you go back again they give you a different one and it's not helping. They make you really stress more and more (...) And you want to solve your problem you go to your GP and there's no help you know. They never really direct you to the right person to go to solve your problem or anything. Instead of that they make your stress level go higher instead of put it down. (Female T, 35-64 years, Afternoon Group)

2.3 Long waiting lists

While many thought their needs were not being met by the tablets offered by their doctors, mention was also made of the long waiting lists to see a counsellor, especially in the University setting.

Well. I was having a nervous breakdown while I was doing my A-levels as an adult and I went to the doctor and it took six months for me to receive a letter saying that I was going to be given counselling. Six months, six months! You know, in six months you recover! (the group laughs) Well I didn't kid myself. (Female A, 35-64 years, Morning Group)

He now 6 months on waiting list – my friend's son. He died about 2 weeks ago. Six months to get in the university, to get to see a counsellor. Doesn't it beg the question 'what's wrong with the university system that there's such as demand?' There's such a long waiting list, and why haven't they got sufficient people to address these.....? This is our future, these young men. You know. What is happening? (Female C, 35-64 years, Morning Group)

And when this began to happen she got in touch with the counsellors at Sussex University where we attend and tried to get some support and she was told there was a four month waiting list before she could get any support.(...) (Male B, 15-34 years, Morning Group)

Citizen's Advice Bureau and other bureaus have long waiting lists. (Male U, 65+ years, Afternoon Group)

2.4 Cost of alternative therapy / support

Some individuals turned to alternative therapy and peer support groups because their needs were not being met by doctors/counsellors, but some of these were associated with additional barriers related to cost.

And I found a homeopath who was absolutely fantastic. (group nods) And still is, you know. And she, treated me. (...) homeopathy is not something they (doctors) agree with because they treat you all with the same brush. If you want the alternatives you have to physically go and find them and you have to pay. (Female I, 15-34 years, Morning Group)

Yes, you have to pay. (Female D, 35-64 years, Morning Group)

That's what I needed after the A-levels and the break down. I started university and I started paying a homeopath. But I had to go with a student as I didn't have a penny and the NHS didn't offer that and I survived all the way through university because of homeopathy. Sometimes I go to the women's centre, as they have a volunteer there who is a professional homeopath. (Female A, 35-64 years, Morning Group)

I went elsewhere and did some homeopathy stuff and that actually helped a bit more. I went to see an osteopath. Fortunately, I had parents who supported that. It was never made available to me, (Male B, 15-34 years, Morning Group)

'Relate' costs you money. (Male U, 65+ years, Afternoon Group)

(...) So we cannot afford to come (together as a community in a hired hall) every two weeks so that's why we stopped. And when they come you can see they're happy, they're enjoying themselves. (Female R, 15-34 years, Afternoon Group)

We can't afford it (to hire a hall for community meetings). You can apply for council funding but you have to have this and that. (Male Q, 15-34 years, Afternoon Group)

2.5 Language

Language was also seen as a barrier for those who had just recently come to this country or those who came to this country when they were older.

But they've got nowhere to turn with limited language. (Male U, 65+ years, Afternoon Group)

I think that the language is also a barrier to some times for our, for people. They cannot speak English. I think that puts them in a stress because they cannot really tell their feeling or tell you what they want to say. If they go to, like, hospital or go to the bank or anywhere, you know, they can't really say whatever they want to say. And that, with the language. (Female T, 35-64 years, Afternoon Group)

But since I came to this country I have seen improvement in that way because when you go somewhere they always ask in which language you want and they try to have somebody for that. But when I came first time in this country it was not like that. You had to deal with yourself. You have to say in English or another. Most of the organisations have a person. (Female R, 15-34 years, Afternoon Group)

Because most of time there aren't interpreter. The interpreter service does not send interpreter to the GP because of 10 minute time. So, most of the time they have problem to send to GP. If the hospital, they send you. (Male O, 35-64 years, Afternoon Group)

That is big problem again (..). Because they don't ask them which language do you understand very well. They bring it (interpreters) from everywhere. For example, I speak Amharic language but some people (from the same country) may not speak Amharic. That person is only speaking their own language and there is a problem again. (Male W, 15-34 years, Afternoon Group)

English I no (sic) very well. But when I came here I didn't speak any English. But now it's better but I only talk a little bit. Er, it's difficult for me. (Male Y, 35-64 years, Afternoon Group)

2.6 Not knowing/ not willing / not being able to get help on your own

This was another common barrier, especially among men. It was often linked to isolation and mentioned in connection with severe consequences, such as substance misuse and suicide.

And I wished I had actually got help earlier on but I just didn't know what it was. I used to, like, panic constantly but I thought it's probably like everyone, its normal. You know,

everyone feels the same, like me. But it's really bad.(...) And I'm thinkin' 'oh no, I'm breaking down here'. (group all laughs in agreement) I end up turning to drugs and alcohol. It's the only thing, you know. (...) And, you know, I've been a very depressed person for a very long time and it's like the relationship I had with my mum. It's not like I could go and talk to her and it's like you don't mention certain things, you keep them to yourself.(...) And sometimes you just don't want to worry your family, you know. (Female G, 15-34 years, Morning Group).

when my sister got really ill and everybody within my friends and family needed someone to rely on and that turned out to be me. So it was me who needed to go out and find external help. It's funny how, like, if you're family structure breaks down you find yourself so incredibly isolated. Its then that you might realise that, it's not to do with intelligence or anything, it's just like, where to go to find help is really hard (...)So, he (family doctor) said that I had to find a doctor in Brighton but I got to Brighton and I didn't have an address so I couldn't register with a doctor's to talk to anyone. So in the end I just like ended up riding it out.(...) Like, I just need to talk to somebody outside of my family. (Female K, 15-34 years, Morning Group)

It's especially difficult, I think, having seen my brothers. They don't, they're not as willing to go and share their stuff with a stranger in that way (talking to a homeopath). I don't think the services are that available for men of colour who have mental health issues.(...) You can have people with mental health issues and they don't want to accept it. They don't want to take that help form anyone. They have a belief that what they think is right, so you're not going to be able to reach them. Especially, my brother's condition, it was a case of, because he wasn't asking for help himself. Because he was a certain age and he was a guy as well. There's lots of Black men that this has happened to. And if they didn't have somebody like my mum they would end up on the streets or they end up back in prison. (Male L, 15-34 years, Morning Group)

