

The mental health needs of the Bangladeshi community in Camden



an action research project



BENGALI WOMEN'S HEALTH PROJECT

Camden **NHS**
Primary Care Trust

Camden and Islington **NHS**
Mental Health and Social Care Trust

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Foreword

The Bangladeshi community is one of the largest minority communities, with a population in Camden of 11,700 and in Islington of 4,700. It is the expressed objective of this Trust to make our services accessible and tailored to meet the needs of the minority groups it serves. The Trust is constantly striving to meet the needs of the entire population it serves and it is acknowledged that many of our services may not be optimally accessible by all.

This project is one initiative that provided us with the opportunity to look at barriers to accessing our services and how they could be overcome. The aim of the project was to facilitate community mental health teams (CMHTs) in the borough of Camden in making their services more accessible and appropriate to the needs of the local Bangladeshi communities. It was also an intention of the project to raise awareness of mental health issues and services within the Bangladeshi communities, and to carry out some mental health promotion work.

Three project workers were appointed in order to carry out this task. South Bank University provided academic supervision. A steering group involving all stakeholders was also set up in order to monitor the progress of the project. This whole process proved at times to be a challenging but rewarding task.

The project has subsequently provided us with some valuable information and insights into the needs of the Bangladeshi communities living in Camden and Islington. It is now up to us to develop a strategy to address the identified needs. We intend to monitor and evaluate our progress in relation to delivering on the strategy.

I would like to take this opportunity to thank all those involved in making this project possible.

Erville Millar, Chief Executive
Camden and Islington Mental Health and Social Care Trust
December 2002

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1. Executive summary

1.1 Why the project was set up

The Bangladeshi community raised the mental health needs of their community with the health promotion service (HPS). As a result of this, the health promotion department of Camden and Islington Community NHS Trust has made mental health promotion work with the Bangladeshi community a priority since April 1999.

At the black and minority ethnic mental health reference group (1999) a member of the Bengali Women's Health Project (BWHP) asked why it was that members of the Bangladeshi community appeared to be under-represented in their use of statutory community-based mental health services.

1.2 What the project did

A steering group was set up. It agreed the following aims:

- To raise awareness of mental health issues including mental health promotion, and of services within the local Bangladeshi communities and to inform other local and national groups about the project, its findings and its recommendations.
- Through the employment of an action research team, to facilitate community mental health teams (CMHTs) in making their services more accessible and appropriate to the needs of the local Bangladeshi communities.

1.3 What has been achieved?

With this type of project it is not possible to point to a direct causal relationship between the project work and particular positive outcomes. However, listed below are positive outcomes that the research project as a whole (including all our stakeholders) and the research team in particular, are proud to have contributed to and to be directly associated with.

1.3.1 Changes in the community

The language used in the Bangladeshi community to talk about mental health issues indicates a greater understanding of mental ill-health, and more people are aware that the community mental health teams (CMHTs) exist, how they work and what they do.

There is a closer working relationship between CMHT staff and community organisations that support Bangladeshi people. Community workers more frequently contact CMHT staff for advice and information when a member of their community is having mental health difficulties.

There is an increased expectation that when a member of the Bangladeshi community contacts a CMHT they will be talking to someone who understands the ethnic and cultural issues associated with any presenting mental health difficulties.

As a direct result of the concern expressed by members at the stakeholder event (February 2002), substance misuse commissioners have established a partnership development group, which will run two further consultation events. The group has made applications for funding to tackle issues that are arising. The group has already drawn up plans for a youth development project, a health promotion campaign, a training development scheme (training about substance misuse for community members), and an environmental development scheme (improving the built environment reduces street dealing).

1.3.2 Changes in primary care

- Doctors in group practices in south Camden view CMHTs as centres that offer an effective service to their Bangladeshi adults experiencing severe or acute mental illness.
- GPs have an increased awareness of the issues associated with mental ill-health in the Bangladeshi community.
- GPs seem to be more aware of the somatic expression of mental illness and are increasingly calling on the expertise of the CMHT staff to offer advice and information about the Bangladeshi community in relation to mental health issues.
- GPs are making more referrals of Bangladeshi adults to CMHTs.

1.3.3 Changes in CMHTs

- Staff in CMHTs appear to find it easier to discuss issues of race and culture openly.
- An understanding of the Bangladeshi community and how they are affected by mental illness, as well as an expertise in working with the community, has been shared across the teams.
- The CMHT has been exposed to the community in a different way which has enabled professional and non-professional groups to come together to create solutions.

1.4 What else needs to be done?

The work of this group and the action research project was to discover why only a relatively few members of the Bangladeshi community used CMHT services. However, having listened to the community, it has been realised that their concerns about mental ill-health extend beyond this rather narrow focus.

The recommendations in section five therefore represent the wider concerns of the Bangladeshi community. The recommendations call for further dialogue and collaboration between primary and secondary services, the community and community organisations, which included local mosques.

1.5 The response from key individuals and groups

- Culturally accessible information and services.
- Workers recruited from the Bengali community.
- Cultural training for CMHT staff.
- Closer working relationships between community organisations and front line workers within the CMHT.
- Raising awareness of health services within the Bangladeshi community.
- Mental health awareness sessions in non mental health settings.
- Innovative ways of reaching out to the community.
- Involvement of religious leaders to facilitate understanding of mental health issues.
- Increased counselling, advocacy and other therapeutic services.
- Increased involvement of the Bangladeshi community in service provision.
- Support for Bangladeshi carers.

Representatives from key organisations that wish to be involved or are already involved in working with the Bangladeshi community will be at the launch of this report on Wednesday 12 March 2003.

These representatives will be presenting for discussion an action plan that, if approved, will be implemented over the next year and beyond.

2.0 Background to project and methodology

2.1 Background

2.1.1 The Bangladeshi community



The Bangladeshi community in Camden are the most recent migrants from Asia. Most of the migrants came to Britain during the in the 1950s to fill labour market shortages. The jobs that were offered to economic migrants were in the lower quartile in terms of skills, wages, working conditions and prospects for promotion.

Their migration history is relatively recent compared with other minority groups, particularly in relation to completed families. The vast majority of the Bangladeshi community came from the rural area of Sylhet region, which lies in the north-eastern part of Bangladesh. Sylheti is the main dialect spoken throughout Sylhet and has no written form. Around 90% of the population are Muslims (Kapasi, 2000).

2.1.2 The Bangladeshi population in the UK and in Camden and Islington

The 1991 census recorded 163,000 Bangladeshi people in the UK; fewer than half of them were below age 16 and around three-quarters were under 35. Out of that population only 2,000 were aged 65 and over. In 1994, a national survey of ethnic minorities revealed that 48%

of Bangladeshi respondents were under 15, 48% were between 16 and 59 and 4% were 60 years and over.

London has 54% of the Bangladeshi population in the UK, and primarily in inner London (45%). The Bangladeshi community constitute 2.8% of the inner London population, 0.4% of the outer London population and 0.5% of the national population (Bhui and Oliajide, 1999).

According to the 1991 census there were 8,656 Bangladeshi people living in Camden and Islington and it is anticipated that the 2001 census will report an increase in this figure. The 1991 census figures showed that the Bangladeshi community constituted 6% of Camden's population, making them the largest Black and Minority Ethnic (BME) community in the borough. The Bangladeshi community is most prominently represented in four wards in the south of the borough, where they represent the following percentages of the ward population:

- | | |
|------------------------------|-----|
| • Regent's Park | 14% |
| • King's Cross | 10% |
| • Holborn and Covent Garden | 8% |
| • St Pancras and Somers Town | 7% |

The age profile of the Bangladeshi community in Camden is slightly different from the population as a whole. The whole population (all adults in Camden) shows a peak in numbers between the ages of 35 and 45, with a steady decline as the age increases. The Bangladeshi community, on the other hand, has a peak in numbers at about 20 years and another smaller peak at about 64 years.

The peak at 64 years is also likely to see a trend of presentations of disorders associated with increasing age, whereas in the population as a whole there is expected to be a proportionate reduction in the presentations.

Learning point

The Bangladeshi community in Camden is not a single homogeneous group: there are at least three distinct groups with very different mental health needs.

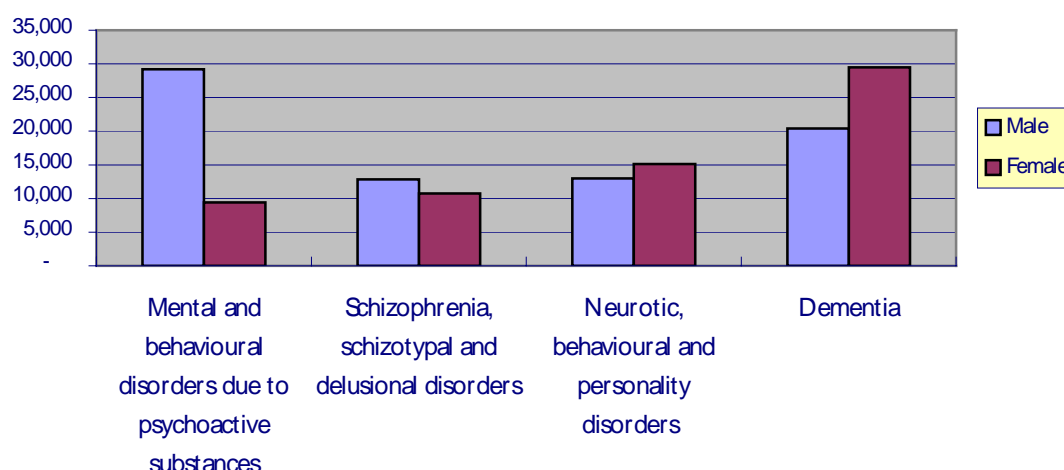
Planners may wish to note that 75% of Bangladeshi people are under the age of 25.

There are also a significant number of adults (men and women) who have come into Camden following their marriage to someone already living in Camden.

Taking local demographics together with the national data published on psychiatric admissions as well as data about psychiatric morbidity in the Bangladeshi community, it is likely that new presentations of

symptoms of schizophrenia and substance misuse by the Bangladeshi community will remain fairly constant over the next 20 years. There are likely to be about 45 Bangladeshi adults requiring CMHT services in any one year.

The national inpatient episode data gives a gender analysis for admissions by diagnosis as follows:



See Appendix 1 for more detailed figures and projections for Camden's

2.1.3 The need for good mental health in communities

Issues associated with promoting 'mentally healthy communities' will be familiar to all mental health professionals. There have been a number of national and local initiatives aimed at addressing these issues, nearly all of which recognised the need for equality. For example, throughout the 1990s, the race and mental health group met in Camden in order to examine and address issues of access to and appropriateness of statutory and voluntary services. Mind in Camden set up a service for ethnic minority service users called FeSo and in 1993/94 Camden Social Services started the Bridge Project, a mental health service offering practical, social and emotional support for people from the African, African Caribbean and Bengali communities. Health trusts and Social Services have offered organisational development and leadership courses for Black and Minority Ethnic workers as well as support and interest groups.

More recently, the *National Service Framework for Mental Health* (DoH, 1999) set out the basis for providing and promoting good mental health within the community. The national service framework (NSF) emphasises the importance of a partnership between people in the community using mental health services and those providing them. In particular it emphasises the importance of:

- Health improvement programmes demonstrating the promotion of

good mental health in the community, particularly to the most vulnerable.

- Access to a range of resources, including support from community organisations and self-help groups – based on the experiences of service users and carers.
- Access to 24-hour services, including resources to manage crises and promote access to services.
- The availability of information on medication, treatment and care.

The Health Education Authority (HEA, 1997) states that one in seven people experience a mental health problem and the chances of this are influenced by a number of social factors, for instance:

- Living in urban areas.
- Living in rented accommodation.
- Unemployment.

2.1.4 The race equality agenda

The Race Relations Act (1976), as amended by the Race Relations (Amendment) Act (2000), gives public authorities a general duty to promote race equality. The Home Secretary has issued an order under the Act, giving local authorities specific duties with regard to policy and service delivery.

The inquiry into matters arising from the death of Stephen Lawrence (the Macpherson report) defines racism and institutional racism as follows:

‘ “Racism” in general terms consists of conduct or words or practices which advantage or disadvantage people because of their colour, culture or ethnic origin. In its more subtle form it is as damaging as in its overt form.

