# No-more small portions of services please

A report of the issues and needs highlighted by the mental health training for Bangladeshi workers

**Bengali Women's Health Project**

**Contents**

**Preface**

This is a focus group report on the mental health issues and needs of Bangladeshi people. The focus group participants were Bangladeshi community workers who had received mental health training. The training course was developed by Camden & Islington Health Promotion Service and the Bengali Women's Health Project. The initiative stands out as a shining example of NHS and voluntary services coming together to involve one of our most disadvantaged communities in mental health service improvement. A particularly striking feature is how the project has identified and built on the strengths and capacity which already exist in Bangladeshi community organisations – despite the impact of racism and social exclusion – to support clients with emotional and mental health needs.

The project, and this focus group report, are already having an impact on local mental health service provision. Camden & Islington Health Action Zone has funded a forum for the training course participants to meet with mental health professionals, other Bangladeshi workers and lay people who are concerned about mental health issues. One of the aims of the forum is to advocate on behalf of the Bangladeshi community, for example by putting forward their views to the Assistant Director for Mental Health at the Health Authority, who is responsible for overseeing the implementation of the National Service Framework on Mental Health across the two boroughs. A variety of agencies, including the Mental Health Trust, the Health Promotion Service and the Bengali Women's Health Project, have come together to develop an action research project which is examining ways of strengthening community involvement and improving access to mental health services for Bangladeshi people.

The Health Promotion Service and the Bengali Women's Health Project have also developed further projects within the Bengali community. A second training course was held in 2001, and participants from this course have gone on to form a mental health promotion working group. The group is being further trained and supported to act as mental health peer educators and to develop information resources.

Community involvement cannot be a one-off time-limited exercise – especially in an area as diverse as Camden and Islington. We must build long term relationships which place communities, service users and carers at the centre of mental health service planning and development. This report highlights successes but also shows how far we have to go in meeting the mental health needs of Bangladeshi people. The mental health trust, Camden and Islington Health Authority and London Boroughs of Camden and Islington are consulting with a view to setting up a new Camden and Islington Mental Health and Social Care Trust from April 2002. Central to our vision is a commitment to equality of access and ensuring that the services the care trust provides meet the varied needs of our local residents and are sensitive to the particular needs of those from black and minority ethnic communities. With that in mind, we are committed to take on the lessons of this report, to work to involve Bangladeshi and other black and minority ethnic communities at a strategic level, and to strive to recruit more staff from these communities so as better to reflect our local population.

# 1. Executive summary

This report aims to highlight key issues and concerns which emerged from a mental health training programme targeted at Bangladeshi community workers in Camden and Islington (section 2.1). The mental health training community project was set up by the Camden & Islington Health Promotion Service in partnership with the Bengali Women's Health Project, with the following aims:

- Raise awareness of mental health, illness and health promotion issues among Bengali workers in order to support them in managing their work with distressed clients better.

- Gather more information about the needs of Bangladeshi communities.

- Develop a network to provide on-going support to workers and create a platform for future developments.

The training took place from June to August 2000. Sixteen workers from diverse backgrounds took part. Emerging issues were identified via a focus group discussion (section 2.4). The project should be seen in the context of the National Service Framework for Mental Health and existing evidence on black and ethnic minority groups' unsatisfactory experience of mental health services (section 3). Among South Asians in the UK, studies have highlighted:

- A pattern of accessing specialist mental health services in acute crisis with low levels of GP referral.

- Higher incidence of misdiagnosis and greater use of medication and ECT compared with talking therapies.

- High rates of suicide, attempted suicide and eating disorders in young Asian women.

- Greater use of in-patient as compared with preventive services.

- Lack of sensitivity of Western-oriented measures of mental distress to symptoms shown by Asian people.

- Particular disadvantage of Asian women in both primary and secondary mental health services (section 3.3).

Local studies have identified some particular factors including:

- Low levels of awareness of existing services and consequent low uptake.

- A pattern whereby Asian women in particular express and talk about physical symptoms when experiencing depression or anxiety, with resultant misdiagnosis.

- Clear unmet needs at a variety of levels (section 3.3).

Bangladeshi communities are among the most disadvantaged in London, with high levels of unemployment, long term limiting illness and poor housing exacerbated by racial harassment or abuse. Local work in Islington has identified additional issues including:

- Women being severely isolated due to the absence in Britain of social support system and networks that exist in Bangladesh.

- Inter-generational stress related to acculturation (section 3.4).

Focus group evaluation identified aspects of the community training programme which Bengali workers had found useful, such as:

- Development of personal and professional skills.

- Stimulation of interest in careers in the mental health field.

- Focussed time to address mental health issues.

- Increased awareness of mental health, the symptoms people might experience, treatment and care options, and how to refer clients appropriately.

- Greater self-awareness as regards their own practices, behaviour and attitudes (section 4.1).