Yeah, about confidentiality, when you said about family, my hiccup with that is that sometimes, a lot of the time actually, there are problems that you'd rather talk about with anybody else than your direct family or people that you know every day. That's where I think peer support groups become very important because you can share problems that you wouldn't even begin to talk with your family. (...) You know, let's be honest, most people can cope but when people cannot cope most people's first refuge is alcohol. Drugs. Yeah, that's my experience. I don't know if I'm living in a special world or if everybody's experience that. (group makes agreeing noises) The coping mechanism for most people is to go the drugs and alcohol.(...) And also what I mentioned about drugs and alcohol goes all the way to self-harm and suicide. That should also be logged in. It doesn't have to stop at feeling bad. People go all the way and I have friends who have. (Male M, 15-34 years, Morning Group)

And obviously with family elsewhere you don't have that kind of support available to you, so you only have your peers at university and we're third years so we were also dealing with dissertations at this time and a lot of studies so there weren't that many people

available to her, except for one or two of her close friends. (...) And if they're not available (family, friends, informal structures) they go back to the direction that you mentioned, towards the drug and alcohol route.(...) And for those who don't have those family structures its friends on the street and that leads to different issues. That's the route that gets turned towards as the structures are not immediately available. (Male B, 15-34 years, Morning Group)

(...) a lot of us don't have family in this country.(...) And there is really something about this isolation, and I mean that when I look at you, some of you are now my family. And some of us cannot speak to our families. Whether they're abroad. And I think that this is something the mental health service does not always understand. That we are really, really isolated. (Female D, 35-64 years, Morning Group)

My son now is a drinker. And last week I was 48 hours on the phone because he was killing himself with alcohol. The police were called to him. (Female C, 35-64 years, Morning Group)

And what we face in our communities is sometimes too much to take, really. You feel so low you just decide, well, I better keep quiet.(...) Men, we tend to keep things to ourselves. We don't think that by exposing our own insides to outside will bring any solution at all.(...) because if you are stressed you end up drinking alcohol, and you start behaving, or beating people, or... (...). There are single people as well. Young men and young women who live alone and don't have that chance of having someone to talk to when they, and really we've been mostly talking about families and we're not talking about single, young people who live alone, cos we do have many of them in our community. They come in and they give them a small room somewhere, they have nobody. No parents, no relative what so ever. The environment is so hostile they can't talk to neighbours as we've said. You can live in the UK for years with your neighbours and you don't even know them. You can't even talk to them. You are confined in this room and really all what is going on is whatever they can do for themselves.(...) They can't talk to no one until the end of the month when we meet and you see them just sat there and they're really, you and just tell that this person is really done, there is something wrong with them. And only when you talk to them they are open to you. (Male Q, 15-34 years, Afternoon Group)

Something happened in our community last year, our brother, our community member. Last year, his problem, he doesn't talk to someone else, he doesn't tell his problem. Talk himself inside. But he can't talk with the people, he can't ask for help. Just go inside his garden and hung himself. Hung himself and he is dead. He left his four children here in Brighton.(...) Like a man doesn't have respect, everything changed. That's why most mans been in stress situation at home but nobody talking, nobody shares his problem. This is personal problem. And in that situation most mans be danger. We see in this country the woman has a right. If she has a right, if she has a problem she can tell her problem. The man does not have right. Who give man right? No, just woman right.(...) Actually, if we needed to help someone, the first thing, the person who need help, they

need to help us first. He can help us to tell his problem first. If you are not telling him your problem, the doctor can't help you. Because the doctor is not God, he can't tell what is happening to you. Some people is rude, is actually rude. If you tell him, 'I feel you are feeling stress or you are feeling depressed', some of them it is open. 'Yes, my friend, I feel stress', or something. 'Please could you help me', he say. Good person. Otherwise, the other one, he give you shout. Tell you you are rude. 'Did I tell you I have a problem? Go away!'. That's why we have to find which way and talk to them. You need some experience people to talk to the people. I believe that. (Male O, 35-64 years, Afternoon Group)

I feel sorry I can't tell my problem to all (in the focus group – group laughs).Maybe when we talk, also all of us, sometime to tell our little problem we talk more and if you feel for that also, not happy (worried about making others unhappy if he talks about his problem). (Male Y, 35-64 years, Afternoon Group)

Excerpt below is from a dialogue between three participants in the Afternoon Session

I feel this pride. I am a man, I can sort it out. (laughs) (Male Q, 15-34 years)
African men. (Female R, 15-34 years)
Well, African men. (Male Q, 15-34 years)
Trust me. Most of the men, its African men. (Female R, 15-34 years)
Arrogant.(Female T, 35-64 years)
Yes, they are arrogant. (Female R, 15-34 years)
It's not arrogance. (Male Q, 15-34 years)
You know, they never share anything. If they have got problems. Not even the wife. They never really share that problem with her. Oh, they just think, he is really strong, he can take it. (Female T, 35-64 years)
Yes, yes. (Female R, 15-34 years)
And at the end of the day, yeah, he can take it, but one day he will rock up. (Female T, 15-34 years)

2.7 Stigma

A number of participants alluded that poor mental health was often viewed as a sign of weakness within BME communities. This was also linked to references of people not knowing/being willing/being able to get help.

You know, 'cos sometimes I tell my friends I'm getting counselling and they tell me 'Oh, what's wrong with you?' 'Cos certainly in the Black culture it's like 'come on, you can deal with it'. You're supposed to be strong, you're form Africa. And I'm thinkin' 'oh no, I'm breaking down here'. (group all laughs in agreement) (...) it's like you don't mention certain things, you keep them to yourself.(...) And sometimes you just don't want to worry your family, you know. (Female G, 15-34 years, Morning Group).