“Institutional racism” consists of the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness, and racist stereotyping which disadvantage minority ethnic people.’

This issue will be familiar in Camden because mental health practitioners, policy and planning staff and the Camden health and race group have been addressing it for a number of years.

For example, the recommendations of the Macpherson report from the Stephen Lawrence enquiry (Home Office, 1999) stressed the importance of combating institutional racism, recognising that any institution is made up of individuals who set policies and procedures:

‘There must be an unequivocal acceptance of the problem of institutional racism and its nature before it can be

addressed, as it needs to be, in full partnership with members of ethnic minority communities.'

Only by creating a more diverse culture in these institutions and organisations, will they begin to change. Since the Macpherson report, many BME organisations have stressed the need for research into the needs of their communities.

A report by London Borough Grants (LBG) into the challenge posed by these issues for voluntary organisations (which can apply equally to statutory organisations), stressed the need to reduce the gap between academic research and policy formulation. It is in this spirit that this action research project into the mental health needs of the Bangladeshi community in Camden was devised and carried out.

2.1.5 The Camden agenda

The wider strategy for mental health services is the NSF. This is translated at a local level into the Camden and Islington mental health and health improvement programme. Other frameworks include the Camden and Islington community involvement strategy as well as the regeneration strategies for King's Cross and west Euston. Additionally, the *Camden community strategy (2001–2006)*, target 22 states:

'We will work with black and minority ethnic organisations funded by the Council to strengthen them and help them deliver better services.'

The strategy also refers to:

'... developing more ways of working with people and communities, particularly harder to reach groups such as ... ethnic communities'.

and says:

'We will not tolerate people losing out in any way from the best Camden has to offer because of their racial background. We have all promised to put the lessons of the Stephen Lawrence inquiry into practice.'

Also, the discussion document on the establishment of a mental health and social care trust for Camden and Islington (September 2002) stated:

'We will do all we can to make sure our workforce reflects the local community they serve and that the local community benefits from the presence of a major employer, such as the Care Trust.'

This project is an attempt to reflect the wider legislation and guidance affecting mental health services and the provision of these services to Camden's largest ethnic minority community.

2.1.6 Reasons for an action research project looking at the mental health needs of the Bangladeshi community in Camden

At a Black and Minority Ethnic reference group meeting, it was noted that although the Bangladeshi community was the largest minority group in Camden, use of statutory community services such as CMHTs by that community seemed unusually low. This project attempted to create an action-focused coalition between the CMHTs and the Bangladeshi community as a whole, as well as between a wide range of stakeholders. The project set out to change the current position by finding answers to some basic questions:

- Is it true that the Bangladeshi community is under-represented in their use of statutory community-based mental health services (such as CMHTs)?
- If there is an under-representation, is this a good thing or not?
- Why is it happening?
- What changes will need to be introduced in order to address this issue?

The project design recognised the need not only to understand the issues, but also for the project to act as a catalyst for change. The findings from this action research project are intended to provide a basis for joint action in the community and among service providers in order to support the Bangladeshi community and build on the progress that is already being made.

This research is particularly timely given the establishment of a mental health and social care trust in Camden in April 2002.

The action research project was also influenced by a meeting in 1999 between Camden Social Services, Camden and Islington Health

Promotion Service and the Bengali Women's Health Project (BWHP) management group. The BWHP management group was made up of representatives from Camden and Islington Health Promotion Service, Camden health and race group, Coram Parents' Centre, Fitzrovia Neighbourhood Centre and King's Cross and Brunswick Neighbourhood Centre. The discussion highlighted the following:

- The need to improve access to services by local Bangladeshi people.
- The need to raise awareness of mental health issues and services and mental health promotion amongst local communities.
- The need for actual changes to be made through the project, not just research and consultation.
- The need to employ local Bangladeshi people as workers so that they become a community and mental health service resource, and the promotion of their professional development and longer term employment opportunities in local mental health services.

The health promotion service drew up a project proposal, based on a health promotional model of action research, as well as community and organisational development. Funding for the project was obtained from three sources:

- Camden Social Services.
- The West Euston Partnership.
- The King's Cross Partnership.

2.1.7 Previous initiatives involving the Bangladeshi community in mental health issues

The Camden and Islington Health Promotion Service and the Bengali Women's Health Project had set up and run a series of health promotion projects over a three-and-a-half-year period prior to the setting up of this action research project, including:

- A mental health needs assessment, involving the community, key community workers and health professionals, started in April 1999.
- Project Aalap, a mental health promotion project started with women using the Hopscotch Asian Women's Centre, started in June 1999.
- World Mental Health Day celebration event, one-day event at Coram Fields, attended by 200 women and officially opened by the Mayor of Camden, Councillor Roy Shaw, in October 1999.

Learning point

This project cannot be fully understood or its success evaluated without recognising that it was part of a whole series of initiatives, some before, some during and, hopefully, some after the project took place.

- ‘No more small portions of services please’, a focus group study highlighting the mental health needs of Bangladeshi people and training of Bangladeshi community workers in Camden and Islington, and drafted in October 2001 (Kapasi, 2000).
- A mental health training programme for Bangladeshi community workers and lay people, run three times in summer 2000, 2001 and 2002.
- The creation of the Bangladeshi mental health forum, October 2001.

These and other developments helped create a base for engaging the community with the project. For example, having the BWHP and health promotion service partnership already in existence provided easier access to the community for HPS and CMHTs. The BWHP also played a key role in the action research project by providing easier access to the Bangladeshi community and obtaining the commitment of the workers in Bengali community projects.

2.2 Project methodology

2.2.1 *What is action research and why was it used?*

Community development is increasingly being used to enable communities to develop sustainable initiatives to address their local health needs. It is important that social, environmental, and economic issues be included in these initiatives.

Action research can be defined as a three-step spiral process of:

- (1) Planning, which involves reconnaissance.
- (2) Taking actions.
- (3) Fact-finding about the results of the action (Kurt Lewin 1947).

Participatory research

Versions of this practice go by many names: **community-based research, action research, participatory action research, collaborative research**, and others. A goal of the research is to engage in action that reverses inequalities, empowers the socially disadvantaged and ultimately transforms society so that power is based in grassroots organisations and individuals.

This action research project is an attempt to focus the dialogue between the community mental health teams and the Bangladeshi community on the apparent lack of CMHT⁽¹⁾ services used by the Bangladeshi community. The project builds on the work already done by the CMHT, Camden and Islington's health promotion service and the Bengali Women's Health Project.

This project also attempts to reflect the wider legislation and guidance affecting mental health services and the provision of these services for the Bangladeshi community, Camden's largest minority ethnic community.

Action research was deemed to be the most appropriate type of project to achieve these objectives. In health, action research aims to improve professional practice and raise the standard of service provision. Participatory research⁽²⁾ is increasingly being used to enable communities to develop sustainable initiatives to address their local health needs. It was agreed that social, environmental, and economic issues should be included in these initiatives. A desirable feature of the action research process was that people from the Bangladeshi community could be fully involved with the researchers in articulating the problems and agreeing possible solutions.

Action research aims to improve professional practice and raise the standard of service provision. (A Morton-Cooper 2002)

The research began by asking people from the community involved in the research to examine a problem within their culture and suggest ways of resolving it. Everyone, including the researchers, is involved and becomes part of the action research network, articulating the problem and having a vision of possible solutions:

Stage A: The team reviews what services are already in existence and how the services were used.

Stage B: Information is gathered through interviews, revised and reviewed.

Stage C: Options are taken and prioritised.

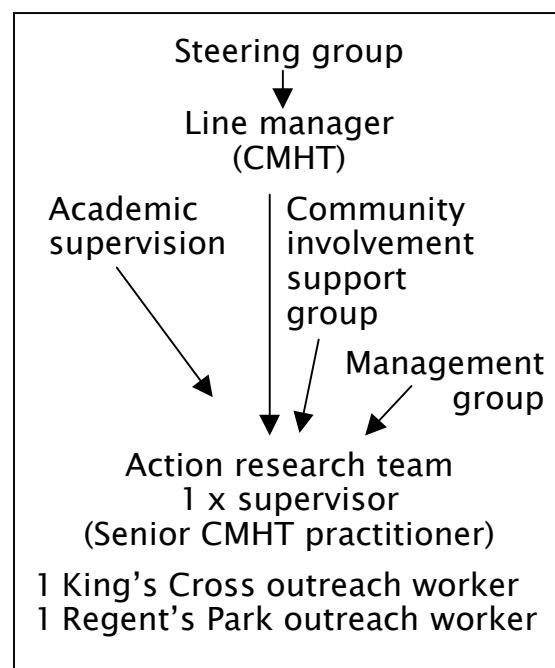
Stage D: Priorities are identified, implemented and tested for users' satisfaction.

2.2.2 Methodology

Two workers, supervised and guided by a mental health practitioner, undertook the research work. Two health promotion specialists also provided them with ongoing support and guidance. A community involvement support group was formed and met regularly. A steering group was formed to oversee the project (see Appendix 6), which included representation from:

- Community organisations.
- The community mental health team at Camden Social Services.
- The health promotion service at Camden and Islington Community NHS Trust.

Overall management of the project came from a steering group. The group had representation from community organisations and religious leaders, the Bengali Women's Health Project (a consortium of Bengali women's groups), Camden and Islington Community NHS Trust, the health promotion service, the CMHT where the team was based, South Bank University and Camden Social Services, as well as the three project staff. (Please note that some of these organisations have different identities since the establishment of primary care trusts in Camden and Islington.)



An assistant locality director, who had overall responsibility for the CMHT where the project was based, chaired the group. Line management of the project was through the existing line management at the CMHT and it was also supported by academic supervision and a management group.

Two workers and their supervisor conducted the direct research for the project. It was agreed that two health promotion specialists would provide support and guidance, in order to ensure active community involvement and delivery of mental health promotion work.

A community mental health team (CMHT) is a community-based mental health service made up of professionals from disciplines including Health, Housing and Social Services. They offer 'joined up' mental health services to adults in their area.

The findings from this action research project are intended to form recommendations for policy makers and service providers in terms of supporting the Bangladeshi community, building on the progress that is already being made.

Funding and support for the project came from four sources: Camden Social Services, West Euston Partnership, King's Cross Partnership and Camden and Islington Community NHS Trust.

2.2.3 Undertaking the research

A bilingual leaflet giving information about the project was jointly developed by the action research team, the health promotion service and BWHP, and then distributed to the Bangladeshi community. Health promotion specialists developed a stage drama to highlight mental health and domestic violence issues. The research team participated in a number of discussion and video sessions. The health promotion service and BWHP organised a training programme on mental health promotion and counselling skills for community and mental health workers. The action research workers were encouraged to attend and they also participated in a mental health peer education project organised by the same organisations.

The researchers spent the first few months in networking and consultation, with the aid of community organisations, establishing a rapport with the community and professionals involved, as well as familiarising themselves with the locations where the research was undertaken. Visits were made to community centres and discussions held with individual workers and people of Bengali origin. Almost all GP centres in the target area were visited. GPs and practice nurses participated in detailed discussions about the project and provided valuable information. The researchers accompanied CMHT staff on home visits to clients and their carers.

Information was gathered from other areas where there is a dense population of Bangladeshi people, such as Tower Hamlets and Birmingham. A literature search was subsequently conducted, looking at similar studies in the UK and contrasting the results with the project's findings. A focus group was held with the steering committee and researchers. This also helped frame the final recommendations. Recommendations on findings were presented to some GP surgeries.

2.2.4 Data collection

Information was gathered by a combination of quantitative and qualitative methods:

- Semi-structured interviews that involved face-to-face consultation with the steering group members and service providers.
- Observing and reflecting on activities and interventions with community groups.
- Discussion, drama and video sessions with the community, then more discussions.
- A focus group with members of the Bangladeshi community.

The direct research part of the project took place in the King's Cross and Regent's Park areas of south Camden and the Killick Street area of south Islington. The sample consisted of 174 members of the community aged from 18 to 65, and 30 service providers.

2.2.5 Interview questions

The questions included a focus on solutions to combat mental health problems. Service providers and stakeholders were asked questions designed to demonstrate their view of and knowledge about the Bangladeshi community, and the influence of their work on this community. Questions also covered the difficulties they encountered and sought their views on how these could be overcome. All interview questions were piloted with a senior member of the CMHT and are detailed in the appendices.