Potential areas for improvement in future initiatives included:

- More opportunities to relate mental health theory to practice through role-play and case studies.

- Better advance information about the course content and more notes and handouts (section 4.2).

As a result of the project the course participants identified mental health issues they had come across in their front-line work with Bangladeshi communities in Camden and Islington:

- Isolation, loneliness and difficulty in accessing services being compounded by people's difficulty in speaking English and uncertainty about whether their cultural background will be understood.

- A tendency for clients to present initially with physical symptoms, with underlying emotional, financial, housing or relationship problems emerging later.

- Reticence about using mainstream mental health services because of stigma and pressures to keep problems within the family to preserve "izzat" or honour, coupled with poor understanding of mental health and illness and what services could offer.

- The adverse mental and physical health impact of socio-economic conditions experienced by Bangladeshi communities such as poor housing, unemployment and low incomes.

- Loss of self-esteem as a result of professional skills and education attained in Bangladesh not being recognised in the UK.

- Disappointment as people's hopes and expectations of a better life on coming to the UK had not been met.

- The stressfulness of seeking to retain and preserve one's identity in an alien and sometimes hostile culture and environment, coupled with divergence of thinking between parents and children in relation to religious and cultural practices.

- The daily reality of domestic violence for a number of Bangladeshi women and their families.

- A need for more family-centred models of care, as families could be left confused and frightened when mental health services did not involve and inform them about what was happening in relation to the care of a family member.

- The fact that although many Bangladeshi people live within an extended family structure, this does not mean that the family provides an effective support mechanism.

- Problems arising because of lack of understanding about how education, legal, mental health and other systems work, with services not being proactive in providing information and explanations to enable people to make sense of what is happening and manage their situation (section 4.3).

This evidence illustrates that the mental health needs of Bangladeshi communities in Camden and Islington result from complex interactions between poverty, inequality, social and cultural identity and democracy. It also underlines the very significant existing support provided by Bangladeshi community workers to their clients. The aim should be to develop an appropriate range of services funded through mainstream mechanisms, rather than specialised, limited or otherwise marginalised and vulnerable resources. Several opportunities and drivers for change can be identified at the levels of national policy and service provision and development (section 5).

At the local level, the community training programme participants' skills, experience and access to local Bangladeshi people offer a valuable resource for mainstream service providers and purchasers. It is important for these community workers to have an opportunity to influence changes in services by feeding into the work of the Black and Minority Ethnic reference group (section 6).

## 1.1. Recommendations

The group of community workers made the following specific recommendations (section 7):

### 1.1.1. At a structural and organisational level

Specific mental health promotion strategy for black and minority ethnic groups

The current draft mental health strategy and local Mental Health National Service Framework implementation plan should specify particular health promotion and service development work to

improve the health of Bangladeshi communities within the context of a co-ordinated strategic approach.

### Introduce systematic 'ethnicity monitoring'

Ethnicity Monitoring is required to be undertaken consistently and systematically at a primary care level where Bangladeshi communities present most often to service providers, but also by mental health service providers.

In order for such monitoring to be effective in improving the quality of services, as well as addressing and identifying the linguistic and religious needs of communities, data needs to be collected on ethnicity, written and spoken language needs and practicing religious needs.

### Set accountable targets and performance indicators for mainstream services

Mainstream services need to take more responsibility for measuring whether their services are accessible to and meet the needs of Bangladeshi communities. Executive and Non Executive Board members should be identified by Trusts, Primary Care Groups and Primary Care Trusts, the Local Authority and Health Authority to take a lead on specific, measurable and practical targets to improve services. Such individuals should then be accountable for meeting these targets.

## 1.1.2.    At a service provision & development level

A number of specific practical service provision and development measures were identified to improve the cultural and linguistic appropriateness of and access to services, such as:

### Bengali telephone helpline

This could be used by a range of individuals in the family and would preserve the anonymity and confidentiality that many users are concerned about in terms of the stigma of mental health.

### More Bengali professionals and advocates

Individuals who have a professional training and can understand the cultural and religious needs of individuals are able to meet language needs should be employed. Bi-lingual Bengali advocates with an understanding of the mental health system were felt to be better placed to meet the needs of Bangladeshi people with mental health needs rather than interpreters whose roles are to be impartial in any communication and not to represent the service users in any way, or enable them to get the best out of the services.

### An inter-agency multi-disciplinary service in King's Cross

Individuals often have to go to ten different places for different aspects of their services and the ideal vision for the community was a one stop mental health shop with a range of professionals from different disciplines who could provide a more holistic package of care for the individual. Team members could comprise of some Bangladeshi professionals, advocates and outreach workers as well as culturally trained non-Bangladeshi professionals to offer a choice in services. It was felt that a 'centre' such as this would be a reference point that could undertake pro-active health promotion and community development work as well as crisis management and specific case work.