'Cos there's one thing – I'd like to see more Black therapists. And whilst I'm saying that, at the same time, they need to realise that there are taboos in our communities. And that means if I were to see maybe a Liberian psychiatrist I might not want to go that that Liberian psychiatrist because he's part of my community and its like, oh God you know there's something wrong with my mind. I don't want you to know that. For me that's really important, to keep a kind of confidentiality and dignity around that. Because as you said, a lot of African communities, we don't talk about it. (Female D,35-64 years, Morning Group)

Some of them, they say that if you go to the mental health doctor there is shame. What happened to him? And they want to know what is wrong with the patient. (Female V, 15-34 years, Afternoon Session)

Let our name be different to help the people because our people they don't need the mental health cos they think mental health, they help crazy people only. (group laughs) Mental health service, our people, I told you, if you refer him there, he never go. 'No! I'm not crazy, why you refer me there?' No, never go. That's why we need not to refer people to mental health service. (...)That's why we have to ask people to tell us their problem they have, if they can tell. If you don't want to tell us, if you feel shame, please take this contact, contact these people.(...) But interpreting is confidentiality. Should be made someone, not your friend. Different. Like, medical or anything. This is your issue, your secret issue. (...) (Male O, 35-64 years, Afternoon Session)

He's right, I might talk to a friend and he will be. He will probably keep quiet today but (laughs) if after today he may not be so understanding. (Male Q, 15-34 years, Afternoon Session)

And, if your thinking of changing 'mental', don't for heaven's sake substitute depression for it because our people are sturdy people and they regard depression as just nonsense and just spineless people who think up feeble excuses. They don't believe in depression; they would never accept it. So if your changing the name form 'mental' to something else don't for heaven's sake introduce depression. (Male U, 65+ years, Afternoon Session) And in our country, if in family, somebody mental, they hide it, hide it, until last minute when it is very bad. (...) because in our country if you hear about somebody in this family sick, is mental, you lose trust in this person and whole family, maybe relative as well. And, er, they whisper on this person, they whisper on all family and maybe talk about grandmother, grandfather, and they lose the respect and mercy and nobody employ.(...) I come from Sudan and if you feel somebody is mental, you know, er, they hear himself or see him but hide it from anybody so you can't see the symptom and then, er, if you tell those in authority, please my friend is mental and I'm worried, then what will happen? I am from Sudan. My community will come to me and say, why you doing this to him? Cos in our culture, in our country, it is wrong. (Male S, 35-64 years, Afternoon Session)

Some people, they are really ashamed. They don't want to tell what they are going through but they must. (Female R, 15-34 years, Afternoon Session)

Theme 3. Suggested improvements to existing services

3.1 Wider dissemination/advertisement of existing services

The group suggested further dissemination of existing services; and pro-active recommendation of peer support groups and voluntary organisations, especially by doctors.

I want her (doctor) to talk to me and tell me, OK there are services out there you can go and get help, go talk to someone. (Female G, 15-34 years, Morning Session)

You know, we are sitting here and saying we need all this but you know, when we access the doctors if they don't know that there are these kind of groups we can turn to then it's a futile exercise. The doctor is also, you know, human. They need information too. That there are all these other groups that people can get help from. (Female I, 15-34 years, Morning Session)

All GP's need to be aware of community organisations, 'cos they're not. If they're not equipped to deal with us I'd rather they sent us to a support group, a peer support group (several people say yes and nod). A BME peer support group rather than tell us crap, basically. It's therefore the PCT's responsibility to inform the GPs on Sussex campus, Brighton campus, all over Brighton, everywhere in the surrounding areas where these community groups are. Because it is unrealistic to say that a GP is going to be able to solve all of this because you can't. (Female E, 15-34 years, Morning Session)
Because the GP didn't recommend any kind of organisation. They have been a life saver – we need more. When you are depressed you can't find these people. (the group agrees)(...) But you need also for the doctors not to be saying there is a leaflet and such and such a place but for the doctor to say do I have permission to get in touch with these groups for them to get in touch with you? You are depressed. You need that. (Female C, 35-64 years, Morning Session)

I had support networks and friends who had been through the system, friends who had tried certain methods that had helped them through nutrition, health. (Male J, 35-64 years, Morning Group)

I've got some friends who have got some problems. They've gone to the Buddhist Centre to do some meditation. You can just go there and give a donation and meditate and that helps them in their mind and with their problems that they're going through. (Male N, 15-34 years)

[You need] to find someone who can listen to your problem, otherwise you have to find solution from outside.(...) the people who have experience or the people organised to help these people who have a problem. Like, organising for us sports, fitness club,

something like that. Because people in that session come together, er, talk together, enjoy together. Learn and do exercise. More, something like that. Not sport only, different things to make people enjoy, to forget his problem. If BMEC(P) can't solve my problem he can tell us where we go. I can't help you in this problem, in this situation, but I can tell you where you go and even I can provide someone to talk to you. 'We can't help you and go'. We can't say that. (Male O, 34-65 years, Afternoon Session)

One of my sisters, she's a post natal worker in the community. We talk a lot. So some time, it really helps. You need to talk to somebody when you're having problems, definitely. Not to keep that to yourself.(...). For me, it's the solution. When I have a problem I talk to all the people around me. (group makes noises of agreement) So it makes me feel better. That's my advice. If you are having anything you should talk, like, to a friend. When you go to work you could find somebody you could talk to well. Just don't keep it to yourself. (Female R, 15-34 years)

You see, the community groups now, it helps. It's very good. You see everyone they know, you. All the community's as a group, you know. They look after each other and they, you know, start to know. And individually groups of men, or, ladies and do some sports and also they help us do some activities. And it lets the ladies come out form the stress and we talk to each other.(Female T, 35-64 years)

3.2 Health education need about mental health/wellbeing in the BME community

The group suggested that it would be most helpful if a mental health expert came to their communities to talk about mental health. They voiced a need for education, guidance and even re-naming the mental health service to de-stigmatize it, as well as information on what other services were available to them outside the NHS mental health service.

Yes, if possible from my, er, from my community, I need someone from the NHS or someone to come to our community meeting. Just to talk to them about the mental health, what is the mental health. To know if anybody feels that mental health, this is not bad. Just to know where to go. (Female R, 15-34 years, Afternoon Session)
That is a very good point she raises. We would really encourage, maybe even twice a year or once in a year for the NHS to contact, to be in touch with this community groups like ours. We meet every month and if we had someone to visit us once and talk to these groups for this mental health they would be happy to confide in this person (...). (Male Q, 15-34 years, Afternoon Session)

So, the problem is knowledge. How do we give knowledge for everyone? Not just for this person who is mental. For everybody. So it is knowledge. (Male S, 35-64 years, Afternoon Session)

Like I mentioned, family problem he need to be educate, we need someone experienced, someone to give advice for all, for all families because all people who come from foreign countries they have, everybody has different cultures. And here different culture, different. It is totally separate. Separate, But, but, we all believe, human right. All believe the same, all the same, can work together, can help all together. But we need to know the right who, everybody. The type of right he have. The limited right the man has. The man has this limited type, the woman has this limited type. She have to respect him, he have to respect her. How can they live together without any stress but with love, with everything. They need someone to teach to the people. All for the people, not one or two, all of us. (Male O, 35-64 years, Afternoon Session)

But we don't know where we go. Only we don't know how we get help or we don't know how we sort it out this problem. And we still waiting from you to helping us. (Male Y, 35-64 years, Afternoon Session)

Participants' feedback on the conduct / benefit of the focus groups

A number of participants gave positive feedback about the conduct of the focus groups (by writing comments in the questionnaire distributed at the end of the session). The comments suggested that the focus group served as a form of peer support group and was itself therapeutic.