2.2.6 Interviews and focus groups

Face-to-face interviews were conducted with members of the community, health visitors, GPs and professionals from the CMHTs. Several group discussions were held with users and carers in community centres. In collaboration with the health promotion department, the research team conducted drama sessions in different community centres. These sessions did not have mental health as a main focus, but they attracted a number of participants who subsequently formed the core of the main research focus groups. These groups consisted of eight to 12 participants (single sex) and were facilitated by a member of the research team in Sylheti and Bengali. A community worker attended each group session and validated the data.

2.2.7 Stakeholder conference

A large number of stakeholders had been consulted over several months and a considerable amount of information gathered. However, once the information had been collated and analysed, the steering group wanted to allow all the stakeholders to meet together to reflect on the findings so far and to have the opportunity to prioritise the large number of recommendations that had come out of the consultation exercise.

An interim report identifying options and priorities was published in December 2001. A half-day event was organised for 7 February 2002. The event allowed a range of stakeholders to come together to discuss the findings and make recommendations.

The main recommendations from the event were:

- The steering group welcomes the positive feedback from the Bangladeshi community. When planning future events, this method of working will be adopted where it is appropriate to do so.
- Access issues have been addressed in part by the recruitment of the action research workers who are based in the community mental health team offices in Tottenham Mews. It is recognised that, at the end of the research project, there will be a need for an outreach worker or a support worker in order to ensure the links between the statutory services and the Bangladeshi community remain strong.
- The need to improve the interpreting services for Bangladeshi adults seeking mental health support will be taken to the appropriate managers with a view to offering additional mental health training to interpreters.
- Concerns about drug-taking in the Bangladeshi community will be addressed through a separate half-day event. In addition to members and representatives of the Bangladeshi community, we will invite Sarah Hart, substance misuse joint commissioner and development manager, as well as other statutory and voluntary sector practitioners.

2.2.8 Publicising the project at community activities

In July and October 2001, the team held a stall with information about mental health at the Bangladeshi *me/a* (festival) and World Mental Health Day respectively. These events enabled the research team to inform the wider community about the project and its objectives. These venues were also good places for networking with other professionals, service users and carers.

2.2.9 Ethical issues

The research team paid particular attention to treating the participants with respect and with gratitude for their participation. The travel expenses of those who attended the focus group were reimbursed and the report of the research will be made available at every community centre. At some groups, tape recorders were used. Prior to this, each participant gave written consent, was assured in their own language that they could withdraw their participation any time they wished and was assured of confidentiality. Ethical approval was sought from the Trust ethics department for involving clients already working with professionals, prior to their participation in the research.

3 What the literature says – summary of literature search

3.1 Socio-economic factors

3.1.1 Social factors and their impact on mental health



The publication *Inequalities in Health*, (Black *et al*, 1980) provided a detailed study of the relationship between mortality, morbidity and social class. Nazroo (1997) argues that ‘the quality of health care received by patients appears to be related to their ethnic background’. He states that ethnic minority groups are among the poorest people in

Britain and they also have the worst health. Other studies extend this link to mental health specifically. Meltzer *et al* (1995) demonstrated a correlation between mental health and a number of factors in social deprivation such as poor housing, poor education and unemployment. Beliappa (1991) and Thompson (1997) showed how factors of social deprivation affected marital and family relationships, making it more difficult for them to provide support to vulnerable members of the family. Indices of deprivation (DLTR) show that King’s Cross and Regent’s Park are among the most deprived wards in the country.

3.1.2 The mental health needs of the community

In June 2000, the Department of Health published a report (ref 2000/0350) highlighting the health inequalities among ethnic groups. The report says:

‘A measure of general psychiatric morbidity shows that a much higher proportion of Bangladeshis may suffer from psychiatric illness (2.5 for men and 2.4 for women).’

The social and economic factors associated with higher psychiatric morbidity are discussed below.

3.1.3 Low income and unemployment

The Bangladeshi community in Britain generally and in Camden and Islington specifically, is one of the most deprived BME communities, 71% of them being in the bottom income bracket (Rukshana, 2000). This is borne out by other studies. An Association of London Government (ALG, 1999) report shows that Bangladeshi communities are among the most deprived communities in London. They have high levels of unemployment and nearly twice the rate of long-term limiting illness as the white population in London. In Tower Hamlets, male unemployment is between 46% and 50% amongst the Bengali population in some wards (Rahman, Dockerell and Gaskell, 1993).

Unemployment is even higher amongst Bangladeshi women: a study of Bangladeshi women by the Commission for Racial Equality (CRE, 1997) showed that only 13% of Bangladeshi women were classified as employed. Of 80% of black women in paid employment, only 20% are Bangladeshi. Bangladeshis are also more likely to be employed in jobs with low incomes. A report by Walker (2002) indicated that although people of south Asian origin form 1.1% of the working population in Britain, only 22.8% of men and 32.3% of women were in white collar jobs. Most Bangladeshi men are in low-paid jobs such as catering.

3.1.4 Stresses on families

Economic and housing problems all add to stress levels within Bangladeshi families. Bangladeshi children have considerable levels of under-achievement in schools, which is compounded by their lower levels of fluency in English, as compared with other more established ethnic minority communities (Home Office, 1986). Kapasi (2000) highlighted conflict and a mutual lack of understanding between Bangladeshi parents and their children. Parents had very high expectations of their children and found their behaviour difficult to understand as their children were more drawn to a western way of life. The same author also cites instances of domestic violence within Bangladeshi families. The report also highlighted the lack of family-centred resources to provide support for families from these communities.

3.1.5 Gender issues

Statistics indicate that more men than women are likely to need psychiatric intervention due to an episode of schizophrenia or substance misuse (Department of Health hospital episode statistics, 1999/00). However, some research indicates that mental illness in

Asian women may be under-reported. There may be a number of reasons for this. Social isolation is a particular issue for Asian women. Many of the stresses in the family bear most heavily on them. One project looked at young Asian women with mental health problems across four wards in Birmingham that had a population of 23,000 Asian women (NHS Ethnic Health Unit/UK Asian Women's Centre, 1999). They found evidence of peer group rejection, low self-esteem, difficulty in making and maintaining relationships and fears for the future. There may also be some cultural disparity between traditional Bangladeshi values in the home and very different values at school and in other external social environments.

Women may be coping in isolation with bringing up a family amidst marital and financial problems. Being seen as 'alien' on the basis of their skin colour adds to this, but GPs may overlook cultural, religious and emotional issues and see only the physical problems (Radia, 1996; Jaus, 1986 and Flockhart, 1986). One example from this study gives shows the range of problems that may be faced:

' . . . a Bangladeshi woman whose only language was Sylheti and she was afraid to go out and to visit others. Her husband died after she came to this country and there were remarriage issues. Her main worry was her daughter's arrival in the UK being delayed and this led to stress and feelings of numbness, insecurity and doubts about her future in Britain.'

As a result of this isolation, many Asian women experience a high percentage of psychological distress such as depression (Beliappa, 1991 and Fenton *et al*, 1993). One study showed that only 11% of the sample would be able to talk about their personal problems to someone of the same gender (Save the Children, 1996).

Social pressures are not confined to women. Studies by Asian family and marriage counselling services have revealed that Asian men often suffer discrimination within their own communities, because of low incomes and poor employment status. The studies go on to remark that the assumption that Asian men do not need services is dangerous as this implies that, as male figures, they do not necessarily have emotions (*Community Care*, September 1996).

Nevertheless, these findings nationally should be treated with caution before being assumed to apply specifically to Bangladeshi women in the Camden area.

3.1.6 Younger Bangladeshi people

One study of a predominantly Bangladeshi community in Newcastle showed that younger men and women had the most complex needs. They felt caught between two cultures and had a reluctance to go to the local GP:

'The GP knows the rest of the family too well.'

'If I go [to a facility] close to home the family gets suspicious.'

Some young Asian women were reluctant to speak to someone from the Asian community if it was a personal problem, for example teenage pregnancy. This could include the GP or other health professional (Save the Children, 1996).

3.1.7 Incidence of racism and lack of integration in society

Littlewood and Lipsedge (1997) examined the epidemiology of mental ill-health among ethnic minorities and black Britons, concluding that mental illness can be a response to disadvantage and prejudice. Nazroo (1997) also includes racial discrimination as a factor affecting the health and well-being of ethnic minority communities. A survey of Camden's Bangladeshi residents (Camden Equalities Unit, 1996) showed that 62% of the group surveyed felt racial harassment was a subject for concern. One in three households had suffered racial harassment and this had resulted in them making changes to their daily lives. Some 34% of those surveyed only visited the shops at certain times.

Experience of racism may affect clients' perceptions of health visitors (Thompson, 1997) and, by association, other health professionals. This makes it more difficult for them to press for the services that their community needs (Radia, 1996). People in one predominantly Bangladeshi community surveyed felt they had little influence over their care and treatment. It was not possible to uphold standards and rights of access to health records, as there is a lack of community languages spoken or written (Save the Children, 1996). Services need to have explicit policies on racism and harassment (Bhui and Bhugra, 1999). A psychiatrist quoted in Swindon Race Equality Council (1997) said an ethnic monitoring of services was needed.

A closely linked factor is feelings amongst the Asian community that they do not belong in British society. One study of a predominantly

Bangladeshi community (Rahman, Dockerell and Gaskell, 1993) included the following quotes:

'The biggest reason why a lot of us go off of our heads is that we are living in a world which has nothing to do with us.'

'The fact that you're not finding yourself [represented in society] means that your self-worth is pretty low.'

This makes it less likely that Asian communities in general and the Bangladeshi community in particular will feel they have a strong voice in policy-making and in pressing for resources to meet their mental health needs.

3.1.8 Low levels of employment in the health professions

Feelings of under-representation in society may be reinforced by the low representation of BME communities in the health professions. For instance, statistics published by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting, (UKCC, 2001), states that of the 218,165 who have registered and are in practice, 89.5% are white, 4.9% black, and 2.8% Asians. Other evidence shows that only 1.1% of qualified nurses are of Asian origin (NHS, 2001).

In Camden, exact data is not available because of the recent creation of a mental health and social care trust. Additionally, the comparisons are based on estimated increases from the 1991 national census. However, workforce data from the Camden and Islington Community NHS Trust show that 0.75% of the staff are classified as Bangladeshi, whereas the Camden Bangladeshi population (aged 18 to 64) is estimated to be 4%.

3.1.9 Housing

Bangladeshi people are amongst the worst housed in London, with high levels of overcrowding, sharing of facilities, lack of basic amenities and children living above ground level (London Research Centre, 2000). Bangladeshi families tend to be bigger than the norm: there are almost twice the UK national average number of families with three or more children per family. Housing often accommodates several generations, which may create difficulties in terms of the generation gap and exacerbate overcrowding. One study showed that 86% of Bangladeshi households had experienced social problems in

relation to housing (Rahman, Dockerell and Gaskell, 1993).

3.2 The interface between the Bangladeshi community and mental health services

3.2.1 Language difficulties

In general, the Asian population has linguistic and communication problems, which make diagnosis more difficult for GPs (Bhugra and Beena, 1999). Language difficulties can be a particular barrier for the Bangladeshi community. One study in Tower Hamlets showed that six out of 10 families did not speak English at home and nine out of 10 pupils were not fluent in English by the time they got to secondary school (Radia, 1996).

Educationalists distinguish between different levels of language skills. Someone who is socially fluent in English for example, may not be able to explain to someone from a different culture what symptoms he or she is experiencing. Educationalists believe that academic fluency (stage 3), would be required in order to explain some symptoms adequately. Attaining stage 3 fluency in English can take several years.

It is not clear from our research the extent to which language is a barrier within the Bangladeshi community in Camden in 2002. Camden education service has indicated that all Bengali and Sylheti-speaking 17-year-old students are socially fluent in English. However, anecdotal evidence says that a significant proportion of Bangladeshi households are Sylheti-speaking.

