Inspiring Progress: Improving Mental Health Services for Black and Minority Ethnic Communities in Suffolk
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Healthwatch Suffolk

Healthwatch Suffolk has the role to listen to local people about views and experiences of health and social care services. It aims to give people real influence over decisions about services by ensuring that what patients and carers experience is seamlessly fed into them. It has statutory powers and the strength of the law behind it, which means that the people who run and pay for health and social care services must respond to concerns from Healthwatch Suffolk explaining what action they will take. It also provides information and signposting to help people navigate the health and social care system and understand what to do when things go wrong.
Healthwatch Suffolk are delighted to have been able to work collaboratively with Norfolk and Suffolk NHS Foundation Trust (NSFT) on an innovative, community-focused project that led to the publication of this report.

The Inspiring Progress Project illustrates the collective voice of many people in Suffolk and shows that research grounded in real-life, day-to-day experiences is a necessity if health and social care services are to be effective for the communities they serve.

Some of the findings will not come as a surprise. For example, that the stigma of mental health and wellbeing is a barrier to better mental health across all communities in Suffolk – as it is everywhere, or that more culturally sensitive services are needed to engage with those from Black and Minority Ethnic (BME) communities.

Many of the findings are new and require careful thought and consideration. Thought and consideration that, Healthwatch Suffolk hopes, will result in progressive improvements to the Trust and the opportunity for all community services to engage meaningfully with the breadth of issues that affect the mental health experiences of people from BME communities.

There seem to be serious barriers to better mental health. One in four BME respondents over the age of thirty-five reported that they had faced racial discrimination when using mental health services in Suffolk; a figure that rose to one in three among those under thirty-five. However, people who speak out about their mental health experiences are powerful agents of change and there are strong indications that the negative experiences some respondents have faced are surmountable.

Respondents expressed positive personal views toward front-line staff, as almost nine out of ten BME respondents thought that staff were helpful, while over two thirds believed that the staff understood their needs. These are strong foundations for change.

Healthwatch Suffolk and the Norfolk and Suffolk NHS Foundation Trust share a commitment. We ensure that the NHS Constitution is upheld, that all service users and carers are at the centre of all aspects of our work and are a vital mechanism in shaping and supporting our service strategy.

We believe that this report is a step towards fulfilling that commitment.
“I believe that mental health and wellbeing is a subject that isn’t addressed enough within our communities and people that are dealing with negative mental health issues are made to feel alienated. Many teenagers are unable to communicate their concerns with their own mental health and therefore repress it which is becoming a severe problem as it makes a lot of aspects of teenage life difficult to deal with such as education, social situations and home situations”
Introduction

This report presents the findings from the Inspiring Progress Project. The project aimed to explore how BME communities in Suffolk conceptualise mental health and wellbeing, their use of NHS services, third sector organisations and charities, and for those that have used the Norfolk and Suffolk NHS Foundation Trust, how they rate specific aspects of their care.

Aims of the project

The main aims of the project were:

1. To expand on the findings and recommendations presented in Norfolk and Suffolk NHS Foundation Trust’s Open Mind Dialogue Workshops 1.
2. To engage with and explore how BME communities in Suffolk conceptualise mental health and wellbeing by giving them a voice.
3. To work towards a better understanding of what BME communities in Suffolk need when facing declining mental health and wellbeing.
4. To gain an overarching consensus of what BME communities face when entering Norfolk and Suffolk NHS Foundation Trust’s services.
5. To breakdown stigma among BME communities in Suffolk while spreading awareness of the Norfolk and Suffolk NHS Foundation Trust.

Norfolk and Suffolk NHS Foundation Trust’s Open Mind Dialogue:

The Open Mind Workshops have actively worked towards fulfilling several of the requirements listed in Norfolk and Suffolk NHS Foundation Trust’s (NSFT) Improving Services Together Involvement and Engagement Strategy 2015-2017 document 2, which stated 1) service users and carers will be able to have their say in Trust business; 2) that NSFT will strengthen links and create partnerships with other agencies and service user and carer-led organisations; and 3) NSFT will reach out to diverse and other under-represented groups.

In September 2014 the Norfolk and Suffolk NHS Foundation Trust (NSFT) held their first Open Mind Workshop in partnership with the Caribbean and African Community Health Support Forum (CACHFS) and Suffolk Refugee Support (SRS). With the hope of fostering a positive ethos of service user involvement the Open Mind Workshop addressed the experiences and barriers that BME communities in Suffolk face when accessing mental health and wellbeing services.
Working out and signing up to the values and principles of service user involvement early in the process of forging partnerships was seen as inherently important as service user recognition emphasises the importance of models of participation that are based on human rights, equalities, and inclusion. This approach seeks to empower people and counter oppressive and discriminatory practice. Therefore, the Open Mind Workshop was created with the ambition of enabling and empowering BME communities to raise any concerns in regards to accessing and using mental health services. It also aims at providing an opportunity for NSFT and other local organisations to listen and gain a better understanding of how mental health is perceived and affects different communities.

During the workshop, several poignant, overarching topics were addressed:

• How to give local BME communities an opportunity to engage and have their voice heard;
• How to gain a better understanding of mental ill health among our BME communities;
• How to explore the barriers to mental health care faced by our BME communities;
• How to have a better understanding of the experiences of BME service users when it comes to mental health care;
• How to identify potential solutions and service improvements; and
• How to help build a positive relation between BME communities and the local NHS staff.

From discussions on cultural competencies acting as a barrier to accessing services to issues of trust and institutional racism and discrimination, the Open Mind Workshop has been an open and transparent attempt to engage with communities often defined by their cultures and ethnicities. As expressed in the summary report 1, the Open Mind Workshops are instrumental in challenging the use of the lazy term known as “hard to reach” when referring to BME populations, the perceived homogeneity within particular groups or communities that may not necessarily exist, and the lack of understanding that leads to BME service users feeling stigma and discrimination.
The workshop found that in the context of participation and involvement, the onus is placed on the communities identified as “hard to reach” – they are perceived to be the problem – and not the ways in which involvement is defined or undertaken. The workshop also revealed that there was a lack of information, lack of cultural sensitivity and understanding when it comes to services in meeting needs of BME groups, lack of understanding leading to stigmatisation and discrimination, and lack of trust in services 1. Moreover, discussions within BME user groups showed that the ideas of “good practice” that mental health services worked with, and those held by service users from BME communities, were often in conflict. Thus, there needed to be more space for discussing or working with the service user’s own sense of what good practice meant and what might be helpful in their assessment, treatment, care and recovery.

The Open Mind project suggested several recommendations; all of which are listed below:

1. To improve access to information about services and access to translated materials when needed
2. Better communication through access to interpreters and sufficient time given to allow for a comprehensive assessment of needs
3. To improve cultural competence skills amongst staff
4. To improve cultural capability within organisations
5. To develop and implement a co-production approach between services and BME service users
6. To improve choice and availability in service provision for BME communities
7. To increase the involvement of BME service users by developing a BME service user forum

Following the recommendations a BME Focus Group was established by NSFT to guarantee that an ongoing discussion would ensure progression among mental health and wellbeing services for BME communities. The Inspiring Progress Project was commissioned as result. It was noted that to better understand how some of the recommendations can be implemented and what they mean to BME communities in Suffolk, a wider piece of research and community engagement was needed. Specifically, the Inspiring Progress Project aims to work towards fulfilling recommendations three, four, five and six of the Open Mind Dialogue Workshops.
Background

“I found being on a psychiatric ward more scary than anything else. If that was supposed to be a place of safety, I shudder to think what being unsafe feels like.”
A substantial body of research shows that BME communities are disproportionately represented in mental health statistics and are over-represented in crisis mental health services.