You did really helped. (Female, 15-34, Afternoon Session)

Very enjoyable afternoon -- & instructive. (Male, 65+, Afternoon Session)

Thank you! (Male, 35-64, Afternoon Session)

Thank you big so much for your invitation, it was extremely helpful. (Male, 15-34, Afternoon Session)

I[t] was help full and I have learn so much about health mental but they still more answers to be found. (Female, 15-34, Afternoon Session)

Really enjoyed the group. Learned a lot about mental health and shared different ideas, which kind of open my mind up and don't really feel alone anymore (Female, 15-34, Morning Session)

I really enjoy it I hope good things come out of it for the good of everybody mental health. (Female, 35-64, Afternoon Session)

Very interesting session. There should be more of these to really solidify and get things going. (Female, 35-64, Morning Session)

Its been an amazing morning, lots of so many relevant conversations about what we as people, as a community really need to help our mental well being. I hope that those powers above are going to really act on the information that has been shared from our hearts and feelings of discomfort we as a people have experienced. I will wish for being heard and a positive outcome. (Male, 35-64, Morning Session)

Let's have more of these sessions. It would help if more people attended the session as from these discussions we learn a lot. (Male, 15-34, Morning Session)

BME Community Survey

Overview and aims

A BME community survey was conducted in 2010 by the Public Health Directorate and Mental Health Team at the NHS Brighton & Hove in collaboration with the BME Community Partnership (BMECP) **and Sussex Partnership Foundation Trust.** The aim of the survey was to assess the need for and sources of mental health-related support sought in the past 12 months, and the barriers encountered in accessing this support among BME group members.

Methods

A brief quantitative questionnaire was developed by the Mental Health / Wellbeing Study Group with space for additional participant comments. The self-administered questionnaire was distributed by the two community **development** BME mental health workers (PK, EH). From April to June 2010 the questionnaires were handed-out and collected in community settings among BME individuals aged 15 or older known to the mental health workers. At the time of questionnaire completion, individuals were also invited to participate in focus groups as part of the study.

Analyses

Responses to quantitative questions were organized in frequency tables. Written comments were reviewed and grouped into themes by one of the researchers (LM).

Participant characteristics

Table 1 shows the characteristics of the 50 BME individuals who participated in the survey.

- About half of the participants were women (n=29, 58%).
- The majority (n=24, 48%) were middle-aged, with 38% being younger (15-34 years) and 14% being 65 or older.
- The ethnic group represented by the largest number of participants was 'Mixed' (n=18, 36%).
- About half had professional qualifications (n=26, 52%).
- 4 out of 5 participants reported being heterosexual.
- 46% were single, 28% were married or living with a partner, 20% were separated/divorced, and 2% were widowed.
- 82% had been living in Brighton & Hove for over 2 years.

Table 1. Characteristics of the community survey participants

	All (n=50) **N (%)**
Gender	
Male	20 (40.0)
Female	29 (58.0)
Missing	1 (2.0)
Age group (years)	
15-34	19 (38.0)
35-64	24 (48.0)
65+	7 (14.0)
Ethnicity	
Mixed (White/Black Caribbean, White/Black African, White/Asian, other mixed)	18 (36.0)
Black or Black British	10 (20.0)
White (British, Irish or other White)	8 (16.0)
Asian or Asian British (Indian, Pakistani, Bangladeshi, other Asian)	4 (8.0)
Chinese (Chinese, or other ethnic group)	3 (6.0)
Level of education	
No formal education	1 (2.0)
Primary (yrs 1-6)	5 (10.0)
Intermediate (yrs 7-9)	4 (8.0)
Secondary (GCSE/A-level)	14 (28.0)
University (degree/diploma/technical qualification)	26 (52.0)
Sexuality	
Heterosexual	40 (80.0)
Gay	3 (6.0)
Lesbian	2 (4.0)
Bisexual	1 (2.0)
Missing	4 (8.0)

Marital status	
Single	23 (46.0)
Married/Civil partnership/Living with partner	14 (28.0)
Separated/Divorced	10 (20.0)
Widowed	1 (2.0)
Missing	2 (4.0)
Residence in Brighton	
1-2 years	6 (12.0)
More than 2 years	41 (82.0)
Missing	3 (6.0)

Summary findings from the survey

This questionnaire survey provided useful information in relation to the need for and sources of mental health-related support sought by members of the BME community in the past 12 months. It also provided information as to the barriers encountered by these individuals in accessing this support.

While it must be noted that these respondents may not be representative of the BME population in Brighton & Hove, the age distribution of participants was not only similar to that of the population of Brighton & Hove, but the large number of participants in the younger age group reflects the younger demographic of the BME population in the city (http://www.bhlis.org/resource/view?resourceId=807). The high proportion of those expressing the need for mental health support in the past 12 months (n=36, 72%) confirms that the participants were known to the community mental health workers and were invited to participate in the needs assessment because of their experience of mental health services.

The six most popular sources of support sought were equally divided between professional and lay sources. The Sussex Partnership Foundation Trust, psychological therapy/counselling and alternative therapies were the most commonly sought professional sources, and friends, family and cultural support were the most common lay sources.

Stigma was mentioned by many as a significant barrier to accessing support both as a response in the questionnaire and in the comments section. The commonly-mentioned barrier that services were inappropriate for cultural norms and beliefs and additional related questionnaire responses and comments suggest that there is difficulty in establishing a positive relationship between providers and users (especially among providers who do not understand them/listen to them/treat them as equals/allow them to participate in determining their care), and that users do not feel like their needs are being met by providers. Other barriers were also mentioned, including long waiting lists for counselling services and the lack of information and/or funding for alternative therapies. Language was also a considerable barrier for some. On the other hand, 4 individuals also had very positive comments on BME peer support groups.