3.2.2 Problems with interpreters

Language difficulties may be exacerbated rather than helped by interpreters. One study (Good Practices in Mental Health Self-Advocacy Scheme, 1994) indicated that interpreters could alter the relationship between clients and professionals. This may happen when an interpreter lacks an understanding of mental health issues and a breakdown in communication may occur (Swindon REC, 1994). Interpreters must have a clear understanding of what they are trying to convey or there will be dangers of misdiagnosis. Middle-class interpreters tended to talk to the GP rather than the client and even told them to 'shut up', as the GP '. . . knows what he is doing'! Sometimes interpreters refused to convey an imam's recommendations as they thought them to be 'nonsense' (Rahman, Dockerell and Gaskell, 1993).

There is a danger in interpreters acting as advocates, as these are two different roles (London Voluntary Service Council, 1998). Another study pointed out the inappropriateness of families and friends interpreting and that they should only be used as interpreters in acute emergencies (Bhui, Bhugra and McKenzie, 2001).

Nevertheless, some studies recommended the availability of professionally trained interpreting services around the clock (Bhui *et al*, 2001) and that advocates and interpreters should be present if a person cannot speak English (Radia, 1996). There were issues of recruitment and training if the interpreting role is to be raised in status and competence (Save the Children, 1996).

3.2.3 Specialised services – for and against

There are a number of arguments for and against the provision of specialised services for people from BME communities that are well summarised in a study by Bhui, Bhugra and McKenzie (2001).

Advantages may be that they:

- Develop more specialist skills.
- Increase knowledge of BME issues.
- Appoint staff with the appropriate cultural knowledge.
- Allow a follow-up of discharged patients using staff from other cultures (presumably as the client is more likely to keep in touch with them and vice versa).

Disadvantages may be:

- Marginalisation by generic services of BME and specialist staff.
- There is less incentive for improvement by mainstream services.
- Ethnic 'matching' is expensive and there is no evidence of improvement.
- This may lead to fragmentation of services.
- People from BMEs may be 'dumped' into specialist services and not necessarily be helped by them.

The arguments for and against specialised services are best summarised by the authors of the study, who conclude that it would be better if statutory services adopted models of informal and culturally flexible services provided by voluntary and community organisations.

3.2.4 Greater involvement of BME communities

A number of studies stress the importance of involving service users from BME communities in the delivery and planning of these services:

‘service users’ voices need to be heard’ (Good Practice in Mental Health Self-advocacy Scheme, 1994). Service user groups could explore reasons for low take-up of psychiatric services (Swindon REC, 1997). Bhui and Bhugra (1999) suggest more multi-professional forums and local users’ groups. Bhui, Bhugra and McKenzie (2001) suggest a review of existing consultation mechanisms and more use of cultural events such as Diwali to get information across.

3.2.5 Inappropriate diagnosis and treatment

Wilson (1993), conducted a study in the London Borough of Waltham Forest showing Asian patients were most frequently admitted to psychiatric hospital through a GP under Section 4 of the Mental Health Act 1983. Patients from these ethnic groups often failed to understand their diagnosis and treatment process. There was a low or delayed uptake of services by Asians and treatment was made more difficult as frequently their mental distress was only detected at a crisis stage. Complaing *et al* (1989) observed that people from BME groups are often misdiagnosed and consequently given incorrect treatments like ECT and psychotropic medication as opposed to therapies, such as counselling and psychotherapy. Dr Sashi Sashidharan, Medical Director of Birmingham Mental Health Trust, notes that:

‘For the Asian patients who are diagnosed with schizophrenia or psychosis, intervention is addressed exclusively through medicines and the social problems associated with the condition are not dealt with.’

(Sashidharan, 1999)

Health professionals should have more perception of the effects an adverse diagnosis can have on the patient – particularly in the light of cultural fears of possession and other similar perceptions of what mental illness entails. This may be exacerbated by delays in interventions, due to the speed at which health services operate (Bhui and Bhugra, 1999).

3.2.6 Need for better aftercare services

Kan and Hassan (1997) showed a general failure of aftercare services operating as laid down by the Patient’s Charter. There was no investment in involving patients in their discharge from hospital. Many of them were unaware of who was responsible amongst health professionals for the operation of their care, and cultural and

religious needs were not being met (Save the Children, 1996). A study by Cornwall (1998) of 5,160 Bangladeshi women patients in east London found that this group were allocated less time for treatment and were more likely to be prescribed medicine that was discontinued within three months of starting, than other members of the community. A review of Camden's care programme approach and discharge planning is needed to determine to what extent this is also happening in Camden.

3.2.7 Low uptake of services

Nazroo (1997) cites a number of reasons for BME groups' low take-up of mental health services including a lack of knowledge of local services, the taboo of mental illness and language difficulties affecting take-up of services. Geetha Rajah, a speaker at a conference organised by the Good Practice in Mental Health Self-Advocacy Scheme (1994), said that many people from the Asian community are intimidated by predominantly 'white' health service professionals and mental health provision which 'systematises and ghettoises' them. There may be a lack of more appropriate services and appropriate information. Olajide and Bhui (1999) pointed out the need for more information on the possible side-effects of medication from GPs and on the likely outcome of treatments.

A study by the Scottish Ethnic Minorities Research Unit (2002) evaluated the accessibility and appropriateness of counselling services based on the account of Asian people. It found that respondents faced limited choices, a lack of encouragement from counsellors, anxiety about counselling and a lack of counselling services led by black staff.

One study of two electoral wards in Newcastle with a high Bangladeshi population (Save the Children, 1996), showed few people surveyed saw the GP or health professional as a source of help unless all other sources of help were exhausted. Their perception was that it was not the role of health professionals to give help with personal problems:

'Doctors only give medical help, they couldn't really be a good listener.'

Kapasi (2000) gives the example of a Bangladeshi woman in Camden who was referred to a psychotherapist. She told a community worker that 'the big doctor' was coming and was clearly uncomfortable about the impending visit.

3.2.8 Need for cultural awareness

Most studies show the need for a common understanding between GPs who are trained in a western style of interviewing and patients from BME communities. Many BME communities had fears about the confidentiality of services and felt they were unwelcoming (Swindon REC, 1994). They also felt stigmatised through having mental health problems and were afraid that GPs would consider them 'mad' if they confided in them.

This lack of awareness may extend to health professionals from BME communities, some of whom are felt to be equally incompetent in dealing with cultural and religious issues (Kan and Hassan, 1997). Some GPs from the same ethnic background as BME patients do not refer patients to psychiatric services, as they do not think they will help them (Swindon REC, 1994).

One study (Save the Children, 1996) into postnatal depression amongst Asian mothers showed how different cultures have their own ways of defining illness. Cultural difference can mean that measures of depression are not an accurate measure of reflecting the mother's mood. Differences in words or phrases may cause misunderstanding – there are taboo subjects in all cultures. Beliappa (1991) said that there is not a mind and body separation in Asian cultures.

Some Asian cultures have a greater emphasis on spiritualism, so find psychiatric services irrelevant. Spirit possession or *jinn* may be blamed for hallucinations and poor communication. One study showed 45% of the Asian community used prayer as a coping mechanism and only 3% had sought statutory help (Ahmed and Webb-Johnson, 1995). A study of the Bangladeshi community in Tower Hamlets showed that Muslims and Sylheti-speaking groups in particular have a very close adherence to cultural life. They do not perceive mental health in western terms and the existing mental health services do not understand the Bangladeshi community (Radia, 1996).

There was a need for better training for professionals in the understanding of other cultures (Cornwall, 1998) and similar training needs for psychiatrists, police and approved social workers (Wilson, 1993). Lowenthal (1999) found health professionals needed more contact with the client's religious peer group, who might be able to distinguish between what they would regard as a religious experience, and psychological disturbance.

Spiritual healing could also be available, with spiritual leaders visiting

hospitals and similar institutions. There could be more use of essential oils, Reiki, herbal remedies, art therapy, reminiscence and culturally-appropriate counselling (LVSC, 1998).

3.2.9 Somatisation

Somatisation was a major issue dealt with in the literature surveyed. It is the process whereby people from Asian communities describe what western society would classify as mental health problems in physical terms. A lack of knowledge of health services by the Asian community tended to highlight differences in perception. Rahman, Dockerell and Gaskell (1993) gave one example of a patient's expectation of being touched when getting medical treatment: 'What kind of a GP was that, he did not touch my heart.'

One of the reasons for the under-representation of Bangladeshi parents in east London at child and adolescent clinics was the lack of somatic explanations or medicines given to the children, contrary to the parent's expectations of the service (Haline-Dickens and Dein, 1999).

Some health professionals thought Asians were not 'psychologically-minded', despite a growing body of literature to the contrary (Save the Children, 1994). Beliappa (1991) found a relatively high proportion were prepared to talk about their mental distress. Richards and Abas (1999) talk of the 'stereotype' of somatisation and that professionals do not acknowledge the extent of suppressed emotion in Asian and African people: 'the lack of energy behind the somatic façade'.

Primary care services were ill-equipped to recognise problems of distress in BME communities and make appropriate referrals (Fernando, 1995). This study noted that there are misunderstandings and incorrect assumptions on the part of Western-trained health professionals. For instance, one woman stated:

'All this [physical symptoms] was caused by stress. I had three miscarriages because of this. The doctor gave me painkillers, but never bothered to find out what the problem was.'

Kapasi (2000) quoted one example where a woman from Camden's Bangladeshi community did not begin to talk about her emotional issues until her third or fourth visit to her GP. Yet her initial presentation of her problems had been that she had 'pain all the time, coming this way and that and here and there'.

Problems with GPs may be exacerbated by GPs with fewer resources being more likely to have a larger number of Asian patients on their list (Patel, 1999). It should also be noted that somatisation can occur across cultures, that is, it can apply to the British too (Hamilton, 1987).

3.2.10 Need for a more holistic approach to service provision

One study criticised the resistance to innovation and potentially more culturally flexible services in the health communities, due to the 'tribe-like' behaviour of professional groups, who stick to their own professional communities, thus providing a barrier to more integrated services (Swindon REC, 1994). There is a need for a more holistic approach, which looks at mental health in a social context:

'Mental health is not the absence of what may be defined as "mental illness", but includes integration of psychological functioning, effective control of personal and social life, feelings of ethnic spiritual well-being and so on.' (Radia, 1996)

'Most Asian people come from a tradition where family and community is as important as personal contentment.' (Fernando, 1996)

3.2.11 Need for more counselling and therapeutic services

Patel (1999) states that GPs should be more aware of the benefits of religious self-help and culturally sensitive therapeutic organisations. Culturally sensitive counselling and psychotherapy services can create safe environments to explore issues. They also help Asian communities to address taboo subjects such as sexual abuse, gender oppression (the abuse of women), domestic violence and alcohol abuse.

Befriending schemes and survivors' groups are also beneficial (LVSC, 1998). For counselling services to be successful, there should be more awareness of mental illness on the part of families. The patient may need the approval of other members of the family before undergoing treatment and there is a basic lack of knowledge in the Asian community of what counselling actually is (Rahman, Dockerell and Gaskell, 1993).

3.2.12 Need for more services located in the community

Sashidharan (1999) highlights the need for more services in the community. Carers from BME communities may require a 24-hour service. BME communities may also require more home treatment and fewer admissions to hospital. An example is given of a local service that was set up as a filter for admissions and helped reduce hospital admissions, even in the case of severe mental illness. Swindon REC (1997) highlighted the need for more community-based mental health centres and crisis houses.

There is a need to ensure confidentiality, and some feelings that consultation should take place outside the community, otherwise confidentiality could not be assured. Nevertheless, there was a perceived need for local services in the community with a community centre or drop-in facility, including places specifically for young people and advocacy services (Save the Children, 1996).

3.2.13 Need for greater mental health awareness of BME community organisations

Due to a general reluctance to use health and social care services, BME communities will generally try to use their own local community organisations. What this means is that community groups are used for 'signposting' when a member of their community is experiencing difficulties. The effectiveness of Sylheti-speaking community workers in dealing with presentations that could be attributed to mental illness could therefore be enhanced by some mental health training (Radia, 1996). In addition, BME community organisations may become overwhelmed by mental health needs that present, especially if there are no specialist services or where statutory authorities are not meeting their needs (Gray, 1999).