The latest Mental Health Bulletin 3 shows that, while there has been a fall in the overall number of inpatients in mental health services, the number of people detained in hospitals has risen for people from Mixed, Asian or Asian British and Black or Black British groups, with proportions of people from Black or Black British groups rising 6% from 2012-13 to 2013-14 4.

It is widely known that mental health services in the UK are critically underfunded. Despite mental health problems accounting for 23% of the total burden of disease, funding for mental health services has been cut in real terms for three consecutive years. At present, mental health services account for only 13% of NHS health expenditure 5.

In 2010 the Government vowed to put mental health on a par with physical health in the NHS. However, this has not come to fruition, as a huge gulf remains between the demand for care and the support that is actually available. Nowhere is this disparity more evident than in nursing where more than 3,300 posts have been lost from mental health services from 2010 to 2014 6.

In England, one in six adults and one in ten children experience a mental health problem at any one time 7. Our wellbeing and mental and social capital make a huge difference throughout our lives. They are shaped by our early experiences in childhood as well as our later experiences in life and are essential to a healthy society, healthy communities, and healthy families. They matter because taken together, they affect our behaviour, our ability to benefit and feel part of the world around us, and our prosperity 8.

We are in a permanent state of flux, moving from different levels of wellbeing and vulnerability to mental health problems. The Mental Health Foundation argue that reducing the number of people across the UK developing a mental health problem is the only way that mental health services will be able to cope with demand in 20–30 years’ time 9.

Mental health problems are the biggest contributor to poor wellbeing10. Therefore, in attempting to increase the proportion of the population who have optimal wellbeing and reducing the proportion of the population who have low levels of wellbeing, more needs to be done to help people recover from mental health problems.
Understanding ‘wellbeing’

When thinking about what ‘wellbeing’ means in simplistic terms thoughts of feeling good and functioning well come to mind. Essentially this is one’s overall perception of health and sense of being, where the physical meets the mental and becomes one. The World Health Organisation defines wellbeing as:

‘a state of mind in which an individual is able to realise his or her own abilities, cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community’ 11

However, when addressing the literature there is significant ambiguity around the definition, usage and function of the word ‘wellbeing’. Essentially, wellbeing is a cultural construct and represents a shifting set of meanings; wellbeing is no less than what a group or groups of people collectively agree makes ‘a good life’ 12.

The meaning and function of a term such as ‘wellbeing’ not only changes through time, but is often found within coinciding yet opposing discourses. There is evidence that the discourse of ‘wellbeing’ - how, for what purposes, and with what effects the term is being used - is at present particularly unstable in the UK 13. Effectively, wellbeing acts like a cultural mirage: it looks like a solid construct, but when approached it has varying nuances according to one’s perceptions of good health or their socio-demographic background.

In the UK, the Office for National Statistics (ONS) measure wellbeing under three overarching indices 14:

1. Hedonic - this refers to the importance of happiness and absence of unhappiness to wellbeing;
2. Evaluative - measuring life satisfaction overall; and
3. Eudaimonic elements - denoting broader definitions of ‘living well’ rather than simple emotion, such as feelings of worth.

Data on wellbeing is gathered through the ONS’s Annual Population Survey 15, which includes four questions on wellbeing. The findings are incorporated in the Public Health Outcomes Framework, helping to shape local authority public health interventions 16.

The questions are as follows:

1. Overall, how satisfied are you with your life nowadays?
2. Overall, how happy did you feel yesterday?
3. Overall, how anxious did you feel yesterday?
4. Overall, to what extent do you feel the things you do in your life are worthwhile?

The ONS data from 2015 17 indicates that with respect to life satisfaction, the White ethnic group reported an average of 7.7 out of 10, compared to 6.8 in the Black
ethnic group, though some other ethnic groups reported similar or slightly higher averages. On the question of ‘how worthwhile the things they do are’ also, the White ethnic group reported a higher average than all other ethnic groups.

Varying self-reported measurements of wellbeing mean a lot. Experiencing low mental wellbeing over prolonged periods of time has been shown to attribute to declining mental health18. Therefore, if there is a statistically significant difference in levels of wellbeing between ethnic populations in the UK, it is imperative that further work is done to create parity among all, not only for those effected by inequality but for the progression of overall social capital in the UK.

Mental Health

Mental health should be a priority for everyone as it involves everything we do. The term mental health encapsulates our cognitive function; the way a person thinks, feels and behaves. On an individual level, mental health problems affect our ability to function from day-to-day and our overall quality of life. When considered on a wider scale, such as collective socio-demographic determinants correlated to decreased wellbeing leading to poor mental health, the effect on society is considerable.

Although mental health and mental health illnesses are becoming commonplace terminology within society, with words such as ‘depression’ or ‘anxiety’ in everyday use, there is a growing cultural trend towards trivialising and underestimating how serious declining mental health can be 19. This may be because mental health problems are hidden; often there are no external signs of declining mental health or mental illness, yet mental health problems feel just as bad, or worse, than any other illness.

Although mental health problems are very common – affecting around one in four people in Britain in any one year 20 – there is still prejudice, stigma and discrimination towards individuals that suffer mental health problems. This can be attributed to a lack of shared knowledge regarding mental health and can be seen throughout Britain and indeed the world10. Moreover, there are a lot of different frameworks used when diagnosing, treating and understanding the causes of mental health, which perpetuates the wider society’s lack of understanding around the issue18.

Mental Health among BME Communities

BME communities experience disproportionately high levels of unemployment, poor and overcrowded accommodation and bad health21, which as mentioned are key determinants of social capital, mental health and wellbeing. It is unsurprising then, that people from BME communities
are more likely to be diagnosed with a mental illness than white people 22.

It is widely reported that BME populations are over represented in the majority of UK’s mental health pathways. But these figures do not account for the unknown number that have not sought help or admitted to suffering from mental health problems 23. Despite having high levels of poor mental health, BME communities have less access to essential treatment, often due to a range of factors. These may include a lack of information about available services, fears and stigmas about mental illness, the use of culturally inappropriate methods in mainstream services, inaccessibility due to language barriers and experiences of racism 24. For example, MIND identifies racism - in both wider society and mental health care - as a stimulus for distrust in services, and a deterrent for BME people seeking help, noting that health professionals not recognising the effects of racism can also further the difficulty in accessing suitable care9.

In an overdue response to the death of David Bennett, a Black inpatient who died in 1998 after being restrained by staff at the Norvic clinic, a medium secure unit for mental health patients in Norwich, the Department of Health (DOH) produced a five year action plan in 2005 that aimed to reduce the unequal levels of BME individuals being sectioned under the Mental Health Act 25. A decade on, and the rates of compulsory detainment remain highest in Black groups. The Health and Social Care Information Centre (HSCIC) statistics show that in 2013 just over 40 per cent of White British and Irish inpatients were detained under the Act, in comparison to 70 per cent of Black inpatients 26. This is a profound statistic that many argue entrenches BME communities’ distrust in mainstream services 27.

Mental Health and Ethnicity

The term BME encompasses many different ethnicities which are not homogeneous. Therefore, each ethnic group has different experiences of mental health, and in some cases noticeable differences in the rates of specific mental health illnesses. Moreover, defining ethnicities is incredibly challenging. To define an individual to an Asian ethnicity is ambiguous at best as there are many differing cultures and cultural nuances within each categorised ethnicity – this is important to remember. However, in the general context the Mental Health Foundation states that people from BME groups living in the UK are:

- more likely to be diagnosed with mental health problems;
- more likely to be diagnosed and admitted to hospital;
- more likely to experience a poor outcome from treatment; and
- more likely to disengage from mainstream mental health services, leading to social exclusion and a deterioration in their mental health.