Detailed findings from the survey

Need and sources of mental health support

Table 2. Need for help

	All (n=50)
	n (%)
In the last 12 months, have you felt so unhappy or anxious that you needed to ask for help?	
Yes	36 (72.0)
No	12 (24.0)
Missing	*2 (4.0)*

- In the past 12 months, 72% of participants felt so unhappy or anxious that they needed to ask for help.

Table 3. Sources of help sought by those who needed help

	Needed help (n=36) N (%)
Of those who felt they needed help, from whom did they ask for help	
Sussex Partnership Foundation Trust – mental health/ wellbeing services	22 (61.1)
Friends' support	21 (58.3)
Psychological therapy/ counselling	16 (44.4)
Family support	14 (38.9)
Complementary services (such as acupuncture, aromatherapy, Reiki or reflexology)	13 (36.1)
Cultural support	12 (33.3)
Voluntary sector organisations providing mental health services (e.g. Mind, Rethink, BHT)	9 (25.0)
Other voluntary sector organisations (e.g. Samaritans, Oasis, Age Concern, YMCA)	5 (13.9)
Religious support	5 (13.9)
Neighbours' support	3 (8.3)
Other	10 (27.8)

Notes: BHT: Brighton Housing Trust; Percentages do not add up to 100 due to multiple responses.

- The top three professional sources of support sought by those who felt they needed help were the Sussex Partnership Foundation Trust – mental health/wellbeing services

(n=22, 61%), psychological therapy/counselling (n=16, 44%), and complementary services (n=13, 36%).

- The top three lay sources of support were friends' support (n=21, 58%), family support (n=14, 39%), and cultural support (n=12, 33%).

Barriers in accessing mental health services

Table 4. Experience of barriers in accessing mental health services

	Needed help (n=36)	**All (n=50)**
	n (%)	**n (%)**
Did you experience any barriers in accessing any of these mental health services?		
Yes	29 (80.6)	32 (64.0)
No	7 (19.4)	12 (24.0)
Missing	*0 (0.0)*	*6 (12.0)*

- Three respondents who did not report having to seek help in the past 12 months also reported experiencing barriers in accessing mental health services.
- Four out of 5 participants who did have the need for help in the past 12 months experienced barriers in accessing mental health services.

Table 5. Types of barrier experienced in accessing mental health/wellbeing services

	Needed help (n=36)	**All (n=50)**
	n (%)	**n (%)**
What were the barriers experienced in asking for help?		
I did not want to be seen entering these health services as mental health is seen as a negative condition in my community	15 (41.7)	16 (32.0)
These health services were not appropriate for my cultural norms/beliefs	10 (27.8)	10 (20.0)
I could not afford the travelling cost to these health services	9 (25.0)	9 (18.0)
I assumed these health services were only for white people	9 (25.0)	9 (18.0)
I did not know that these mental health services existed	5 (13.9)	6 (12.0)
I feared that accessing these health services may affect my benefits	4 (11.1)	4 (8.0)
I did not know how to get access to these health services	3 (8.3)	5 (10.0)

I needed support with my language, such as interpreting/translation	3 (8.3)	6 (12.0)
I feared that accessing these health services may affect my status as a refugee/asylum seeker	2 (5.6)	3 (6.0)
These health services were not appropriate for my religious beliefs	2 (5.6)	2 (4.0)
Other barrier	15 (41.7)	16 (32.0)

Note: Percentages do not add up to 100 due to multiple responses.

- The most commonly reported barrier was not wanting to be seen entering mental health services as mental health problems are seen as a negative condition within their communities (42% of those needing help or 32% of all participants).
- An equally high proportion of respondents reported 'Other' barriers not included in the list provided in the questionnaire; some of these may have been addressed in the written comments section at the end of the questionnaire.
- 10 participants mentioned that services were not appropriate for their cultural norms and beliefs (28% of those needing help or 20% of all).
- Around one in four participant needing help mentioned cost as a barrier (25% or 18%), or a perception that the services were only for white people (25% or 18%).
- About15% of the participants reported issues about knowledge of the services and how to access them, the need for support with language issues or concerns about refugee/asylum seeker status.

Written comments

Comments were also written by some of the participants at the end of the questionnaire. These were reviewed and grouped into themes, and are summarised below. Direct quotations from the questionnaires, by theme are listed after the summary.

- Ten participants provided comments around the general relationship between service providers and users, with the users' needs not being met by the providers.
- The stigma associated with mental health issues was mentioned by 9 individuals.
- Six participants made comment on the long waiting times for counselling and the experience of racism.
- The lack of publicity and financial support for alternative services, and the desire to participate in the management of their own mental health were each raised by five participants.
- Four participants made positive comments in relation to peer/community support groups.
- Three participants each raised concerns related to the ethnicity of health providers and fear associated with treatment for mental health.
- Isolation was noted by 2 participants.

Notes/ comments from questionnaire, grouped into themes (Note: grammar, punctuation and misspellings are not corrected)

1. Relationship between providers and users; needs not being met by providers

The most commonly occurring comments in the questionnaires were related to the poor quality of the relationship between service providers and users, that they were not being listened to or understood and that their needs were not being met by the medication often provided by doctors.

Not welcoming, made it look as though it was afraid, into saving bed space. (#13)
When I asked for change of CPN I was struck off. They made me feel that because they did not want to cater for my needs. It was easier to be taken off. (#1)
Not taken seriously / have to put on a facade (...) Forms are self serving to GP – to be absolved of any responsibility. Forms – want to put an easy answer don't want to be a problem – lie on forms to cost the least problem as don't self esteem is low don't want to take up anyones time because u don't feel you are worth it – Dont look if they did they see body language would show – eyes – red from crying loss of weight etc. take the form & don't look at the person EASY OPTION. (#15)
GP very dismissive & prescribed student advisor. (#5)
Tendency to prescribe drugs with most situations very quick. (#7)
Medication – from GP- not what I wanted. (#16)
I don't access services as I found them not helpful because I come from the point of knowing what I need for myself which is not medication. (#19)
You are told, not listen(ed) to. People using the service should be listen(ed) to. (...) People should be provided with more support not just medication medication medication. (#45)
GP – given medication – family did not believe in – MH treatment. (#4)
GP – knew suffered bereavement – and offered DRUGS – anti-depressant – brother ADDICTED – so mom took away drugs. (#5)
Against forced medication. (#6)

2. Stigma

Many also mentioned stigma in various forms associated with poor mental health.