4.0 What the action research project found

4.1 Socio-economic factors

4.1.1 Social factors and their impact on mental health



In common with findings by Nazroo (1997), Meltzer *et al* (1995) and Beliappa (1991), the project found evidence of social factors and resulting stress as a major cause of mental health problems. This was a particular view of some GPs:

‘ . . . Bangladeshi patients are experiencing a great deal of mental problems. But social problems are the main cause of mental illness.’ (GP)

This was a consensus of other general practitioners, where a number of cultural and social factors were cited, for example:

‘ . . . unemployment, financial pressures, housing issues, difficult relationship with children and husband and wife, these problems are very common in our Bengali patients and it needs to be addressed. . . Deprivation, many people who come to us are living in over-crowded flats – all of these affect a person’s mental health.’ (GP)

- Some of the contributory factors that exacerbate mental health problems and that were generally agreed upon among the CMHT,

GPs and the community were:

- Difficult relationships between parents and children.
- Family relationships – marital problems, extended family living situations.
- Immigration stresses.
- Social issues, for example poor housing and unemployment.
- Low income.
- Isolation.
- A lack of monitoring of the mental state of people in the community.
- A lack of one-to-one support working.

4.1.2 The mental health needs of the community

The researchers found evidence of mental illness in the Bangladeshi community. The main diagnosis of the 28 users in King's Cross and Regent's Park CMHT in the end of October 2001 was as follows:

Diagnosis	Percentage
Schizophrenia	51.85%
Depression	22.22%
Bipolar affective disorder	7.41%
Other disorders	18.52%

This evidence was consistent with the experiences of primary care professionals and the Bangladeshi community generally agreed that there appeared to be a higher than normal existence of mental health problems within the Bangladeshi community:

'Depression is increasingly found among the Bangladeshi patients, and there is now the problem of psychotic illness . . . as professionals serving the community we need to recognise it.' (GP)

'There are so many people in our community who are suffering from this kind of illness, they are suffering in isolation.' (Woman from a focus group)

4.1.3 Low income and unemployment

Men who had recently come to this country expressed similar views to the women quoted in the previous section. In Bangladesh they were very hard-working and they had respect. However, in this country,

they lack confidence because they don't have the language skills and therefore they work in restaurants, which is something that they had never done before. This compares with other findings of low status amongst men from Asian communities, because of their reduced employment status in this country. They found having to work very long hours very demoralising and a cause of stress:

'Looking for job in this country is very difficult. You have to work in restaurants; you don't have the skills to do any other kind of jobs. And even if you have the qualification from Bangladesh, you still have to work in restaurants, you have to start off all over again in the academic world and for this you need money. Also there is a pressure to send money back home too. There is so much pressure on you. If you are a young person coming to this country, then your family has expectation of you to send money back home, they don't really understand how hard it is here. . . There is no time to spend any time with your family at all because you are always at work. You spend very little time with your children, your wife. I have no life, I work 11am to 3pm and then 5pm to 11pm.' (Restaurant worker)

Women faced similar problems, although in Bengali culture it is not the norm for women to support their parents financially after marriage:

'You think about where you'll get the money from to send some money to your poor old parents in Bangladesh. . . Sometimes you have to hide this from your in-laws.'

Another lady laughed and said:

'And sometimes you have to hide it from your husband too.' (Woman at drama session)

The project also revealed family pressure in providing for children's needs, for example, buying clothes and school-books, and paying for trips all added to financial difficulties. In addition, relatives were visiting constantly, which is a feature of Bangladeshi life and the custom is that one has to make sure that the guests eat well. This was

exacerbated by unemployment:

'Unemployment is a big problem, a lot of us are unemployed; our sons don't work, and they go out a lot and wonder around and do nothing.' (Man at drama session)

'My daughter has just recently become unemployed and I worried whether she can find another job, because my family depends on her income.' (Man at drama session)

4.1.4 Stress on families

The project, in common with studies by the Home Office (1986) and Kapasi (2000), found evidence of stresses within the family. Although some GPs and CMHT members said the Bangladeshi community could often rely on family support, other CMHT workers saw family support as a problem:

'They tend to have a lot of family around and keep it contained within family . . . this can have a positive and negative impact on the client.' (CPN)

Despite the image of the strong Bangladeshi family, community members stated that they are sometimes on their own, that is single parents. More women than men said that they lived as single parents. Either their husband has died or their husbands spend most of their time in Bangladesh. They were pretty much alone in this country, with little family support.

'I came to London seven years ago; my husband passed away straight after we came to this country. He left me with four children. I am constantly worrying about how I am going to bring them up on my own. I don't have anyone who can help me. Yes, I have relatives, but after a while people are busy and they don't have the time to come round and help you. I constantly worry about how I am going to marry off my daughters, where am I going to

get the money for their weddings.' (Woman at focus group)

Case study

A young woman in the *mela* (festival), said that she got married at the age of 19, when she wasn't mentally prepared for marriage and didn't really foresee all the growing up she had to do immediately after her marriage. It was expected of her to give up some of the things she did before her marriage, such as work, to be with her new family. According to her, she once used to be a very out-going, lively and ambitious person. However, after marriage she had to stay at home to be a wife, mother of a two-year-old and daughter-in-law to her elderly parents-in-law:

'They are always ill, and they need constant looking after. . . I don't mind all this because they are my husband's parents.'

She also said how her life has changed significantly since she been married: she has no time for herself, and she is always busy taking care of other family members. Throughout my conversation with this lady she always reassured me by saying that she is happy with her life and has no complaints.

On the other hand, some felt that there were problems because of a tendency in the Bangladeshi community to 'keep it in the family'. As a result, members of the Bangladeshi community with severe mental health problems were being directly admitted into hospitals with severe mental illness, without ever accessing community mental health services. The findings indicate that most of the service providers acknowledged that there may be significant barriers to the Bangladeshi community's access to mental health services.

4.1.5 Gender issues

In common with studies by Radia (1996), Jaus (1986) and Flockhart (1986), the project found evidence of stresses on both genders, but particularly on women in the Bangladeshi community. Both men and women have said that they have marital problems. This was the case with the middle-aged women who said that their husbands were spending most of their time in Bangladesh, leaving the wife to look

after everything here, that is taking care of the children and all financial difficulties. A number of women interviewed said they were expected to cope with all family difficulties. It was common for the women to take care of the whole family, including parents-in-law, husband and children. Some said they don't get any support, especially from their husbands, adding to their mental health problems:

'A lot of us have problems with our husbands. . . But we can't tell anyone about this.' (Woman at drama session)

'It doesn't matter what your problem is with your husband, we shouldn't complain about them.' (Woman at drama session)

'Parents-in-law think that you are being lazy and disrespectful.' (Woman at discussion session)

A discussion at the focus group gave examples of families split between this country and Bangladesh, which added to social pressures. For instance, one woman had children here and one in Bangladesh and visited the one back home every few years. Children who have been brought to this country may not remember the life they had before they came over here.

Examples were given where older children were not given visas by the immigration service as it said it could not be sure whether they were the families' children or not. So parents thought it better to bring some children and left some back home. Children back home would also need to be constantly supported. There were also single mothers who were widowed or separated and who supported children alone.

An illuminating finding of the study was the contrast between the lifestyle of young women in Bangladesh, as compared with their life in this country. Many of the participants expressed their concerns about leaving family members back in Bangladesh. They were worried about their health and safety, and whether they would ever see them again. Women in particular said it was very difficult for them to adjust to living here and they got very lonely. Four young women, who had just recently arrived from Bangladesh, made some striking points about life being very much restricted for Bangladeshi women in this country:

'We can't really go out anywhere on our own, you always have to wait for someone to take you somewhere. If you're ill, and you're in pain, there is very little you can do on your own. You have to wait for your husband to come home and take you to the doctor's.' (Woman from focus group)

This was in contrast to the life they led in Bangladesh, where they felt very confident and enjoyed carrying out their daily chores. The difference was that they were able to pop into their neighbour's any time with no restrictions and they would go for a swim in the pond every day, with all the other village ladies, where they would all laugh with one another. In this country they spent most of their time behind closed doors, with lots of people living in the same household.

A number of women complained about a lack of space, living in small flats with a lot of other people:

'There are children running around making so much noise. I am scared to let them play outside. Instead they play indoors and fight with each other; sometimes that can really stress you out – I can't stand too much noise, my head just heats up.' (Woman at drama session)

A young man from the restaurant group made a further comment:

'... in some ways Bengali people are more tolerant to mental illness. For example, a lot of people suffer from depression, even in Bangladesh, but they tend to bear it as part of life, especially among women.' (Restaurant worker)

Although the suicide rate does not appear to be high amongst women in the Bangladeshi community as compared with other Asian communities, there were views in individual interviews with mental health professionals that there may be instances of undiagnosed depression.

Ethnicity is not recorded on death certificates, so accurate data on suicides in the Bangladeshi community is not available. However, Dr Robert Kyffin, senior public health information analyst, Islington Primary Care Trust, states:

'Between 1998–2000, there were no recorded suicides amongst women born in Bangladesh (or indeed, the whole of the Indian sub-continent).'

4.1.6 Relationships with children

The project found that Bangladeshi parents were concerned that their children were losing their cultural and religious values:

' . . . children are getting out of control . . . we want our children to be educated, civilised, socially acceptable human beings.' (Woman at drama session)

Many of the parents also expressed a lot of dissatisfaction with the teaching their children have at school. The children's education was felt to be contradictory to the cultural and religious values taught at home. The participants also stated that they were constantly worried about their children's marriage:

'It is very difficult to find the right match and these days boys and girls don't want to go to Bangladesh to get married.'

There was a very strong emphasis that parents worry to the extent that they get themselves very ill. This is a major concern to the Bangladeshi community, in particular the mothers who are subjected to so much pressure from all directions – their husband, community and children:

'If children do not listen to their parents . . . then everyone blames the mother. . . In our community the mother and daughter suffer the most.' (Woman at discussion session)

'We worry so much that we can't think clearly and reach a state that nothing makes sense . . . we fall ill from worrying.' (Woman from focus group)

Members of the focus groups reported a significant degree of drug abuse amongst younger men in the Bangladeshi community and that this creates additional strain for families, who try and hide these problems because of the stigma.

4.1.7 Experience of racism and the lack of integration in society

In common with studies by Nazroo (1997) amongst others, social pressures and in particular feelings of isolation were found to be increased by experiences of racism. There were fears of going out alone because of racial attacks; this is one of the reasons why many women refrained from going out as much:

'What if we get attacked in the street – it is not safe to walk in the streets on your own.' (Woman at drama session)

Thompson (1997) found perceptions of racism extended to health services. Interviewees from the Bangladeshi community stated that they felt they faced discrimination from statutory service staff such as reception staff, hospital staff and other officials.

4.1.8 Low levels of employment in the health professions

The mental health services did not feel that dependency on interpreting and advocacy services was a solution. They felt the need for mental health workers that reflect the community. The Bangladeshi population surveyed by the project researchers echoed this wish. They felt that this would be the most appropriate way of enabling the Bangladeshi community to overcome the language barriers and access a more culturally appropriate service:

'We have very few Bengali people coming here. Those people who come here can speak English, but I think the real reason why we don't have many Asian people is because we don't have Asian staff here.' (Manager of a service)

Most of the Bangladeshi people interviewed said that it works well when they can talk to someone who speaks the same language and shares common references. Therefore, there is the need to recruit people with language and cultural awareness, for example Sylheti-speaking social workers:

'It will be good for our community, if there are Sylheti-speaking social workers . . . it will be easier for the

community to accept mental health issues and not be daunted by the stigma attached to it.' (Carer)

'We have had a Bengali-speaking locum social worker last year; he proved to be a very valuable team member.'
(Social worker)

'The staff in the CMHT should represent the client group.'
(CPN)

'Client needs are a Bengali-speaking worker for their care and engaging with the family.' (Social worker)

This was echoed by the views of service providers.

4.2 The interface between members of the Bangladeshi community and mental health services

4.2.1 Language difficulties

The project research found both men and women from the Bangladeshi community lacked the confidence to approach health services, because of language difficulties. This bears out findings from other studies, for example, Bhugra and Beena (1999). Many of them did not have the vocabulary to use terms such as 'depression', 'anxiety' or 'schizophrenia'. Even in Bengali, as most speak the Sylheti dialect, they lack the vocabulary through illiteracy:

'We don't speak English, and get worried about going out. Before I go out, I keep worrying to myself, that how will I talk to someone, or what will I do if somebody says something to me. Because I don't speak English, I don't know much about what's going on.' (Woman at drama session)

The research findings evidently state that the Bengali communities here do not understand the Bengali word or term for mental health as such. However, they use the term 'madness' in order to explain it. The word 'mad' has negative associations and this is where some stigma comes from.