Irish People:
Irish people living in the UK have higher rates of alcoholism, depression and suicide compared to the White British majority. Additionally, Irish people have higher hospital admission rates for mental health. However, the Mental Health Foundation note that the particular needs of Irish people are rarely taken into account in planning and delivering mental health services. Moreover, existing community research has tended to write about service users rather than with or for them 28.
**African Caribbean People:**
African Caribbean people living in the UK have lower rates of common mental disorders than other ethnic groups but are more likely to be diagnosed with severe mental illness. The 2006 census of inpatient services in England and Wales found that for Black African and Black Caribbean people:

- The rates of admission to hospital were three times higher than average.
- Referral rates from general practitioners were lower than average and rates of referral from the criminal justice system were higher than average.
- There was greater involvement of police in referrals.
- Rates of detention under the Mental Health Act 1983 were between 19 and 38 per cent higher than average.
- There were higher rates of detention in medium and high secure wards.
- There were higher rates of control and restraint.

The 2014 Bradley Report Five Years On stated that African Caribbean people are over-represented in criminal justice services and are also over-represented in detentions under the Mental Health Act in the mental health services. As a result, some Black people receive their first mental health assessment as a result of the criminal justice system. This highlights that African Caribbean people are also more likely to enter the mental health services via the courts or the police, rather than from primary care, which is the main route to treatment for most people.

**Asian People:**
The literature on Asian mental health statistics are inconsistent. The literature is most commonly grounded in qualitative interviews with relatively few service users that are of a specific Asian origin. However, the findings produced from research carried out suggests the following:

- That mental health problems among Asian communities are often unrecognised or not diagnosed.
- Asian people have better rates of recovery from schizophrenia, which may be linked to the level of family support.
- Suicide is low among Asian men and older people, but high in young Asian women compared with other ethnic groups.
- Western approaches to mental health treatment can be unsuitable for Asian service users as there is a lack of holistic approaches to recovery; Western approaches are often seen as culturally insensitive.

**Chinese People:**
In spite of the number of Chinese migrants in the UK, an all-encompassing overview of Chinese mental health needs has yet to
be completed. Rather, there are a growing number of academic research papers that have sought to address Chinese community’s mental health needs in geographic locations, such as The University of Nottingham's Mental Health Needs Assessment for Chinese and Malaysian International student 31.

It has been suggested close-knit family structure of the Chinese community provides strong support for its members 32. While this may be beneficial, it may generate feelings of guilt and shame, resulting in people feeling stigmatised and unable to seek help. As many Chinese are not integrated into mainstream society, some of them are living in the margins of this society without knowing about sources of support available.
“I personally believe that students and people in general don’t know enough about mental health and wellbeing, and more should be done educate them about it.

Secondly many younger people may be worried of asking their parents to organize an assessment (for example with a GP) as the parents may think that they are either over exaggerating or making things up.

Adults on the other hand will most likely not want to do much about it as they too may think that they are over exaggerating and that it would waste the GP’s time (where by the patient ratio to GP is constantly rising) therefore there’s no need to either discuss it or have an assessment done”
Methodology

A mixed methods approach was used under the framework of Community Based Participatory Research to gain both a quantitative and qualitative insight into how Black and Minority Ethnic communities in Suffolk conceptualise mental health and wellbeing, their use of NHS services, third sector organisations and charities, and for those that have used the Norfolk and Suffolk NHS Foundation Trust, how they rate specific aspects of their care.

The methodology implemented for this project utilised a two-stage approach:

1. A questionnaire
2. Semi-structured interviews

The Questionnaire

The questionnaire was designed by Healthwatch Suffolk in collaboration with members of the BME community, BME service users and carers. As many concepts needed to be addressed within the questionnaire, the service user reference panel thought it best to limit the number of open-ended questions. There was also a consideration that for some respondents English would not be their first language and open-ended questions would deter them from completing the questionnaire.

The questionnaire was uploaded to Survey Monkey, an online survey service. However, hard copies of the questionnaire were also made available and disseminated to all of the relevant organisations in Suffolk.

The questions within the survey aimed to explore the following themes:

- How mental health and wellbeing is understood and identified in terms of family relations, religion, and the wider community.
- For those that had mental health and wellbeing problems, what services they had used. Similarly, for those that had concerns about their mental health and wellbeing but did not seek help, why they had not used the services in Suffolk.
- The extent to which the Norfolk and Suffolk NHS Foundation Trust is known within communities in Suffolk.
- For those that have used the Trust, what their experience was (this comprised of eleven questions distilled from the literature review and talking to service users).

Interviews

The one-to-one interviews followed semi-structured scripts and were conducted face-to-face with service users. Semi-structured interviews were chosen as they are conducted with an open framework which allow for focused, two-way communication. Unlike the questionnaire framework, where detailed questions are formulated ahead of time, semi structured interviews allow for further exploration of topics that are of interest.

As a relatively small population were interviewed Healthwatch Suffolk acknowledge that the qualitative transcripts cannot be generalised beyond the interviews conducted. Additionally, Healthwatch Suffolk note that there was a selection bias among respondents as only respondents who had said they wished to be contacted were interviewed.
Healthwatch Suffolk acknowledge that the data provided in this report is not all-encompassing and cannot be seen to represent all BME people in Suffolk. Rather, the Inspiring Progress Project has been an initial step in the right direction, giving Suffolk’s communities a voice. Healthwatch Suffolk understand that there is still a long way to go and we hope that the information provided in this report will act as a catalyst for further community engagement.

Dissemination and Respondent Sample

2,000 questionnaires were printed by Healthwatch Suffolk and delivered to various organisations that had agreed to aid in the dissemination process. Additionally, the questionnaire was advertised via Healthwatch Suffolk’s website, other voluntary organisations throughout Suffolk, Healthwatch Suffolk’s community development team, and electronically to Healthwatch Suffolk’s existing network of contacts within the community. The dissemination process was carried out over a six month period (March to August).

Targeted Sampling 34 was used when disseminating the questionnaires as it was seen as the most efficient way to contact respondents. Healthwatch Suffolk received 772 completed responses. The response rate cannot be confirmed as the sample population cannot be defined due to the deployment methods of the online survey link.

Respondents were asked to answer six questions that invited them to share demographic information about themselves (see figures 1 to 6 below).

The survey was also circulated by the Healthwatch Suffolk Information Team in the following ways:

- An article in the Healthwatch Suffolk quarterly newsletter issued to Friends and Members (the newsletter and bi-weekly update reach over 3,100 local people who have registered as friends or members of Healthwatch Suffolk);
- Repeated articles in Healthwatch Suffolk electronic fortnightly updates;
- Regular social media updates on Facebook and Twitter; and
- Front-page feature on the Healthwatch Suffolk website including a banner animation with supporting updates on the news, consultation and surveys page.

Figure 1 and 2: Respondent sexual orientation (left) and age (right).
Figure 3: Respondent ethnicity.

- White British: 45.9%
- Asian/Asian British - Indian: 6.5%
- Asian/Asian British - Bangladeshi: 4.5%
- White Polish: 4.4%
- Black or Black British - African: 4.4%
- Asian/Asian British - Pakistani: 4.2%
- Black or Black British - Caribbean: 4.2%
- White Other: 3.8%
- White Irish: 3.5%
- Black British: 3.0%
- Chinese: 2.9%
- Mixed Background - White and Asian: 2.9%
- Mixed Background - White and Black African: 2.7%
- Mixed Background - White and Black Caribbean: 2.1%
- Would rather not say: 2.0%
- Black or Black British - Other: 1.7%
- Mixed Background - Other Mixed: 0.9%
- Asian/Asian British - Other Asian: 0.5%

Figure 4: Respondent disability.