The catchment could be for all residents in Camden and Islington and the service could also be offered in the evenings and at the weekend.

### Equality and cultural awareness training for professionals

All mental health providers should undertake training, which familiarizes them with cultural specific issues and needs which can cause and impact on the mental health of Bangladeshi people. Any such training should not fall into the trap of encouraging professionals to stereotype communities and their needs, but simply heighten awareness of issues they need to take into account and the different types of questions they may need to ask to provide more sensitive and appropriate care. Training should also provide individuals with a clear context of the wider socio-economic inequalities and discrimination and alienation experienced by Bangladeshi communities.

### Family orientated models of service provision

A number of cases were cited by workers where interventions needed to involve the whole family in order for them to be effective. Thus, it was felt that mental health providers should use more models of family–orientated interventions and have more family workers to address this need and gap.

### Mental health link workers or 'co-ordinators of care' in primary care teams

GPs were felt to be key individuals in identifying and promoting the mental health needs of Bangladeshi communities. Workers recalled instances of people being referred by GPs, sectioned and discharged and going through repeated cycles of being admitted to hospital without any communication or follow up by the GP.

The time constraints that GPs often work under were well recognized and so with the employment of mental health 'linkworkers' or 'co-ordinators', they could take the role of referral and co-ordination of the care of the individual as well as spending time with the individual to raise awareness of mental health, explain how the system works and answer any questions the individual or their carers might have.

### Continuity of care

The experience of workers was that even though many services claim to work on a key worker basis, clients did not appear to receive continuity in their care and sometimes this fell apart at the primary care level and discharge into the community as well as in hospitals. Thus, the monitoring and effectiveness of community and hospital based workers needs to be improved by getting qualitative feedback from clients about how it is working for them.

### Targeted work with young people

It was felt that there is a great need to target young people as a 'sub-group', who may be using drugs and involved in criminal activities due to various pressures and needs, which have not been met or overlooked. Specific awareness work, support work and rehabilitation work were identified as priorities.

### Outreach work by mainstream organizations

It was felt that mainstream organizations need to change their 'mind set' from complaining that people do not want to use their services or are not using their services to being more pro-active in improving access to their services and promoting understanding of their services. Outreach workers were felt to be central to such a process working and should be attached to all major mental health services.

## 1.1.3.    At a community development, capacity building & health promotion level

### Community Peer Educators

As a result of the stigma of mental health, low levels of understanding of mental illness and fear and confusion about what mental health can provide or offer, a useful model to adopt would be Bangladeshi 'community peer educators' who have received mental health training in a form provided by the mental health training course who could be available at a range of access points in the voluntary and statutory sector, attached to youth services, at GP practices and in hospitals, with education and social service departments..
Further, a 'team of peer educators' could raise awareness and understanding of mental health as well as doing activities to promote mental health.

### Public awareness raising events at particular target groups

The awareness raising events that have been run by the Bengali Women's Health Project and Camden and Islington Health Promotion Service were evaluated as being very positive and successful with communities. This model could be extended to target young people, older people and men, however, rather than being one-off events they could be run more often, thereby providing continuity and incrementally tackling more issues and information needs.

### A simple guide to mental health services

A simple guide to knowing your way around services does not currently exist. This could be used in a range of settings by various service providers as one way of increasing knowledge and empowering people.

### Radio and TV publicity

This is currently under-utilised in raising public awareness and it was felt to be a more effective way of reaching Bangladeshi communities than leaflets and posters as many people may not use services and may not be able to read Bengali or English.

## 2. Introduction

### 2.1. Report Aim

This report aims to highlight the key issues and concerns which emerged from a mental health training programme targeted at Bangladeshi community workers in Camden and Islington. These key issues form the basis for broader recommendations about how this work should be taken forward and developed by a range of stakeholders.

### 2.2. Background to the project

The mental health training programme for Bangladeshi workers was developed in partnership with the Bengali Women's Health Project as part of Camden & Islington Health Promotion Service's community development work. A joint post between these two organisations was established in 1999, following which the post-holder recognised that community workers were in frequent contact with clients in emotional distress, and felt inadequately prepared and supported for this work. The training programme was developed in response to this need.

### 2.3. About Bangladeshi Communities in Camden and Islington

Bangladeshi communities make up the largest non-white ethnic minority group in Camden, comprising 9.5% of the population[1] and 2.31% of the population in Islington[2]. The largest number of Bangladeshi people in Camden are concentrated in eight wards in South Camden. Somers Town has the largest Bangladeshi population, the others being Regent's Park, King's Cross, Bloomsbury, Holborn, St Pancras, Camden and Brunswick.