Interviews with service providers, such as GPs, health visitors, community workers and CMHTs revealed an awareness and acknowledgement of a lack of the language skills and cultural awareness required within the team to enable them to treat clients efficiently.

4.2.2 Problems with interpreters

There was also felt to be a lack of interpreters, as well as advocacy and information available in other languages. It is widely acknowledged that there is a need for specially trained mental health interpreters:

‘Mental health should have their own interpreters because of the complexity of language and cultural interpretation as well.’ (Approved social worker)

Despite the difficulties around using interpreters found by other studies for example Swindon REC (1994) and Rahman, Dockerell and Gaskell (1993), such as withholding information and confidentiality, it was felt that in some services full-time advocacy workers are required. The lack of language support means that it is often the family members that provide the language support, which is not ideal. In some instances Bengali-speaking administrative staff have been asked to interpret, which the GPs acknowledge raises concerns around quality and other confidentiality issues:

‘We use advocacy services – I can see this is a problem for the Bengali patients who need interpreters – we have to book an appointment. To book an appointment with interpreter you have to book two weeks in advance. In emergency we depend on family members.’ (GP)

At the focus group, there were problems raised around having access to interpreters when an intervention was urgently needed, for example in the case of crises. This means CMHT staff may have to rely on a member of the family to interpret in these situations, which may be particularly inappropriate in the circumstances.

Findings indicated that interpreters are not always effective because some people do not feel comfortable in their presence, as they feel what they say will not be kept confidential. In some cases issues have also been raised about some interpreters not interpreting all of the

information:

'It can be very difficult engaging with the client through an interpreter.'

'Interpreters do not interpret everything. . .' (Occupational therapist)

A community worker at the focus group said that she had attended a conference: 'Culturally competent health care: Do we understand it? How do we provide it?' The issues raised at that conference highlighted the importance of women having access to a female interpreter if they want one.

The terminology used in mental health is often difficult to interpret in Bengali, which raises the need for more training in mental health for interpreters and the need for regular support and supervision:

'Mental health services should have separate mental health interpreters, because the language used in mental health is so different, there are so many different terminology used. Bengali language is very different . . . there are not many equivalent word in Bengali. . .' (Clinical psychologist)

4.2.3 The different perceptions of the Bangladeshi community and health professionals

Swindon REC (1994) and Complaing *et al* (1989), dealt in detail with the lack of mutual understanding between Asian communities and health professionals. Both service providers and Bangladeshi interviewees recognised the difficulties in defining mental illness in the Bengali person. Nevertheless, one of the clearest issues revealed by the research was the different perceptions of mental health problems such as depression, stress and schizophrenia, between the Bangladeshi community and health and social care professionals, including GPs and CMHT and community workers:

'There is not very much understanding of mental health in the Bangladeshi community . . . don't understand the various different types of mental health issues eg

depression, post-natal depression. . .' (Health promotion specialist)

This difference in perception clearly has ramifications for service providers, as it highlights the fact that service providers and GPs need to be aware of how the Bangladeshi community views mental health and provide a more appropriate service accordingly:

'There is evidence that the family of one of my clients have a very different understanding of mental illness from the prevailing British psychiatric approach.' (Social worker)

'I have been given 10 different tablets to take in one day. I took these, felt very bad, my head was spinning, my doctor didn't explain the side-effects.' (Woman from focus group)

Different perceptions caused a lack of understanding of the role of general practitioners within the Bangladeshi community. GPs were expected to offer a 'cure' and if they were not cured, then the GP did not understand their problems. In other cases it was thought that GPs could only help with medical problems:

'If it is a medical problem then the doctor can help.' (Man at discussion session)

On the other hand, many of the participants did state that they consult their GPs very frequently, but these cannot find anything wrong with them. The responses also show that GPs give very little consultation time, and due to this they don't take the time to explain issues to them carefully. Also because of language issues they don't understand the GPs' language:

'You go to your doctor's with your problems, but GP doesn't understand your mental illness. . . They don't find anything wrong with you.' (Man from focus group)

4.2.4 Lack of liaison between service providers

The findings, as with other studies, for example Radia (1996), revealed that sometimes there was little knowledge of what the other

services were providing. The action research also found evidence to support these findings. For instance, primary care and mental health services wanted to know more about the services available at the local community centres:

'I'm aware of some of the community centres, but don't have that much idea about what they do or in terms of where we fit in, whether we can send any of our Bangladeshi clients there. It would be nice if someone came to us and gave a little talk in our team meetings or at joint business meetings.' (Occupational therapist)

Some of the service providers identified a need for a directory or similar resource, listing all of the services, that is community centres, health centres, GP services and mental health services:

'I think there should be some sort of resources that we all have access to.' (Approved social worker)

Beliappa (1991) and Radia (1996) showed how different cultural and religious beliefs can affect the understanding of mental health issues. The term *manoshik shasthyo*, a Bengali term for mental health, was not familiar to the Bangladeshi focus groups interviewed. *Manoshik shasthyo* is not a term that is used in their everyday language. When it was explained to the group, the participants used words such as *moner durbolota or matat dush dora* in order to describe mental health. The researchers perceived these terms as more effective, because they were terms that the community is familiar with and at the same time could identify and relate to.

Additionally, terms such as depression, anxiety and stress had very little meaning for the participants. They had very little understanding of the different types of mental health problem and there are no equivalent words in Sylheti for depression. Although many of the women have heard of depression from their GP, they were not clear on its meaning. Similarly, the term schizophrenia was not understood, although once it was explained people were easily able to recognise the symptoms.

The participants emphasised very strongly that an increasing number of the Bengali community are experiencing mental health problems, but are indeed suffering in silence, because of the lack of awareness on the subject:

'It is very important for people to start talking about it . . . even I who grew up here, haven't really thought about mental health issues before until I came to your stall. Everyone is affected by it in our community because of so much going on, whether it's family, external pressure; there are always some problems. To some extent I think that I myself might be experiencing some kind of mental illness, but never thought of it as much.' (Woman at Bangladeshi mela)

4.2.5 Religious and cultural beliefs

Symptoms presented to a GP may clearly be seen in an entirely different light by a Bengali person. For example, depression may not even be acknowledged, but would be seen as a kind of spiritual matter such as black magic:

'In our culture not everyone understands what depression is, they will think that it is black magic or the evil eye. . . ' (Carer)

'Bangladeshi community has very little understanding of what is depression. To them is understood as madness or possession.' (Stakeholder)

Learning point

It is important to recognise that individuals have a number of ways in which they cope and make sense of their lives. In planning new services or changes to existing services, care needs to be taken in order to ensure existing coping strategies are not undermined.

Some members of the Bangladeshi community sought a spiritual cure, for example from an imam. The imam or moulana, might prescribe herbal remedies such as a *tabeez* or *pani pora* (holy water) or *tel pora* (holy oil). The cultural understanding of mental illness was that to a large extent it was seen as 'madness'. Madness was the immediate response that was obtained from the participants. There was also a strong belief in spiritual causes, that is being possessed by spirits or *jinn*, and the third understanding of mental illness is the will of God, and 'no one else can help us other than God'. Younger men tended not to share these beliefs and were more sceptical about cultural treatment.

The older members (both men and women) made the comment that 'if it is a medical problem then the doctor can help'. Older members in the family more readily used and believed in the traditional methods and they had a significant influence over decision-making. They felt that their fate is in the hands of Allah (God), and it is already written down in fate and set (*amar takdiro/kopalo lekha ase*), and many had the belief that God is punishing them for previous sin. Additionally, the community has a strong faith in God's power to heal and without the will of God they will not get better:

'There is no treatment for our worries. . . We pray, pray to Allah . . . for forgiveness. . . I find that praying helps me keep calm. . . I get peace for that one hour when I am praying.' (Man at discussion session)

Nevertheless, people from the Bangladeshi community stated that they would still consult their GP, especially if the GP was from their own community:

'If you don't tell the doctor your problems then how can he or she help?' (Man at discussion session)

'There was a Bengali locum doctor in the surgery, she was very good, she understood our problems but she left and now it is very difficult for us.' (Man from focus group)

However, in the focus groups and at the half-day stakeholder event, several members of the Bangladeshi community expressed dissatisfaction with a Bengali doctor who worked in Camden:

'We used to go to a Bengali doctor, we hoped that he would understand our problems and to get some help from him, but got no help from him, we even got no help from him in an emergency situation. Sometimes you would go to him, you wait hours to be seen by him and he wouldn't see you.' (Man from focus group)

4.2.6 Knowledge of the Bangladeshi community's culture and mental health issues

The researchers encountered some apparently opposing views about the need to understand the Bangladeshi community's culture when offering mental health services. Interviewees from the mental health and primary care services felt that their knowledge of Bangladeshi culture and health beliefs were limited. However, some service providers felt that the mental health issues of the Bangladeshi community were no different from any other community, therefore implying that cultural knowledge is not important. Most felt, however, that there was a difference between western and Asian perceptions of mental health, and that cultural knowledge was important. Some stated that all-encompassing terms such as 'ethnic minority' or 'black and Asian' do not acknowledge the variety of different cultural needs of communities such as the Bangladeshi community.

' . . . we need to look at the Bengali culture separately, there is no point just saying ethnic minority group, it needs to be more specific. The Bangladeshis have different ways of doing things, eating, clothes etc, than the black community. There is a lot of assumption too. We don't really know why things are done in a certain way, I really think that all disciplines should really understand the cultural concepts. ' (Approved social worker)

A community worker speaking at the focus group noted that health professionals often have limited time to see patients. This compounds issues of lack of understanding of what people from the Bangladeshi community are trying to express.

4.2.7 Community organisations' knowledge of mental health services

Radia (1996) and Gray (1999) highlighted the need for BME community organisations to improve their knowledge of mental health services. Community workers interviewed by the project researchers said that although they had an understanding of Bangladeshi culture, they had difficulty identifying mental health problems and how best to deal these clients. They stressed that they had not received any training on mental health, as a result found it difficult to recognise the symptoms of mental health problems, and are therefore not able to offer the appropriate assistance or support that the Bangladeshi community needs. They strongly emphasised

that many of them were not aware of the community mental health teams – some confessed that their encounter with this action research project was the first time that they had heard of the CMHTs.

The community workers felt that it was important for them to have mental health training because of their role in the front line:

'I have had no mental health training. I do need training but it is important that management in the voluntary sector should recognise the importance first.' (Community worker)

'I would say that I have some knowledge but not adequate – my job helps me to some extent as I cover mental health issues. Also I have been attending the training on mental health from the Bengali Mental Health Forum.' (Community worker)

4.2.8 Somatisation

All the participants including community staff have said that the Bengali clients in particular present symptoms in physical forms, which is borne out by other studies such as Rahman, Dockerell and Gaskell (1993). Some GPs perceived a tendency within the Bangladeshi community to express their mental health stresses somatically, that is, manifested in aches and pains. The impact of explaining symptoms without a shared language and framework reduces communication to a level of explaining their difficulties and 'where it hurts'. GPs are therefore presented with somatic complaints that do not explain the underlying causes of mental illness. GPs realised that somatisation takes place and wanted to understand why this occurs. Some GPs tried to explain the concept of somatisation to their clients:

'We are struggling very much with this concept of somatisation . . . it is very difficult to get the community to understand this. . .' (GP)

Most of the GPs stated that they were finding it difficult to diagnose the Bangladeshi community's mental health problems at early stages:

‘Different cultures have different ways of interpreting mental illness, which can cause problems in terms of diagnosis.’ (GP)

Other GPs managed to identify depression among their patients, but because of somatisation it often took longer. This delay sometimes made the Bengali community feel anxious as to why the GP had not managed to identify their problem, and then conclude that the GP couldn’t help them because their problem was not a medical one.

During interviews and focus groups, many of the participants expressed and presented their mental health problems in somatic terms (physical complaints), such as headaches, body aches – cramps on their legs and arms, head spinning and dizzy spells, poor appetite and not able to sleep through the night. Also, women in particular frequently experienced panic attacks: ‘heart pounding’. During the discussion of presenting mental illness, the participants, including men and women began pointing to parts of their body and gesturing where they felt the pains. Their facial expressions also showed signs of discomfort.