- No Disability: 68%
- Physical disability: 8%
- Mental ill health: 26%
- Learning disability: 2%
- Sensory impairment: 2%
- Rather not say: 2%

Figure 5: Respondent religion.

- Christian: 20%
- Hinduism: 11%
- Muslim: 22%
- Agnostic: 1%
- Atheist: 32%
- Buddhism: 3%
- Church of England: 4%
- Catholic: 3%
- Humanist: 1%
- Spiritualism: 1%

Figure 6: Respondent gender.

- Female: 57%
- Male: 41%
- Rather not say: 2%
Healthwatch Suffolk recognise that the Inspiring Progress Project enters a contested area of knowledge when concepts such as ‘race’, ‘ethnicity’, ‘culture’ and mental illness are linked. It is common practice to deconstruct each of these terms in an attempt to understand what they mean.

However, this report takes a different stance. This can be summarised by the Race Equality Foundation:

‘Race and ethnicity should be viewed as social constructions, which therefore will have different individual and societal meanings depending on the context in which they are applied. An important issue to consider is the meanings that are attached to ‘race’ and its subcomponents of ethnicity, culture and racism. More importantly, it has to be acknowledged that these concepts carry the association of negative social meanings. One cannot therefore assume that all black people will assign similar meaning and value to being cast in the role of ‘other’ and, by implication, an inferior, so may not identify themselves as being part of an institutionally racist situation. ‘Race’ also constitutes only one dimension of black [and minority ethnic] identities, albeit an important one, but it overlaps with other social divisions such as age, class, gender and sexuality.'
Key Findings

“I think it should be easier and comfortable for anyone of any race or background or religion to talk to a specialist about their mental health problems and to be able to sit down and have a chat with anyone.

I think there should be more small local community help trust and wellbeing groups for anyone of any age gender etc. to just go and sit down in a group have a chat with each other about how they may or may not be feeling”
The questionnaire sought to find out how the general population of Suffolk conceptualised mental health and wellbeing, their use of mental health and wellbeing services, and for those that have used the Norfolk and Suffolk NHS Foundation Trust, what they thought of the services provided. Although this Report specifically focuses on the BME population of Suffolk, White British respondents were also asked to complete the questionnaire for comparative purposes. Where applicable the data has been related to wider literature.

Section One: Conceptualisations of Mental Health and Wellbeing

The first group questions asked respondents conceptual questions relating to mental health and wellbeing. The questions were broken down into groups under the following overarching titles: 1) “amongst my family and friends, mental wellbeing is…” 2) “amongst my family and friends, when people have mental health problems they tend to…” and 3) Please tell us if you agree or disagree with the following statements. Each of the questions were then rated via the Likert Scale. For a simplistic overview, the responses have been aggregated by age and sentiment.

Q: Amongst my family and friends, mental health is difficult to talk about.

"Amongst my family and friends, mental wellbeing is..." difficult to talk about
Those that find it hard to talk about mental health issues will often have trouble approaching services. When looking at the averages, those that identified themselves as Asian or Chinese show a higher level of reluctance to talk about mental health. This is most prevalent among the over-35 categories of Asian origin.

From the lowest average percentage of 1 in 5 Black or Black British Caribbean respondents agreeing that mental health is difficult to talk about to 1 in 3 White British and over 9 out of 10 Chinese respondents, the average aggregated percentages show that talking about mental health is difficult regardless of ethnicity. Rather, it is the prevalence of perceived difficulty that differs. From the interviews conducted, Healthwatch Suffolk found that this is due to varying levels of stigma among different communities. More detail is given under the heading of ‘stigma and shame’ on page 44.

Q: Amongst my family and friends, mental wellbeing is something we talk about.

Many of those who were part of the service user reference panel acknowledged that although mental health can be difficult to talk about, there is a growing number of people who will talk about their problems. Therefore, the question above sought to gauge if respondents talk about mental health.

The divide between those over thirty-five and those under thirty-five is evident. Apart from Mixed Background – White and Asian, all Asian respondents over the age of thirty-five showed a greater reluctance to talk about mental health compared to younger respondents of the same ethnicity. Moreover, the views of Asian / Asian British – Indian and Pakistani respondents show the greatest divide in opinions when comparing those under and over thirty-five, as all of those over thirty-five years of age disagreed or strongly disagreed that mental health was something they talked about. In contrast, all Black or Black British – Caribbean respondents (n=28), agreed or strongly agreed that mental health was something they talked about.
Q: Amongst my family and friends, mental wellbeing is not a term we use.

A common theme throughout the questionnaire consultation period and early engagement events was that in an informal setting younger people do not relate to the terms mental health and mental wellbeing. This was predominantly attributed to the stigma attached to these words, notions of ‘street credibility’ and the mass media’s negative portrayal of mental health and wellbeing. Yet, 58% of the 772 people who responded to this question disagreed or strongly disagreed that ‘mental wellbeing is not a term [they] use’. Furthermore, there was little variance in the responses when broken down by age and ethnicity.

However, almost 1 in 4 (24%) of the 772 respondents did not use the term mental wellbeing. When exploring alternative terms used to describe mental health and mental wellbeing via qualitative questions and interviews, it is apparent that words such as ‘mad’, ‘crazy’, ‘bonkers’, ‘insane’, ‘dizzy’, ‘loopy’, ‘nuts’, to name a few, are still common terms among all communities when among peer groups in an informal environment.

National literature which looks at attitudes to mental health reveal that younger people have very negative views and use judgemental terms in their everyday language. This is associated with a low level of knowledge about mental health. These negative attitudes seem to increase with age, although younger children have been shown to be aware of everyday terms and language concerning mental health, and gain this knowledge through family, friends and the media 37.

This was something that became apparent through qualitative interviews. Stigma causes people to be secretive about their problems, and discourages them from seeking appropriate help. However, stigma is created through the language people use and is a term which has evaded clear, operational definition. It can be considered as an amalgamation of three related problems: a lack of knowledge (ignorance), negative attitudes (prejudice), and excluding or avoiding behaviours (discrimination); all of which contribute to slang words being used that create and reproduce negative connotations of mental health.
Q: Amongst my family and friends, mental wellbeing is being close to your faith, belief or spiritual needs.

The service user reference group noted that although a connection between spirituality and mental health has been recognised in Eastern ideologies (such as Buddhism) for many centuries, they had not seen a significant emphasis on the religion, spirituality and mental health in the UK. The service user reference group recognised the value of an integrated approach to understanding a person’s mental health and assumed that relationships between religion and mental health were likely to be bi-directional, interactive and open to influence from other factors. Therefore, it was advised that respondents were asked if mental wellbeing is being close to their faith, belief or spiritual needs.

Of the 772 people who responded, almost 2 out of 5 (38%) agreed that amongst their family and friends, mental wellbeing is being close to their faith, belief or spiritual needs. When isolating those over the age of thirty-five, White British respondents rank lower than all other ethnicities on aggregated agreement. However, the graph also shows, on average, that across almost every ethnic group presented those under the age of thirty-five do not place as much emphasis on mental wellbeing being close to their faith, belief or spiritual needs as those over the age of thirty-five.

“I feel that many people talk to their friends and in my own experiences many people do not practice religion in my age group”
Q: Amongst my family and friends, when people have mental health problems they tend to talk to their family.