Feared that accessing health services would affect future/career. (#15)
When I was first on antidepressants, I was told I shouldn't – became unwell – due to stigma – as I was too embarrassed to talk to something/ask for help. (#13)
Concerned about having child – and maybe seen as not able to care for child – fear that taken away. Want to be honest but some time fearful. Even if capable still feel u are under the microscope scrutinised (?) psy since age of 9. (#3)

Fear of being 'ticked' in a box – sometime not even represented i.e. ethnicity. Fiting in a box – double-edged sword – feels like losing control – to be put in a box & being in a box – does not adequately describe who you are. (#6)
Seen as stigma – applying for jobs. (#7)
With friends I'm open but the wider community there is a judgement/people have fear (...) fear of being labelled. (#12)
Don't feel able to talk to anyone outside family (and even sometimes within family) feel ok to talk about due to stigma. (#16)
Lots of stigma in my area. More sensitising is needed and community support. (#49).
Community spaces not labelled as mental will be suitable for people like me. (#50).

3. Long waiting lists for counselling

A number of responders mentioned the long waiting lists for counselling.

Length of time to wait to see a counsellor particular in deep crisis. (#15)
Cruse – Bereavement -- fill out long form and then wait for a long time – it's too late/ already in desperation. (#2)
Time – GP says you have to wait 6 months. (#12)
1) limited time for counselling 2) huge waiting list. (#16)
Length of time/ waiting list for counselling. (#17)
It took long time before GP referred me but once I got appointments it was fine & welcoming. (#24)

4. Racism

Concerns were raised as to how they, as ethnic minorities, were being treated.

(...) issues come from identity – (racism). (#2)
If not white not kind, second class treatment. (#15)
Health services are geared for white people. (#12)
Fairly happy but needs to feel more at ease with service providers, in the way ethnic minorities are treated, and spoken to. (#34)
I just think the system makes it hard for us. The daughter I had with a white girl has now been taken away. I have been stopped to see her. That is discrimination. (#42)
Have to improve. Culturally sensitive. (#44)

5. Costs

A number of comments related to the costs of alternative services.

Could not afford paying for services. (#15)
Paying for alternative services. (#12)
(...) counselling services very expensive. (#16)
Payment for counselling. (#17)

Some activities like massage and swimming are good but they are expensive. (#50)

6. Lack of information on alternatives

Also mentioned was a lack of information or publicity on the present mental health needs assessment and other alternatives to mental health problems.

Not publicised enough. (#2)
No one told me about WOVEN need to have more awareness of alternative rather than big centres which may feel institutionalised. (#3)
Publicity – info – knowing where to go – only knew could go to GP for medication – very hard to know where to go for HELP! (#16)
Information – being informed i.e. this consultation how widely was it publicised. I belong to the Refugee Forum, the Racial Harassment Forum and on Mosaic management committee and did not hear/know about consultation – why was it not publicised on Radio/Argus/BME groups around city B&H – don't think PCT take BME issues seriously. (#17)
I did not know who can help. In my case: first I can't ask all and everywhere are you involve, can you help. It is look sily question. Second short in information. Thired: it is mix between mental & solistor and who the wright one? I know? Could miss leading with my friend. (#50)

7. Self

Comments were made in relation to their desire to manage their own mental health, especially because of previous unhelpful experiences with services, although the need for external help was also referred to.

SELF I want to manage my own wellbeing because of trouble accessing services. (#1)
SELF – Activities that bring you into the moment. (#7)
Don't recognise barriers – 'I'm a fighter' but accept there are vulnerable people. (#10)
I don't access services as I found them not helpful because I come from the point of knowing what I need for myself which is not medication. (#19)
My own attitude – I thought I could handle it/ thought I would have to resolve it on my own. (#14)

8. Peer/community support groups

Some participants had positive comments in relation to peer/community support.

WOVEN appealed to me because of the diversity of participants, camaraderie. (#8)
Joined WOVEN as it is a BME women's group and we share and support each other (#11)
Having a glorious time with BMECP elderly group. (#35)
Service received is just about right by more improvement and community support – support in the community. (#41)

9. Ethnicity of health providers

Some mentioned that having more BME health providers would be useful, because they would be more likely to understand them and their experiences.

Could not find a BME psychotherapist who understands ours issues – who have walked in our shoes. Know what has broken us and know what we have to do to get through the day. (#15)
Not sure - Come to expect that people providing service will be white. (#16)
Don't want to feel i have to explain myself in terms of my Black exp. When working w/ someone in my own ethnicity – understanding, body language, straight talking – felt very comforting worked much better with me more competently because of understanding Black exp. (#12)

10. Fear

Fear was also mentioned by a few in connection with mental health, because of not knowing about what would happen to them or how they would be treated.

Anxiety – if had to go into a large institution – mostly white people – medicated. (#12)
Didn't know what to expect and was very frightened. (#27)
I feared being used as experimentation fodder and not real practical help. (#34)

11. Isolation

Being alone and not having a community were additionally referred to by 2 of the participants.

People of colour are being forgotten and have nowhere to go – isolated, sometimes no family – NOWHERE TO GO. (#2)
Don't have a community – what is 'my country' not in 'British'. (#10)

12. Other comments

A few comments which did not fit into any of the previous themes were also made and are included below.

BMECP will benefit on cognotic therapy (from cognitive therapy). (#46)
Booked appointment w/ GP & had a 2 month telephone bill & employment slip, passport & place to live but told I needed a bill to prove – so was unable to register was not living long enough in Brighton – even though there was a real need to see GP. GP said it was depression – offered antidepressant & CBT but told to register in Brighton. (#14)

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Appendix 1: BME population of Brighton & Hove and mental health service use

Table 1. Estimated resident population by ethnic group, age and sex, 2007

Brighton & Hove City	All ages		0-15 years		16 + years	
	n	%	n	%	n	%
All Groups	253.5	100.0	40.7	100.0	212.8	100.0
White: British	212.6	83.9	34.6	85.0	177.9	83.6
White: Irish	3.6	1.4	0.2	0.5	3.4	1.6
White: Other White	14.0	5.5	1.4	3.4	12.6	5.9
Mixed: White and Black Caribbean	1.2	0.5	0.5	1.2	0.7	0.3
Mixed: White and Black African	1.0	0.4	0.4	1.0	0.6	0.3
Mixed: White and Asian	1.9	0.7	0.6	1.5	1.3	0.6
Mixed: Other Mixed	1.7	0.7	0.6	1.5	1.1	0.5
Asian or Asian British: Indian	3.7	1.5	0.4	1.0	3.3	1.6
Asian or Asian British: Pakistani	1.5	0.6	0.3	0.7	1.3	0.6
Asian or Asian British: Bangladeshi	1.4	0.6	0.4	1.0	1.0	0.5
Asian or Asian British: Other Asian	1.5	0.6	0.2	0.5	1.3	0.6
Black or Black British: Black Caribbean	1.6	0.6	0.2	0.5	1.4	0.7
Black or Black British: Black African	2.4	0.9	0.4	1.0	2.0	0.9
Black or Black British: Other Black	0.4	0.2	0.1	0.2	0.3	0.1
Chinese or Other Ethnic Group: Chinese	2.6	1.0	0.3	0.7	2.3	1.1
Chinese or Other Ethnic Group: Other	2.4	0.9	0.2	0.5	2.2	1.0

Note: Figures in thousands. Source: Office for National Statistics.