The other literature surveyed makes much of issues of somatisation. It is worth pointing out that other studies, such as Beliappa (1991) and Fernando (1995), deal more with the impact of the lack of mutual understanding of health professionals and Asian communities. The other literature broadly suggests that with a greater understanding of somatic issues and cultural awareness, health professionals would be more readily able to pick up issues of mental distress amongst Asian communities.

4.2.9 Barriers to accessing services

A major finding from the research was that significant factors existed preventing the Bangladeshi community from accessing the services or approaching mental health problems in a way that may lead them to go to GPs and be able to seek support from the mental health care system. The factors, which can be described as barriers, were more or less agreed by both the Bangladeshi community and service providers. The barriers identified are broadly those revealed by the findings of other studies.

The main barriers to accessing services found by the project are set out here.

4.2.10 *Stigma*

Nazroo (1997) highlighted the stigma of mental illness amongst Asian communities. The project researchers found many people in the Bangladeshi community feared the gossip and social ostracism that might occur if they were found to have mental health problems. It was a taboo subject, so if a family member was found to have mental health problems, they could feel as though they had 'lost face' or their 'reputation' in the community. As a result, many were reluctant to approach GPs or mental health services openly, unless there was a crisis:

'It is embarrassing, you can't tell anyone, people will say "that family is bad. . .".' (Man at discussion session)

'There is a lot of fear that other people will find out about their problem, and I think . . . the Bangladeshi community will ostracise the family.' (Occupational therapist)

However, the female participants who attended the discussion session did say that their understanding increased as a result of attending regular mental health sessions at the community centre. A difference was identified in the level of understanding between men and women. The younger women in general had a better understanding of mental health issues than men did.

4.2.11 *Access to services*

GPs sometimes did not refer to a CMHT because they felt that a CMHT might not be appropriate for their Bangladeshi clients. This points to a deductive dialogue between the two services being required:

'I have my own preconceived ideas about the CMHT services, they ring me about white patients of mine, and I just think that they probably don't have any Bengali patients.' (GP)

Primary care services, particularly GPs, expressed their difficulties in referring patients with mental health problems to mental health services, particularly with regard to the medical model:

'Difficulty lies in the medical model – the Bangladeshi community do not always recognise depression the way we medical professionals do, but that doesn't necessarily mean that they do not have any understanding of it. Different cultures have different ways of interpreting mental illness. This can cause problems in terms of diagnosis and the right treatment for the patient.' (GP)

One CMHT practitioner acknowledged their need for training saying:

'I have no knowledge of cultural issues, I need to further develop my understanding and knowledge of cultural issues.' (CPN)

However, many of the service providers felt that training in culture and mental health will not replace the need for Bangladeshi mental health workers:

'... but I still do not think it will replace the benefit of a [Bengali] worker.'
(Clinical psychologist)

Importance was also placed on the mental health services changing their current working practice and taking a positive approach in encouraging the community to use services and to share knowledge of specific community issues, so that CMHT staff can better meet community needs:

'We have an educational role to play as part of our jobs. We should go out and talk to groups at community centres, schools, about mental health services and day centres, about what we do and how to access services. We as professionals should also work on reducing the fear.'
(Social worker)

One striking solution from health professionals for those perceived as not meeting mental health service criteria, also made by a psychiatrist in Swindon REC (1996), was the provision of an intermediate service:

‘ . . . there is a middle service that is missing, because we are a secondary service, there should be something in-between for those who need short term help.’ (Approved social worker)

Some community organisations and GP services suggested provision of community-based counselling services at community centres and GP surgeries could be an option, and that they could refer clients to mental health services when necessary:

‘I definitely feel that there should be a specialist worker in mental health, for example a counsellor based at a community centre within the community and they should refer clients on.’ (GP)

‘I think we should have more counselling services based at community centres and GP surgeries so that people can have easy access and if needed then refer them on.’
(Community worker)

4.2.12 *Choice of a male or female worker*

It was also felt that women from the Bangladeshi community should be able to choose counselling services from someone of the same gender:

‘Cultural and religious beliefs must be respected and acted upon if we are to provide equal access to our services.’
(Project officer – primary care)

Some also felt, as shown in Bhui and Bhagra (1999), that long waiting periods involved in referring patients to mental health services were a barrier:

‘We need better access to psychiatrists. The long waiting list is a barrier to access to the services.’ (Man from focus group)

4.2.13 *Location of services*

Another difficulty for some Bangladeshi patients, as found by Save the Children (1996), was related to their difficulties in physically accessing mental health services:

'Services needed to be close enough to the home address.'
(Community worker)

5 Recommendations

5.1 Culturally accessible information and services

The Bangladeshi community in Camden made a number of recommendations to facilitate more culturally accessible mental health services. Additionally, a study by Kan and Hassan (1997) of Bengali and Somali mental health service users in Tower Hamlets – where 23% of the population are of Bangladeshi origin – made a number of additional recommendations:

- A greater concentration on health promotion in the Bangladeshi community to reduce problems with somatisation.
- Information in accessible formats that people can understand, including community languages, for example books, videos and magazines.
- Bilingual workers.
- More English language classes for the Bangladeshi community.
- Information on alternative therapies and other available services.
- Information on hospital admission processes.
- A telephone helpline in Bengali and Sylheti.
- Bengali health and community workers.
- Local imams should be actively involved in making mental health awareness reach all Muslim families.
- Cultural and religious consideration, for example of catering staff – choice of meals, washing facilities, meal times, religious and gender considerations.



5.2 Workers recruited from Bengali community

There was a realisation amongst CMHT members that simple training around cultural issues would not be as helpful on its own. It was suggested that a worker from the Bengali community within the team will add to their knowledge base:

‘Training will not replace the skills a worker will bring to the team.’ (Social worker)

Many interviews suggested that opportunities should be created for secondments and training opportunities for young Bengali graduates.

There was recognition that there were not enough Bengali social workers or graduates entering the health professions. There was a feeling that such groups needed to be encouraged to see social work and other mental health professions as a career opportunity.

NB: It is arguable whether all members of the community and service providers would entirely agree that the presence of a professional from this cultural background will solve the problem. Nevertheless all respondents in the research recognised that a problem exists and that this should be addressed by both sides.

5.3 Cultural training for CMHT staff

Most of the service providers welcomed the opportunity of training to improve their understanding of Bangladeshi culture and mental health needs:

'We need more training around cultural issues – would like to know more about Bangladesh, in particular Sylhet, as most of our clients are from that part. Also how religion has an impact on people's life, the belief system around mental health. Right now there is not anything like this available.' (Approved social worker)

Some CMHT workers have stated that many of their Bangladeshi clients are young. Therefore it would be helpful to have more insight into how culture has an impact on their mental health. There was a demand for training for CMHT staff on the culture of the Bangladeshi community, and how they perceive mental health issues. For instance, GPs said that they would be interested in receiving training on Bangladeshi culture, health beliefs and perceptions of mental health issues:

'Throughout the last couple of years, more people are asking for help, they are questioning their mental illness . . . focus on physical pain, very easy to talk about physical pain . . . GPs need to make that link and be careful too . . . it will be helpful to have someone from the community for cross-referencing cultural issues.' (GP)

One GP felt that the project had made a big difference in raising awareness of Bangladeshis' mental health amongst health

professionals. Since the project, 74% of total referrals have been from GPs. Previously, the bulk of referrals came from hospital accident and emergency departments. The work of the project should be built on to ensure that GPs refer people from the Bangladeshi community to the appropriate mental health services.

5.4 Closer working relationships between community organisations and front line workers within the CMHT

The findings identified the community organisations as a valuable source of cultural knowledge. It was suggested that workers from the community could act as intermediaries between health services and the Bangladeshi community. Many of the community workers themselves felt that they should be able to refer people to the mental health services. They felt that if they had links with the mental health services they could improve the community's access to them.

'Yes, it is important that we can call someone from the CMHT and seek advice, and refer clients too.' (Community worker)

It was stressed at the focus group that workers from community organisations are often the first point of contact for people from the community who want to address mental health issues, so it is particularly important that these workers have sufficient knowledge of mental health issues and where to refer for advice and assistance. They can also encourage people from the community to use these services. However, some felt that they could not claim to be experts, because cultural knowledge is not finite:

'I have some cultural knowledge but I should also add that I might be a Sylheti Bengali woman, but that does not mean that I understand the cultural issues affecting the mental health of all Bengali women.' (Community worker)

Community organisations emphasised more training in mental health. Some service providers expressed the need to ensure adequate training for community workers, without which there would be a higher risk of wrong referral. There were also concerns that this could compromise the community workers' role within the community. Many of them felt that GPs should remain as primary care contact and that GPs should refer their clients to mental health services if necessary:

'It depends how much training they have, also it will be putting community workers in a very difficult situation, because the community may not be so accepting of their new role.' (Occupational therapist)

'I would say GPs should remain as primary care contact – and they should refer the patient on.' (GP)

However, it is important to note that some of the community workers indicated that they would be interested in pursuing a career in mental health, if adequate training and a career path were made available:

'I would like the opportunity to go on further training courses, to further improve my career perspectives. I wouldn't mind going for counselling post since currently I am more or less providing counselling services but I am not qualified in that practice.' (Community worker)

A primary care professional stated that it is not possible to train everyone, but raising awareness of mental health issues can change attitudes:

'Yes – but it is not possible to train formally everybody, but you can provide resources to increase their knowledge, which will change their attitude to mental health.' (Health promotion specialist)

Participants on a mental health training programme for Bengali workers said that the course had helped them develop listening and problem solving skills (Kapasi, 2000). Training courses like these should be a continuing feature of Bengali community workers' training.

5.5 Raising awareness of health services within the Bangladeshi community

Most people from the Bangladeshi community who were interviewed said that they would consult their GP when they felt unwell, and some said that they got comfort from their GP. Some members of the community found health services very helpful when they used them, particularly younger women. Thus, many of the participants in the

male and female group said that talking about their problems does help, although they are afraid of gossip from others in the community.

Although some people found difficulty in accessing the service, once they got to it, they realised the benefit of it, and this is demonstrated in the response given by a young girl in one of the discussion sessions (see second case study, below).

5.6 Mental health awareness sessions in non mental health settings

Some participants from the community felt it would be beneficial to have on-going mental health sessions at community centres. The mental health sessions that we have had with the community group proved to very successful:

‘If I go to community centres, then I learn more, I have learnt more about my health. . .’ (*Man at discussion session*)

Case study

A woman in the focus group session said that going to the GP was very helpful for her because she had been feeling very low for a long time. It was very difficult for herself and her family: ‘I was no good to my family. I was a burden on them.’ Things only got better when she went to her GP who explained about the effects of depression, as well as prescribing an anti-depressant. The doctor also told her that she should go out to community centres and meet people; she needed to keep herself busy and happy. She did find it very helpful talking to people about her problems, as she realised that other people are in far worse circumstances, but they’re still coping well.

Case study

One participant’s brother has mental health problems and is diagnosed with schizophrenia, which she does not have a good understanding of. When her brother was first experiencing his mental health problem, the parents thought that *jinn* possessed him and therefore they sought help from the religious healers such as a *mullah*. At the same time the parents took the son to their GP, but had not had much luck. Eventually the patient had to be taken into A&E because his condition was very bad. Since going into A&E her brother had a key worker from the community mental health team. This had a positive impact on her family’s life:

‘My parents are feeling better, before they were constantly worrying about my brother, we just didn’t know what to do with him . . . he went round talking to himself in the house, shouting, yelling . . . violent behaviour . . . my parents thought it was black magic, and if they get a good mullah, then they’ll be able get him cured.’

5.7 Innovative ways of reaching out to the community

People from the Bangladeshi community found the drama on mental health very effective in delivering the message; they requested more drama sessions and further suggested that there should be a video, so that a larger population can view it.

The drama enabled the Bangladeshi people to address what for them are taboo subjects and gave an opportunity for people from the community to discuss mental health issues openly. This also provided an opportunity to improve their understanding of mental health services and how these could help them with their problems. The drama was particularly effective in facilitating awareness of the action research project. After the drama one woman made the following comment:

'In our society a lot of these things happen but we don't address it or accept, will just hide and by ignoring it we think it will go away. . . It is good watching that drama, because it makes you think . . . because the problems are very real.'

The project has been highly successful in reaching out into and involving the community and this success now needs to be built on, by acting on the recommendations arising from it.