Of the 772 people who responded to this question, 58% agreed or strongly agreed that amongst their family and friends, when people have mental health problems they tend to talk to their families. When looking across the ethnic groupings presented, all of the Chinese (100%), White Polish (100%), Black or Black British Other (100%) and the majority of Black or Black British Caribbean (96%) respondents agreed or strongly agreed that amongst their family and friends, people talk to their families.

However, among all of the ethnicities represented an alarming percentage disagreed or strongly disagreed with the statement. Almost 1 in 3 White British (31%), over 1 in 3 White Irish (35%), 1 in 4 Black British (25%), over 1 in 3 Mixed Background - White & Black Caribbean (36%), more than 2 out of 3 Mixed Background - White & Black-African (72%), 2 out of 5 Mixed Background - White & Asian (42%), almost half of all Asian / Asian British – Indian respondents (49%), and over half of all Asian / Asian British – Bangladeshi respondents (60%) disagreed or strongly disagreed that amongst their family and friends, when people have mental health problems they tend to talk to their family. The response to this question in the broader sense, it seems, cannot be defined by ethnic origin or specific cultural characteristics. Rather, it is an inter-cultural occurrence which is embodied by differing discourses of stigma. Some of these discourses are discussed on page 44.

“Chinese people do not talk about these issues. We deal with this inside the family”

“No one understands how hard it is to be a Muslim and use a mental health service. It has helped me but I have lost friends and I know some of my family now looks at me differently. I feel better for the doctors help but I also feel worse because my family and friends are now distant. They see me as crazy because I have an eating disorder”

Q: Amongst my family and friends, when people have mental health problems they tend to ask advice from a faith leader, such as an Imam, priest or rabbi.

“talking to friends was not an option yet family and spiritual leaders etc were”

Of the 772 people who responded to this question, almost 2 in 3 respondents (63%) disagreed or strongly disagreed that amongst their family and friends, when people have mental health problems they tend to ask advice from a
faith leader, such as an Imam, priest or rabbi. However, the highest levels of aggregated agreement were found among respondents that identified themselves as Asian / Asian British – Bangladeshi (73% average, 100% for those over 35), Black or Black British – African (62% average), Asian / Asian British – Indian (44% average, 100% for those over 35), and Asian / Asian British – Pakistani (36% average, 100% over 35). In comparison, 10% of respondents who identified themselves as White British agreed or strongly agreed that amongst their family and friends, when people have mental health problems they tend to ask advice from a faith leader.

As one would expect, there is a stronger correlation to seeking advice from religious leaders when the data is broken down by faith rather than ethnicity. Muslim respondents have a higher level of aggregated agreement to this question than respondents from other faiths. This was highlighted in the interviews conducted in the community as Muslim respondents that were vocal about their faith spoke of a sense of community within their mosque, and that talking to their religious leaders was preferable. They explained that this is due to the fact that there are already personal relationships in place and an understanding of a shared culture (specifically, a sense of many ethnicities sharing one religious outlook) and cultural needs. One respondent spoke of Imams (traditional spiritual leaders) being seen as indirect agents of Allah’s will and facilitators of the healing process. It was noted that Imams may also play central roles in shaping family and community attitudes and responses to illness.

A study of East London Muslims found distrust of mainstream mental health services. Participants saw services as custodial and felt psychiatrists did not understand their culture, with mental illness ascribed to Jinn spirit possession. Rather than seeking help, participants attended Imams and healers, often at great expense. It was also stated that ‘Islamophobia’ may have significant negative effects upon the mental health and treatment of Muslim families and children, and that where services fail to meet the needs of Muslim patients Imams have the cultural expertise to bridge the gaps. However, while faith leaders could form a major bridge between their communities and statutory services, they remain under-utilised.
Q: Amongst my family and friends, when people have mental health problems they tend to keep it a secret because they feel ashamed.

Of the 772 respondents who answered this question, just over half (51%) said that amongst their family and friends, when people have a mental health problem they keep it a secret because they feel ashamed. This rose significantly among Chinese, Bangladeshi, and Mixed Background - White and Black African respondents as over 4 out of 5 respondents said that when people have a mental health problem they keep it a secret because they feel ashamed.

“If I say I have something wrong I could lose my job. If I lose my job I have nothing my family has nothing”

“There is a shame culture in Muslim communities. Services have to remember this and try to work around it”
Q: Amongst my family and friends, when people have mental health problems they tend to contact a mental health organisation.

“Amongst my family and friends, when people have mental health problems they tend to…” Contact a mental health organisation

“To use a service would bring trouble to me and my family. It is dangerous”

Of the 772 respondents who answered this question, 2 out of 5 people (40%) disagreed or strongly disagreed that amongst their family and friends, when they have mental health problems they tend to contact a mental health organisation.

Respondents showing the highest levels of reluctance to contact a mental health service can be seen among Chinese, Asian/Asian British – Bangladeshi, Asian/Asian British – Pakistani, and Black or Black British African who are over the age of thirty-five – all of whom disagreed or strongly disagreed that when people have mental health problems they tend to contact a mental health organisation.

“It would bring shame on my family”
Of the 772 respondents, almost 1 in 3 (31%) agree or strongly agree that mentally ill people are seen as scary or dangerous. Among Chinese respondents this increases to 95%, while 83% of Bangladeshi respondents agree or strongly agree and three quarters (76%) of Black or Black British – African agree or strongly agree. In comparison, just under 1 in 5 (18%) of White British respondents agree or strongly disagree that mentally ill people are seen as scary or dangerous.

Q: Please let us know if you agree or disagree with the following statements: younger people in my community have a better understanding of mental wellbeing and are more tolerant.
Of the 772 respondents, just over half (52%) agreed or strongly agreed that younger people in their community have a better understanding of mental wellbeing and are more tolerant. In comparison, 1 in 4 (25%) disagreed or strongly disagreed. Those who showed the highest levels of agreement to this statement were Asian / Asian British – Bangladeshi respondents (97%), Black or Black British – African respondents (93%) and Asian / Asian British – Indian (86%).

Section Two: Accessing Services

The questions asked if respondents had used any mental health services in Suffolk. Thereafter, respondents were asked if they had heard of NSFT.

Of those who answered the question, 68% of the BME respondents had been to their GP to talk about their problems, while half (50%) had received a referral to a specialist service.

Of those who answered the question, almost a quarter of BME respondents had received counselling or therapy from the Wellbeing Service, while 1 in 5 had received treatment from community services and 17% had received help from specialist services for children, young people and families.

1 in 4
Almost 1 in 4 of those who responded have received counselling or therapy from the wellbeing service
Of those that responded to the question, over a third of BME respondents had used Suffolk MIND in comparison to just 13% of White British respondents. Thirteen per cent of BME respondents had used the Big White Wall and Suffolk Family Carers (2% and 8% of White British respondents had used these services, respectively).

All respondents were asked if they had heard of NSFT. Of those that responded, over 2 out of 5 (43%) had not heard of NSFT. Among BME respondents over half (49%) of those that answered had not heard of NSFT, while for White British respondents it was just over 1 in 3 (37%).
Of those that responded, 47% had used NSFT. Of the BME respondents who answered, 56% had used NSFT. On average, the service users rated NSFT 7 out of 10 regardless of their ethnicity or age.

Those that had previously used NSFT’s services were asked eleven questions relating to their care. The findings are presented below.