Table 2. Estimated resident population by broad ethnic group, age and sex, 2007

Brighton & Hove City	All ages		0-15 years		16 + years		ratio adults/children
	n	%	n	%	n	%	
All Groups	253.5	100.0	40.7	100.0	212.8	100.0	5.2
White: British	212.6	83.9	34.6	85.0	177.9	83.6	5.1
White: Irish	3.6	1.4	0.2	0.5	3.4	1.6	17.0
White: Other White	14.0	5.5	1.4	3.4	12.6	5.9	9.0
Mixed	5.7	2.2	2.0	4.9	3.7	1.7	1.8
Asian or Asian British	8.2	3.2	1.3	3.2	6.9	3.2	5.3
Black or Black British	4.3	1.7	0.6	1.5	3.7	1.7	6.2
Chinese	2.6	1.0	0.3	0.7	2.3	1.1	7.6
Other	2.4	0.9	0.2	0.5	2.2	1.0	5.0

Note: Figures in thousands. Source: Office for National Statistics

· The ratio of adults to children of the White British population estimated in 2007 was similar to that of the Asian & Asian British population and that of the Other Ethnic Group population, with about 5 individuals over 16 years of age for every one child 15 years of age or younger.

· There ratio of adults to children was slightly increased among the Black or Black British, Chinese and Other White population, ranging from about 6 to 9 individuals over 16 for each child 15 years or younger.

· The ratio of adults to children was considerably higher than other ethnic groups in the White Irish population (about 17 adults for each child).

· The ratio of adults to children was considerably lower than other ethnic groups in the Mixed population (about 2 adults for each child).

Table 3. Mental health service usage in Brighton & Hove by broad ethnic group, January to December 2008

Estimated resident population by ethnic group, 2007 (Office for National Statistics)		Ethnic groups for Brighton and Hove Locality, Jan-Dec 2008						
		Working Age Mental Health Services (WAMHS)					Children and Adolescent Mental Health Service	Older People Mental Health Service
	Brighton and Hove	ACCESS	RECOVERY	ACUTE	OTHER AMH TEAMS	ALL	CAMHS	OPMHS
White: British	83.90%	84.67%	82.63%	78.62%	78.56%	82.77%	87.59%	90.18%
White: Irish	1.40%	1.09%	1.51%	1.04%	0.93%	1.34%	1.30%	2.93%
White: Other White	5.50%	6.11%	5.79%	5.35%	7.03%	6.28%	3.20%	4.51%
Mixed	2.30%	1.47%	2.38%	3.77%	4.12%	2.23%	5.20%	0.42%
Asian or Asian British	3.30%	2.02%	2.03%	1.56%	1.54%	2.01%	0.93%	0.92%
Black or Black British	1.70%	2.07%	2.49%	6.53%	3.77%	2.32%	0.86%	0.06%
Chinese	1.00%	0.25%	0.23%	0.00%	0.17%	0.22%	0.05%	0.12%
Other	0.90%	2.32%	2.95%	3.13%	3.96%	2.83%	0.87%	0.86%

· The over-representation of individuals from the White Irish ethnic group in the Older People Mental Health Service in relation to the estimated resident population, may be a function of the older age structure of the White Irish population in Brighton & Hove, as compared to other ethnic groups; Individuals from the White British population were also over-represented in these services, whereas those from Asian, Mixed, Black and Other White backgrounds were under-represented.

· The over-representation of individuals from the Mixed ethnic group in the Children and Adolescent Mental Health Service in relation to the estimated resident population, may be a function of the younger age structure of the Mixed population in Brighton & Hove, as compared to other ethnic groups. Individuals from the White British population were also over-represented

in these services, while those from Asian, Other White, Chinese and Black backgrounds were under-represented.

- Individuals from Other ethnic groups were over-represented in all Working Age Mental Health Services, where the opposite was true for those of Asian or Chinese background; those from Black or Mixed backgrounds were over-represented in Acute and Other Adult Mental Health Teams. In addition, those of Mixed background were under-represented in Access services, whereas those of Black background were over-represented in Recovery services. White British or Other White backgrounds were over-represented in Access services. In addition, those of a White British background were under-represented in all other Working Age Mental Health Services, whereas those of Other White backgrounds were also over-represented in Other Adult Mental Health Teams.

Appendix 2: Self-administered questionnaire for Focus Group participants

NHS
Brighton and Hove

BME Mental Health / Wellbeing Needs Assessment – Focus Groups

This questionnaire forms part of research being carried out by the Public Health department of *NHS* Brighton & Hove. It is aiming to assess the level and quality of mental health and wellbeing services being accessed by the BME people. It should help decision makers to improve access to these services and the quality of treatment within them.

The information will be kept anonymous and confidential, and used only for improving mental health and wellbeing services for the Brighton & Hove BME Community.

1. Gender

Male	☐
Female	☐
Transgendered	☐

2. Age group (years)

0-14	☐
15-34	☐
35-64	☐
65+	☐

3. Level of education

No formal education	☐
Primary (years 1-6)	☐
Intermediate (years 7-9)	☐
Secondary (GCSE / A level)	☐
University (degree / diploma / technical qualification)	☐

4. Ethnicity

White (British, Irish, other White)	☐
Black or Black British (Caribbean, African, other Black)	☐
Asian or Asian British (Indian, Pakistani, Bangladeshi, other Asian)	☐
Chinese (Chinese, other ethnic group)	☐
Mixed (White/Black Caribbean, White/Black African, White/Asian, other mixed)	☐

5. Marital status

Single	☐
Married / living with a partner	☐
Civil partnership	☐
Separated / Divorced	☐
Widowed	☐

6. How long have you been living in Brighton & Hove?

1-6 months	☐
7-12 months	☐
1-2 years	☐
More than 2 years	☐

7. Sexuality

Heterosexual	☐
Lesbian	☐
Gay	☐
Bisexual	☐

Notes / Comments

Thank you for completing this questionnaire.