5.8 Involvement of religious leaders to facilitate understanding of mental health issues

Managers at the Huntley Centre, St Pancras Hospital, the mental health in-patient facility for the Trust, have been employing an imam one day per week in order to care for Muslim patients' religious and spiritual needs. Muslims are the second largest patient group, after Christians, being admitted to the Trust in-patient services.

In addition, Ms Sue Salas, assistant locality director, the Huntley Centre and Dr Sushrut Jahav, senior lecturer in cross-cultural psychiatry, UCL and consultant psychiatrist have begun a one-year project: 'Working towards providing a culturally competent mental health service for Muslim in-patients'. This project has been funded by an award from the Transcultural Nursing and Health Care Association and also by the former Camden and Islington Health Authority. The aim of the project is to enhance in-patient mental health workers' knowledge base in relation to Islamic cultures and

religion.

Two project workers will be appointed for one year, to work one day a week with Sue Salas and Dr Jadhav on the project. A literature search will be conducted on Islam and mental health, then a questionnaire will be devised for staff about their current knowledge base and experience of Islam and mental health issues. Gender-specific focus groups will then be conducted with Muslim service users to clarify their experiences of being admitted to the service. A training package will be devised and delivered. The effects of the training package will then be evaluated.

5.9 Increased counselling, advocacy and other therapeutic services

It was suggested that culturally appropriate counselling services should be more available to the Bangladeshi community to enable them to express their needs and views on the treatment options available. At the half-day stakeholder event, community representatives thought that additional counselling services, based in GP practices, would be advantageous.

Advocacy services should be available for people from the Bangladeshi community:

- Interpreters must receive professional training in mental health issues in order to convey accurately the needs of people from BME groups with mental health problems.
- Interpreting services should be available 24 hours a day.
- Ideally, an interpreter and advocate should be present when a person who cannot speak English consults with a health professional.

5.10 Increased involvement of the Bangladeshi community in service provision

The project revealed a mutual lack of understanding between CMHT staff and the Bangladeshi community, as well as the lack of knowledge of the community of mental health issues. This makes it particularly vital that the Bangladeshi community be meaningfully involved in the provision of mental health services.

The health promotion service is now running ongoing training courses (on mental health issues and service provision) for lay people in the community, which would provide a basis for informed opinion. A Bangladeshi mental health forum with a range of people on it has been developed after an initial mental health training course.

Although it is a worker's forum, health promotion are looking at ways of engaging lay people and carers to join the forum.

5.11 Support for Bangladeshi carers

Since April 2001, carers have had the right to have their own needs assessed under the Carers (Recognition and Services) Act 1995. The Carers and Disabled Children Act 2000 gives carers the right to an assessment of their own needs even if the person cared for does not want a service. Current service provision includes a Bangladeshi carers respite service, which was set up by Camden Crossroads in 2000, and there is an Asian carers' support worker based at the PRT Camden Carers Centre.

5.12 Other suggestions from the Bangladeshi community

Participants from the Bangladeshi community made a number of other suggestions:

- More interpreters to be placed at GP surgeries.
- More outreach workers.
- Bengali-speaking counsellors placed at GP centres.
- Participants felt that producing Bengali leaflets about different services is another way to inform the community, and collectively agreed that posting these leaflets by hand to all the Bengali houses would be another way to inform the community better.
- Language seems to appear very often in the discussions. The younger women were interested in learning English and gaining more knowledge, and are keen to attend ESOL classes. These would be easily accessible if they could be close to their homes.
- All of the participants realised the importance of keeping fit, and therefore would like to see more regular exercise classes.
- A Bengali telephone helpline offering advice on mental health issues.
- BME patients should be assessed at the point of request for admission, to ascertain whether treatment in the community is more appropriate.
- There must be adequate follow-up on discharge from hospital and full consultation with service users and their carers.
- There must be an adequate explanation of treatment that is being given, to alleviate fears.
- Workers from BME backgrounds could be appointed to act as a link with mental health services for BME communities.
- Mental health professionals should have more cognisance of traditional cultural treatments and the role of religious beliefs in combating mental health issues and giving treatment.

- More mental health services should be provided within community locations.

6 Appendices

Appendix 1 – The Bangladeshi population in Camden

Camden Social Services – 15th April 1998

Bangladeshi																
	Male								Female						Total	
	1991	1996	2001	2006	1991	1991	1996	2001	2006	1991	1991	1996	2001	2006	2011	1991
	1		1		–		6	1	6	–		6	1			–
	2011								2011						2011	
0–4	467	550	679	677	199	425	509	615	617	181	892	105	129	1294	1272	380
												9	4			
5–9	544	501	580	684	131	432	449	528	613	176	976	950	1108	1297	1283	307
10–14	431	595	572	650	313	471	510	539	617	223	902	1105	1111	1267	1438	536
15–19	470	548	713	683	301	395	614	659	696	390	865	1162	137	1379	1556	691
													2			
20–24	265	477	534	658	346	261	457	713	663	473	526	934	124	1321	1345	819
													7			
25–29	150	195	285	281	197	199	221	343	459	213	349	416	628	740	759	410
30–34	197	166	201	251	47	166	190	207	287	190	363	356	408	538	600	237
35–39	127	202	175	217	132	191	185	213	232	112	318	387	388	449	562	244
40–44	53	124	188	162	153	134	207	202	241	130	187	331	390	403	470	283
45–49	75	65	130	181	82	111	154	222	212	145	186	219	352	393	413	227
50–54	235	116	113	176	19	125	134	175	237	96	360	250	288	413	437	77
55–59	159	249	143	153	51	85	136	143	181	153	244	385	286	334	448	204
60–64	114	158	230	137	43	25	82	124	127	135	139	240	354	264	317	178
65–69	46	103	137	189	70	10	24	73	105	95	56	127	210	294	221	165
70–74	27	42	86	110	122	13	11	23	62	73	40	53	109	172	235	195
75–79	8	21	32	62	70	6	12	10	20	44	14	33	42	82	128	114
80–84	4	6	14	19	34	3	5	9	8	12	7	11	23	27	53	46
85+	2	3	4	7	9	0	2	4	7	8	2	5	8	14	19	17
Total	337	4121	481	5297	228	3052	390	480	538	2849	642	802	961	1068	1155	5130
	4		6		1		2	2	4		6	3	8	1	6	

Appendix 2 Interviewees and venues used

Name of the events	No.	Community centres	Gender group	Age group	No. of participants
Mental health discussion session followed by a drama	1	Chadswell Healthy Living Centre	Female	18–55	37
	2	Camden Carers Centre and Surma Centre	Female	18–60	18
	3	Fitzrovia Neighbourhood Centre	Female	20–65	26
	4	Bedford House Centre	Female	20–65	18
	5	Chadswell Healthy Living Centre/Marchmont Community Centre	Male	55–65	12
	6	Somers Town Bengali Association	Mixed group	20–65	20
Mental health discussion session and video	1	Shan House Community Centre	Male	35–65	12
	2	Fitzrovia Neighbourhood Centre	Male	55–65	5
	3	Hopscotch	Male		5
	4	Hopscotch	Female	20–45	12
	5	Suma Centre	Female	20–45	6
Mental health discussion	1	Restaurant workers	Male	20–40	3

Bangladesh i <i>mela</i>		Bangladeshi people from Camden, Islington and other areas.	Mixed group	7-50	About 100
	Total				174 (excluding people at the <i>mela</i>)

Appendix 3 – Checklist for the focus groups study

Date: _____	No of Participants: _____
Name of place the interview is taking place: _____	

1. What do you think the term Mental Health means i.e. how would you explain mental health?

Without any prompting, purpose of this question is to see what they understand as MH

Do you understand what the terms depression, stress, and anxiety mean and do you consider these as mental health issues?

Have you heard of the term schizophrenia?

2. What do you think are the causes of mental health problems?

Prompt if necessary – why do we worry so much?

3. If you or your family were to suffer from mental health problem (depression, stress and anxiety over a long period of time) then what would you do?

Prompt if necessary would you go to your GP

Have you been to your GP with these problems before please share your experiences

How do you explain your problems to your GP, how do you describe your symptoms.

And suppose a member of your family starts hearing voices and seeing things that you and I can't, what do you think of this and what kind of help would you seek.

Prompt

4. How much do you know about mental health Services in Camden, have you heard of the community mental health team before?

How can we inform you about these services, so that it will be easy for you to access?

5. What can we do to improve services better/ how can we go about increasing your knowledge inform you about the different services?

Prompt with examples e.g. what do you have to do to go to your GP, health clinics, hospitals and etc

Appendix 4 – Checklist for Interviews with Service Providers

Date: _____ Group (No.) _____

Job title(s) _____

Dept. _____

Full-time ☐ Part-time ☐ Permanent ☐ Temporary ☐ Duration _____

Gender: Male ☐ Female ☐ Ethnicity _____

1. One of the main aspects of this research is to focus on the mental health needs of the local Bangladeshi community living in South Camden.

What do you think are the current needs of the local Bangladeshi Community in terms of mental health?

What are your needs?

2. How much of your job involves working with the Bangladeshi community and how many Bangladeshi clients do you have on your caseloads?

Do you use interpreters for your clients?

If so what determines when to use an interpreter?

What proportion of the client group use them?

What issues do interpreters/clients throw up (e.g. confidentiality in community)?

3. From your experience of working with the Bangladeshi Community, how would you say that the Bangladeshi Community address Mental Health Issues?

And do you think that they have an awareness of Mental Health issues?

4. What are the main barriers to the Bangladeshi community in accessing the CMHT services and other mainstream services?

5. How do you think that we can generate a greater understanding of Mental Health to the community?

What kind of tools/approaches should we adopt when trying to increase awareness of mental health issues?

6. As you work closely with the community do you feel that you have adequate training and knowledge of mental health and cultural issues so that you can effectively use this knowledge to feed it back at community level?

7. Do you think that other staffs are generally aware of cultural issues? How do you think that we can go about increasing awareness of Cultural Understanding?

What do you think would work for you?

8. Do you think that community workers should have basic training of Mental Health issues?
9. Do you think that there is a need for a separate training session on Bengali Culture and Mental Illness? If available would you attend one? And who should attend this training.
10. Are you aware of local community centres such as Hopscotch, Surma Centre, Bedford House, and Calthorp Project? These are just some of community centres that the local community very frequently use, therefore:
Do you think that services like the CMHTs should have a more formal link with community workers?

How far do you think this link should be extended to? Do you think that the community workers should be able to refer users to CMHTs for assessments?
And do you think that those Bengali Clients come to you understand the concept of your role?
If not why do you think that is so?
11. Research has shown that members of the Bangladeshi community do not partake in many of the community services that are available. Why do you think is so, and do you think that this is accurate, if so why?

Appendix 5 – Project steering group

Name	Title	Organisation
Sue Salas, Chair of the action research steering group	Assistant locality director	Camden and Islington Mental Health and Social Care Trust
Iliasur Rahman	Chair of multicultural organisation	Multicultural Organisation
Israth Begum	Asian carers worker	Camden Carers Centre
Maureen Brewster	Co-ordinator	Camden health and race group
Samina Dewan	Neighbourhood worker,	Bengali Womens' Advisory Group,
Kawser Zanath	Community development worker	Chadswell Healthy Living Centre
Florence Ekiko	Community psychiatric nurse	Camden and Islington Mental Health and Social Care Trust
Sundra Singam	Health promotion manager	Camden and Islington NHS Trust,
Leroy White	Principal lecturer	South Bank University
Anne Clilverd	Team manager,	Camden and Islington Mental Health and Social Care Trust
Alan Denney	Team manager	Camden and Islington Mental Health and Social Care Trust
Dr Sushrut Jadhav	Consultant psychiatrist	Camden and Islington Community NHS Trust
Abu Sayeed	Muslim chaplain,	The Huntley Centre, Camden and Islington Mental Health and Social Care Trust
Razna Mia	Bangladeshi mental health action research worker	Camden and Islington Mental Health and Social Care Trust
Mohammed Bablur Hossain	Bangladeshi mental health action research worker	Camden and Islington Mental Health and Social Care Trust

Hasneen	Senior health promotion	Camden and Islington Health
Choudhury	specialist	Promotion Service
Neil Bisby	Project officer	Camden Social Services
		community commissioning

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