The eleven indicators have been divided into three subdivisions, which can be seen below. As found in the Open Mind Workshops, the responses indicate that the Trust is still falling short of ‘good practices’ in regards to cultural sensitivity. Moreover, the fact that 1 in 3 BME respondents under the age of thirty-five have faced racial discrimination needs to be addressed. Healthwatch Suffolk acknowledge that racial discrimination on any level is unacceptable. However, it is worth noting that the responses are quantitative and need to be qualified in terms of the modes and severity of discrimination via qualitative means to get a fully informed understanding of the discriminatory nature of the service.
Healthwatch Suffolk have also found that the Trust is severely lacking in efficient information dissemination as over 9 out of 10 BME respondents disagreed with the statement ‘it is easy to find information on NSFT’. However, there is hope. Respondents expressed positive personal views toward front-line staff, as almost nine out of ten BME respondents thought that staff were helpful, while over two thirds believed that the staff understood their needs. These are strong foundations for change.

**Faith, Culture and Discrimination**

- 45% of BME respondents thought that NSFT’s service were not culturally sensitive.
- 1 in 4 BME respondents over the age over thirty-five had faced racial discrimination. This figure rose to 1 in 3 for BME respondents over the age of thirty-five.
- Almost 1 in 3 BME respondents had been asked inappropriate questions according to their faith or culture. For those that were over thirty-five, this figure was 17%.

![Disagree that services are culturally sensitive](image1)

![Faced racial discrimination using mental health services](image2)

![Asked questions not acceptable to the person’s culture or faith](image3)
Feeling rushed, repetition, and lack of discussion

- Over half (57%) of BME respondents under the age of thirty-five felt that they did not have enough time to explain everything during their appointments. This figure was over 1 in 3 (35%) for BME respondents over the age of thirty-five.
- 4 out of 5 (80%) BME respondents under the age of thirty-five felt that they had to repeat themselves each time they attended an appointment. This was almost 1 in 3 (64%) for BME respondents over the age of thirty-five.
- Over half of the BME respondents (53%) agreed that instead of discussing their problems they were given a prescription.
Information and waiting times

- Almost 1 out of 3 (63%) BME respondents over the age of thirty-five disagreed with the statement 'I do not have to wait too long for appointments'. This rose to almost 4 out of 5 (78%) among BME respondents under the age of thirty-five.
- Over 9 out of 10 (91%) BME respondents disagreed with the statement 'it is easy to find information on NSFT'.
Staff

- Only 1 out of 10 (10%) of BME respondents agreed with the statement 'mental health staff are not sufficiently trained'. This was considerably better than the sentiment from White British respondents as 27% agreed that staff were not sufficiently trained.
- Almost 9 out of 10 (87%) BME respondents thought that the staff were very helpful.
- Over 2 out of 3 BME respondents (67%) agreed that the staff understood their needs.
Qualitative findings

Shame and secrecy

Mental illness is a taboo subject, meaning there is little open discussion about mental health problems. People with mental health problems agreed that their diagnoses were something to be kept private and not openly discussed, even with immediate family.

Among Asian respondents the reason for this is the need to preserve the family's reputation and status at all costs. Preventing community gossip, which can go on to negatively affect the whole family was a dominant theme. Among those with and without mental health problems, the fear of the community knowing of a mental health problem was the most influential and common reason for Asian participants not admitting to mental health problems. This was directly associated to the social standing of their family.

One interviewee mentioned that rarely does the family make a formal decision to keep their relatives mental health problem secret. Instead it is simply taken as given that as few people as possible should be told. This ingrained acceptance of secrecy was particularly evidenced in the focus groups and interviews with those that self-identified with Asian and African cultures.

Misconceptions and mental health

The culture of secrecy that surrounds mental illness can, in part, be attributed to misunderstandings and misconceptions that have grown up around all aspects of mental health problems over many years. From the interactions had over the period of the Inspiring Progress Project, these misconceptions can be seen in different forms across all communities. However, the misconceptions

Several interviewees from different that self-identified themselves as British Asians, British Pakistanis and Africans noted that caring for people with mental health problems is the family’s responsibility, largely because many in the community do not believe that a mental health problem is a medical condition that can be managed and treated professionally. Instead, there is often misunderstanding about the causes of mental health problems. These include included ‘black magic’ which was seen as a cause and a remedy, the will of God or Allah, genetic (which was described by several people as a defect within the family), and bad parenting.

It is perhaps unsurprising, therefore, that treatment options can be severely restricted. Even those who do recognise mental health problems can be reluctant to seek the appropriate treatment, either because they fear the family reputation will be hurt, or because they
believe the cause is genetic and so cannot be cured. Once someone is
given the label of having a ‘mental health problem’, many believe it can
never be removed. Therefore, a lifetime of stigma can result from an
individual admitting to declining mental health. This misunderstanding
around the levels and types of mental illness also demonstrates a lack
of knowledge of the hopeful, positive reality of recovery for many people
with mental health problems.

Lack of awareness and understanding in families can also result in
families neither recognising symptoms nor supporting people in getting
formal help early. The role of family also has a particularly strong impact
on women’s ability to get help. One Asian female participant highlighted
the role that men play in either allowing or restricting access to formal
support for women with mental health problems, noting that men in her
community have the power to both grant power to or withdraw power
from women. Therefore, the dependence on male support can leave
many women, already hindered by the social norms in the community
around mental health problems, even more isolated and without the
means to recover. This was particularly evident in one case Healthwatch
Suffolk came across.

**Social pressures**

Within the Asian community, adhering to cultural and social norms
is important; people acting outside of these are often considered
abnormal. This was typified by one Asian respondent in particular who
had concealed her mental health from the community at the request of
her family. This is widely cited in the literature on Asian mental health.
However, Healthwatch Suffolk found that a loyalty to social norms is
the key to achieving and maintaining respect and standing within the
community regardless of ethnicity. Through Healthwatch Suffolk’s
ongoing engagement, it is apparent that regardless of ethnicity there is
a societal need to conform to doing well academically, being married,
having children and being employed. This sentiment was stronger
among younger people who often said that living outside of these norms,
whether through poor academic achievements or otherwise, would lead
to stress and anxiety due to a societal expectations.

Through community engagement it was noted that many self-identifying
African respondents noted that social pressures also play a part in
increasing the isolation of people with mental health problems. They
commented that many Africans with non-stigmatising attitudes towards
mental health problems may still be hesitant to interact with those with
mental health problem for fear of being associated with mental health,
and damaging their own social standing.
Marriage prospects and family relations

With many participants stating that among their community mental health problems are both incurable and passed on through the family (i.e., inherently genetic), it was often voiced that marriage and mental health problems are closely linked.

Mental health problems can be a serious threat to marriage prospects in families where arranged marriages are common, either for the person experiencing mental health problems or for relatives who become tainted by association. This was clearly articulated by one respondent who was born in Suffolk but had Asian parents who arranged her marriage. After experiencing mental health problems she was ostracised by her family and husband in an attempt to preserve her family's standing in the community.

Ethnicity and mental health

The Inspiring Progress Project has enabled Healthwatch Suffolk to discuss the topic of mental health with communities throughout Suffolk. The primary aim of this Project, as discussed in the introductory paragraphs in this report, was to expand on the findings and recommendations presented in Norfolk and Suffolk NHS Foundation Trust's Open Mind Dialogue Workshops and engage with and explore how BME communities in Suffolk conceptualise mental health and wellbeing by giving them a voice.