Appendix 3: Focus Group discussion questions

NHS
Brighton and Hove

BME Mental Health / Wellbeing Needs Assessment
Focus Group Discussion Questions

Statement to be read out by facilitator: This focus group forms part of research being carried out by the Public Health department of *NHS* Brighton & Hove. It is aiming to assess the level and quality of mental health and wellbeing services being accessed by the BME people. It should help decision makers to improve access to these services and the quality of treatment within them.

The information will be kept anonymous and confidential, and used only for improving mental health and wellbeing services for the Brighton & Hove BME Community.

1. For people who have USED the mental health services in Brighton & Hove during the last 12 months

1.1 Tell me about the mental health service(s) that you have been in contact with.

1.2 Get a list of the services they have used (A&E, out-patient, in-patient, community services, counselling, SPFT, GP, psychiatry hospital etc.).

1.3 Describe what were the issues / experiences / difficulties you encountered - such as:

- Accessibility of the service / delay in access / referral system
- Language / need for interpreters / translation / use of Sussex interpretation service
- Personal or cultural beliefs / religion / spirituality
- Community / family / stigma
- Satisfaction / perceived benefit of the service
- How did you feel about the help / outcome you received from the service?
- Good and not so good elements of the service
- How the service can be improved?

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2. For people who have NOT USED mental health services in Brighton & Hove – but may have an unmet need to use these services

2.1 Tell me what mental health / mental wellbeing means to you? What do you do to maintain a good mental health?

2.2 What would you do if you had difficult emotions/thoughts or anxiety? Do you know what mental health services are available to you in Brighton & Hove?

2.3 Describe any time in the past **12 months** when you felt the need to contact/seek help from the mental health service, but were not able to seek help.

2.4 Discuss issues / factors / experiences for not taking an initiative to contact/seek help from the mental health services.

2.5 Tell me about the barriers for you or other BME people accessing mental health services:

- Describe the main barrier.
- How do you feel about going to your GP for help and possible referral to a mental health service?
- How do you feel about encouraging your family/friend/colleague to use mental health services if you thought they needed help?
- Possible Barriers to access the services:
  - Accessibility of the service / referral system
  - Language / need for interpreters / translation
  - Personal or cultural beliefs / religion / spirituality
  - Community / family / stigma

2.6 What are some changes to the services (or how things are done) that you think will encourage you or other BME people to access the mental health services? (e.g. referral system, pathways etc.)

Other questions:

- Why so many BME people are sectioned?

- What are BME people's experiences of accessing or using IAPT services.

Notes / Comments
Please check that these questions also relate to the DRE action plan. Two focus groups conducted on a day (at least 12 people in each group).

BME Mental Health Needs / Wellbeing Assessment Group

Appendix 4: Self-administered questionnaire for the BME Community Survey

A Survey of BME Community Mental Health / Wellbeing Needs This questionnaire forms part of research being carried out by the Public Health department of *NHS* Brighton & Hove. It is aiming to assess the level and quality of mental health and wellbeing services being accessed by the BME people. It should help decision makers to improve access to these services and the quality of treatment within them.

The information will be kept anonymous and confidential, and used only for improving mental health and wellbeing services for the Brighton & Hove BME Community.

1. Gender

Male	☐
Female	☐
Transgendered	☐

2. Age group (years)

0-14	☐
15-34	☐
35-64	☐
65+	☐

3. Level of education

No formal education	☐
Primary (years 1-6)	☐
Intermediate (years 7-9)	☐
Secondary (GCSE / A level)	☐
University (degree / diploma / technical qualification)	☐

4. Ethnicity

White (British, Irish, other White)	☐
Black or Black British (Caribbean, African, other Black)	☐
Asian or Asian British (Indian, Pakistani, Bangladeshi, other Asian)	☐
Chinese (Chinese, other ethnic group)	☐
Mixed (White/Black Caribbean, White/Black African, White/Asian, other mixed)	☐

5. Marital status

Single	☐
Married / living with a partner	☐
Civil partnership	☐
Separated / Divorced	☐
Widowed	☐

6. How long have you been living in Brighton & Hove?

1-6 months	☐
7-12 months	☐
1-2 years	☐
More than 2 years	☐

7. Sexuality

Heterosexual	☐
Lesbian	☐
Gay	☐
Bisexual	☐

8. In the last 12 months, have you felt so unhappy (or anxious) that you needed to ask for help?

Yes	☐	→ If yes, please complete questions 9 and 10
No	☐	→ If no, thank you for completing this questionnaire

9. If you answered 'Yes' to question 8, from whom did you ask for help? Tick all that apply:

Sussex Partnership Foundation Trust - mental health / wellbeing services	☐
Psychological therapy / counselling	☐
Voluntary sector organisations providing mental health services (such as Mind, Rethink, Brighton Housing Trust)	☐

Other voluntary sector organisations (such as Samaritans, Oasis, Age Concern, YMCA)	☐
Complementary services (such as acupuncture, aromatherapy, Reiki or reflexology)	☐
Religious support	☐
Cultural support	☐
Family support	☐
Friends' support	☐
Neighbours' support	☐
Other – please specify: ……..	☐

10. Did you experience any barriers in accessing any of these mental health / wellbeing services or other support opportunities?

Yes	☐	→ If yes, what were the barriers you experienced? Tick all that apply below:
No	☐	→ If no, thank you for completing this questionnaire

Barriers:

I needed support with my language such as interpreting or translation	☐
I did not know that these mental health services existed	☐
I did not know how to get access to these health services	☐
I could not afford the travelling cost to these health services	☐
I assumed these health services were only for white people	☐
These health services were not appropriate for my religious beliefs	☐
These health services were not appropriate for my cultural norms / beliefs	☐
I feared that accessing these health services may affect my benefits	☐
I feared that accessing these health services may affect my status as a refugee/ asylum seeker	☐
I did not want to be seen entering these health services as mental health is seen as a negative conditions in my community	☐
Other – please specify: …….	☐

Notes / Comments

Thank you for completing this questionnaire.