The result of this has shown that individuals should not be pigeonholed by ethnicity, religion or culture. Yes, there are subtle nuances among each ethnic group and culture, but no one ethnic group or culture can be seen as homogeneous. This is an issue that was highlighted in the data and during community engagement events. Rather, the determining factor that controls one's perceptions and understanding of mental health and wellbeing can only be understood in terms of their identity. Thus, being part of a minority ethnic group is only one aspect of their identity and only accounts for one cog in a larger mechanism that creates perception and understanding of mental health and wellbeing. It is for this reason that there is a necessity to treat each individual holistically.
Conclusions

“Nobody understands”
Conclusion

Service user views

Healthwatch Suffolk has interacted with many services users through the Inspiring Progress Project via community engagement events, questionnaires and interviews. The consensus among service users from ethnic minority groups is that there needs to be an emphasis on holistic approaches to mental health care. Many of the Asian participants emphasised the need for lower level mental health problems to be referred to and treated by voluntary organisations. Healthwatch Suffolk attribute this to a belief among many service users that voluntary organisations are not necessarily confined by NHS guidelines and, therefore, can deliver a more holistic and culturally understanding service.

A common theme was that few people knew how they could complain about their care if dissatisfied. This was largely due to a lack of information provided by the Trust, as evidenced in this report by the statistic of 9 out of 10 BME respondents disagreeing or strongly disagreeing that it is easy to find information on NSFT.

The lack of culturally sensitive services was a sentiment shared among many that Healthwatch Suffolk spoke to. This is evidenced in the key findings. It is necessary for the Trust to continue its work with BME communities in Suffolk to find out what forms of racial discrimination and cultural insensitivities have taken place and where in the Trust they are more prevalent.

Although some of the statistics represented in this report raise concerns, many people were happy with mental health services. This raises further questions that need to be addressed; why do some people receive a markedly better experience compared to others?

Understanding mental health

The various minority ethnic communities’ social, cultural and religious responses to mental health problems posed a number of key obstacles for individuals from such communities in acknowledging Western medical understandings of mental health problems. Gossip, negative stereotypes, social rejection and lack of understanding all made it harder for people to identify symptoms of declining mental health as a problem. Indeed, several interviewees said that they would ignore declining mental health as they thought it was a part of life. The lack of understanding was exacerbated by a lack of positive media portrayals of people living well with mental ill-health. Spiritual and faith leaders were identified as key figures who are currently not involved at all with statutory mental health services but are sorely needed.
Perceived causes of mental health problems

Ethnic minority groups’ understanding of what caused mental health problems differed noticeably with the model adopted by NHS services. Rarely did any participant or respondent identify with biological causes of mental health problems. Rather, social problems, family difficulties, isolation, and life in a different culture or a new country, stress generally, spirits and indeed psychiatric medication itself was cited as more likely explanations. This of course represents significant challenges for services to engage ethnic minority groups with their own model of mental ill-health. But it also offers itself to opportunities of educational initiatives that can be provided by the Trust in geographical localities that need them the most.

Finding help

Although some BME groups said a medical professional would be the first person they sought help from, many people suffer in silence. A number of people from Asian and African communities felt it would be better to forget their problems than to talk to somebody else about them. Having family support was identified as critical to help seeking for some, but not an option for others. This ethos varied among respondents and could not attributed to any one ethnicity, religious affiliation or cultural background. However, the majority of Muslim men, by contrast, identified faith leaders as the appropriate person to seek help from.

Not everyone is aware of the services and help available. This was common as 2 out of 5 respondents had not heard of NSFT. Therefore, an advertising campaign is needed to ensure that those suffering in silence or struggling to find help know what services are available in their county.

Accessing mental health services

Ethnic minority groups wanted services to be delivered more holistically. Some people wanted complementary and alternative therapies to be available. Although this is a somewhat contentious issue, the NHS does currently provide some of these therapies and they may be a crucial way of engaging ethnic minority groups by illustrating that services go beyond the Western model that many BME communities widely think of and often referred to throughout the process of the Inspiring Progress Project.

Many service users struggled to get their physical health needs taken seriously and ethnic minorities with multiple needs felt
they were continuously being referred from one agency to another. Similarly, it is important to mention that this issue went beyond BME respondents and was the general consensus of all participants. However, one interviewee mentioned that the habitual relations between White communities and ethnic minorities mean there are profound reasons why some people will be suspicious of what is seen to be a White-dominated service. In challenging this obstacle it was suggested that ethnic minority groups’ care should be complemented by a range of talking therapies delivered by ethnically diverse teams. However, Healthwatch Suffolk acknowledge that this could be difficult considering the demography of Suffolk.

Primary care

A number of concerns deterred people from ethnic minority groups from seeking help at the primary care level. People said they expected primary care practitioners not to have enough time to listen to them, to prescribe anti-depressants as a default solution or to be dismissive of their needs. Many people felt their problems to be social, while some people really struggled with the ‘what if’ questions, assuming that any waiting list they would be put on would be so long that it would not be worth seeking help.

Many felt that there was a lack of communication between the primary and secondary care provided by the Trust, which resulted in some service users facing uncertainty and confusion.
"My experience of mental health services is through my son and daughter. In both cases I have found the service falling short of what I would expect from a professional organisation. Neither of my children have ever received therapy for their conditions even though they have both spent a considerable time in hospital. They are mainly given ‘shut up drugs’ that do not address the illness but instead make them more compliant and easier to manage (this has been admitted to me). Finally, I keep on hearing how the service has improved and yet Carlton Court is being closed down which is going to put even more pressure on beds.”
Recommendations

Healthwatch Suffolk believe that the following recommendations have the potential to make the most significant impact on ethnic minority communities’ perceptions of mental health and services and, therefore, their likelihood of seeking help as early on in their illness as possible.

Improvements for service users

Creating a culturally sensitive workforce

The Norfolk and Suffolk NHS Foundation Trust has taken important step towards acknowledging its responsibility to ensure a more culturally competent workforce by implementing mandatory cultural competence training. However, the training itself does not specifically focus on how staff will actively change their own clinical practice in order to improve cultural competence and, as shown by some of the findings in this report, there is still a significant level of cultural incompetence. Thus, the training provided is not reflected in day-to-day relations with service users from ethnic minorities.

A progressive step is to have a session of the training delivered to a group of ethnically diverse service users and gain their feedback on what needs to be improved. Since Equality and Diversity forms part of staff members’ Knowledge and Skills Framework, cultural competence should form an official part of every staff member’s personal development plan and should be considered during annual appraisal. The training also needs to be extensively evaluated internally and externally, gauging the increased level of knowledge by staff and the effects it has on the service user population.

Most importantly, it is Healthwatch Suffolk’s understanding that the current cultural competencies training does not include any work on different cultural explanatory models of mental health and illness, which should be a key factor in helping mental health staff to understand the needs and perspectives of ethnic minority groups. The training should also discuss the different social challenges which affect ethnic minority groups’ mental health. Suffolk’s local ethnic minority voluntary sector has a wealth of expertise of working with these groups which thus far has not been utilised in cultural competencies training. Therefore, greater local involvement and contribution to NSFT’s staff training should be considered.

Publicising all improvements

Healthwatch Suffolk acknowledge that NSFT often publicise ongoing improvements. However, the announcement of improvements rarely
reach lay people in Suffolk. Rather, the ongoing progress made by the Trust is communicated among organisations that have an active interest in the work of the Trust. Therefore if services are to expect their users to be actively involved in the planning process then much more effort needs to be made to communicate to clients exactly what is being done by the Trust in response to user feedback. This also applies to complaints procedures. A retort to this recommendation would be that the Trust actively feeds information back via events. Healthwatch Suffolk know this to be true. However, service users do not often participate these events and a proactive initiative is needed. The Trust needs play an active role in the communities of Suffolk.

Much more needs to be done in response to complaints for service users to feel that making a complaint is worthwhile. This might be achieved, for example, through publicising the improvements made by an individual’s complaint (should they want to make known any information).

**Creating a public dialogue**

Respondents identified the lack of public community forums about mental health as a factor in supporting secrecy and shame. People wanted open places where members of the public could take part in discussion and ask questions about mental health problems, whether in a GP surgery or community building. It seems that the first step should be for NSFT to bring together all of the third sector groups who are involved in supporting mental health. Having done so, such a group could explore how best to set up this type of mental health forum. For example, a cultural adaption to the Men's Sheds initiative could provide the chance to talk about mental health to promote mental health in the community. Interested statutory sector staff must also be involved to ensure that there is partnership between the sectors for this project.

**Involving children and young people**

One factor often considered likely to deter young people from engaging with mental health services was the social isolation attached to diagnosis. Healthwatch Suffolk found that although the majority of young people were accepting of those in the community with mental health problems, there was still stigma attached to using mental health services for personal reasons.

However, national literature indicates that nationally the numbers of children and young people with mental health problems is rising. For this reason, breaking down the stigma attached to mental health among younger people in an environment that they can share their views openly and honestly is a necessity. One young Caribbean male stated that he would like to spend time with people talking about hobbies that related to him and his peer group. The needs of people too young to feel comfortable among traditional day services is a neglected area, one which should be investigated further by the Norfolk and Suffolk NHS Foundation Trust's Early Intervention Team. One organisation that the Trust could learn from is Volunteering Matters as they have a positive and active role in shaping the lives of many children and young adults.
Medication

A number of people that Healthwatch Suffolk spoke to were taking medications which they did not understand, including side effects they knew very little about. Detailed information about medication is available to clinicians in the Norfolk and Suffolk NHS Foundation Trust in many community languages. However, it seems that these details may not be routinely shared with service users. This type of information is an excellent resource and it is recommended that it should be made readily available to ethnic minority service users in all teams in Norfolk and Suffolk; for example, placed in waiting rooms or distributed to all psychiatrists.

Educating Suffolk

Reinforcing positive perceptions of mental health

Healthwatch Suffolk have heard a breadth of misconceptions about mental health and about services which abound in all communities in Suffolk during the Inspiring Progress Project. While staff in community engagement roles are instrumental in providing informal promotion of services with community groups, Suffolk’s mental health services need to start actively publicising themselves in a positive light to counteract current misconceptions. This type of publicity must be professional and carefully thought out, recognising that one type of publicity may not reach out to all groups. Therefore, NSFT should actively involve voluntary sector representatives of prominent ethnic minorities in the design of publicity campaigns. Using positive personal testimonies from mental health service users from ethnic minorities is also a valuable way of ensuring a representative voice is heard.

Information

Whilst leaflets should never be the main focus of any education or promotion campaign, the stigma surrounding mental health problems is such that some people simply will not attend GP surgeries, nor will they take heed of advertisements on buses or attend promotional events of any kind. Many groups commented that members of their community are unaware of what help is available. Brief, clear information about the steps that should be taken to seek help for mental health problems must be available in every important community language. These should include key South Asian languages (Hindi, Urdu, Gujarati, Panjabi, Tamil, Bengali) and African languages (such as Somali, Swahili) and other widely spoken languages such as Arabic. A concerted campaign must then be undertaken by Community Development Workers to ensure that this information is available in the most appropriate locations. Appropriate locations are in the heart of the community. This means going into the communities that have a higher density of BME people. The Norfolk and Suffolk NHS Foundation
Trust need to become known within communities rather than individuals from communities feeling lost when trying to seek services. An example of proactive work can be seen from the charity Maslaha who have worked with AT Medics, London’s largest group of NHS GP practices, to break down the stigma associated with mental health in BME communities.

**Being creative**

A focused programme of education and promotion aimed specifically at children and young people, mirroring to a degree the cultural competencies training received by NSFT’s staff. Talks and leaflets simply do not capture communities’ imaginations or affect their behaviours. A big part of this should be interesting, appealing events which pupils, and indeed their parents, want to attend.

Much of the problem of mental health ignorance in ethnic minority groups stems from entrenched beliefs passed from one generation to another. Working with young people therefore represents a fantastic opportunity to raise awareness in the new generation.

There has not yet been a focused, coordinated initiative to raise awareness about mental health among school-aged children themselves and this is notable by its absence. A pilot initiative which involves service users and carers in its design, perhaps of using the model mentioned above, implementing what BME service users have learnt from their time with NSFT, could be worked on in future.

It will be important to promote an open-minded approach to different people’s explanatory models of mental health problems but it seems likely that greater understanding of a biological model of mental health problems could reduce stigma by emphasising the fact that the illness is beyond the control of the service user. Many service users said that they would like to see the presence of the Trust in their community rather than them having to attend formal events. This is an idea that the Trust should embrace wholeheartedly.

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

**The Needs of BME Communities**

**Holistic services**

Holistic therapies are a priority for ethnic minority groups. Their availability is crucial for people to feel their problems are being considered, and that they are not simply being given the default treatment of medication. Provision must be developed if services are to be responsive to Suffolk’s community need. Holistic care need not be expensive, as in many cases they will not need to be delivered by a psychologist. For a significant number of people, there was simply a need to talk their life circumstances. This does not need a trained psychologist. Rather a
person to lend a sympathetic ear. This was the case for the majority of people that Healthwatch Suffolk interviewed.

It is important to recruit mental health workers for this low-level talking therapy from a representative range of ethnicities so that clients have some choice over who they see. Some will only feel able to open up to someone from an ethnic group which they identify with, while others may be suspicious that their words will not be confidential when spoken to someone from their own community. However, as previously stated, Healthwatch acknowledge that the demography of Suffolk may present some challenges when addressing this recommendation.

**Services to support physical health**

As part of a movement towards a more holistic approach to healthcare, ethnic minority groups want their physical health needs to be addressed in order to improve their mental health. The Norfolk and Suffolk NHS Foundation Trust has a physical health policy, which is derived from The Department of Health stipulation that every client on an Enhanced Care Programme Approach have a physical health Care Plan. However, current service users did not seem to have felt the benefits of these policies yet. This should be addressed.
“NSFT staff who deal with me are kind and really want to help. Unfortunately they do not have the time to do this. Their caseloads are high and if you are very ill they do not have the availability or resources to deal with the crisis. The Out of Hours Service is pointless as they don’t have the staffing to deal with the number of cases”
End Notes


31. Community-based participatory research (CBPR) is an applied collaborative approach that enables community residents to more actively participate in the full spectrum of research (from conception – design – conduct – analysis – interpretation – conclusions – communication of results) with a goal of influencing change in community health, systems, programs or policies. Community members and researchers partner to combine knowledge and action for social change to improve community health and often reduce health disparities.

32. Targeted sampling uses pre-existing indicator data (qualitative and quantitative) to construct a sampling frame from which recruitment sites are then randomly selected. There are several limitations: 1) sampling may be bias due to the population using non-emergency transport and difficult to replicate; 2) geographic areas may not be sampled in proportion to the number of members in the population of interest; 3) the probability of selecting a member of the population of interest may not be known.

34. Various kinds of rating scales have been developed to measure attitudes directly (i.e. the person knows their attitude is being studied). The most widely used is the Likert Scale. A Likert-type scale assumes that the strength/intensity of experience is linear, i.e. on a continuum from strongly agree to strongly disagree, and makes the assumption that attitudes can be measured. Respondents may be offered a choice of five to seven or even nine pre-coded responses with the neutral point being neither agree nor disagree.


37. Please see http://www.talkingfromtheheart.org/