The majority of the Bangladeshi population in Camden and Islington are from the agricultural region of Sylhet in the north east of Bangladesh and migrated in the 1940's, 1960's with families, wives and children joining them in the 1970's, 80's and 90's. Local surveys show that Bangladeshi people in Camden and Islington are mainly Muslim, with a strong cultural identity with their place of origin (Rahman, 1997; Camden Equalities Unit, 1995). For example, in the Camden survey, 86% of respondents always saw themselves as 'Sylheti', and in terms of regional and linguistic identity Sylheti[3] was much stronger than the wider 'Bengali'.

An accurate profile of the literacy levels among the Bangladeshi population in Camden and Islington is not available, but local studies and work (for example, see Rahman, 1997; Camden Equalities Unit, 1995) suggest that among the older age groups (over 45 years) ability to speak English is poor, with women less likely to be able to speak English. For the younger age groups, the predominant language is English.

### 2.4. The Training in Mental Health for Bangladeshi Community Workers

#### 2.4.1. Aims and objectives

The mental health training community project for community workers was set up by the Camden & Islington Health Promotion Service in partnership with the Bangladeshi Women's Health Project. The training aimed to:

- Raise awareness of mental health, illness and health promotion issues among Bengali workers in order to support them in managing their work with distressed clients better

- Gather more information about the needs of Bangladeshi communities

- Develop a network to provide on-going support to workers and create a platform for future developments.

The programme ran for 8 weeks (2.5 hours per week) from June to August 2000. The specific objectives of the training were to:

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[1] Source: Age distribution of residents by ethnic group, LB Camden, 1999: LRC 1998 round demographic projection.

[2] Source: London Research Centre, Islington total projections for 1998

[3] Sylheti is a spoken dialect only; there is no written version of the language.

- Develop a basic level of knowledge of mental health, illness and mental health promotion
- Provide information about existing services and how to access them
- Gather information on community needs through case studies and discussions
- Support workers in learning how to recognize symptoms/early signs of illness and in clarifying their roles in relation to distressed clients
- Support workers in learning how to deal with their personal emotional and psychological effects of supporting clients in distress
- Provide ongoing support to the trainees/workers who are working in the community.

A total of 16 workers from diverse backgrounds participated on the programme. Their professional roles included health advocates, doctors, community workers, outreach and youth workers, welfare rights advisors, parent education workers and football coaches.

The content of the course encompassed mental health theory, definitions of mental health, different cultural manifestations of mental illness and an overview of formal treatments such as counselling, therapy and hospitalization. A key element of the programme was to develop the individual awareness and skills of workers in dealing with personal emotional and psychological needs when supporting clients in distress. A course attendance certificate was provided at the end of the programme for all participants.

### 2.4.2. Evaluation methods used

Emerging issues were identified via a focus group discussion with the Bangladeshi community workers who took part in the programme. The focus group discussion was tape recorded, and observed by a third party who also took notes thus enabling the accuracy of the data to be checked.

Focus groups are group discussions organized to explore a specific set of issues. The focus group was chosen as an appropriate method for evaluating the training since it is ideal for research that is exploratory or explanatory. One of the key aims of this review was to enable providers and purchasers to better understand the mental health issues for Bangladeshi communities in Camden and Islington as well as to get feedback about the value of the mental health training undertaken by community workers.

## 3. The context: Mental health and Black and Minority Ethnic communities

### 3.1. What is Mental Health?

Joubert and Raeburn (1998) define mental health as *'the capacity of each of us to feel, think and act in ways that enhance our ability to enjoy life and deal with the challenges we face. It is a positive sense of emotional and spiritual well being that respects the importance of equity, social justice, interconnections and personal dignity'*.

They define mental health promotion as *'the process of enhancing the capacity of individuals and communities to take control over their lives and improve their mental health. Mental health promotion uses strategies that foster supportive environments and individual resilience, while showing respect for culture, equity, social justice, interconnections and personal dignity'*.

Within the context of this definition, it is clear that good mental health is the product of a complex set of factors and that a number of organizations and individuals have the responsibility, potential and opportunity to promote mental health at a number of levels.

The National Service Framework for Mental Health[4] (DOH, 1999) recognizes that in order to improve health, knowledge–based practice is required, together with partnership working between those who use and those who provide services; between different clinicians and practitioners; across different parts of the NHS; between the NHS and local government; and reaching out to the community, to individual groups and organizations, including the voluntary, independent and business sectors.

The National Service Framework for Mental Health sets out standards which relate to:

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[4] The Mental Health National Service Framework is the government's agenda to drive up quality and reduce unacceptable variations in health and social services(Department of Health, L46/01 16575 COM 30k 1P, Sep 99, SA)

**Mental health promotion**

Performance in this area will be monitored by for example, things such as health improvement programmes demonstrating action within the linkages between organisations to promote good mental health in schools, workplaces and neighbourhoods, for individuals at risk, and for groups who are most vulnerable.

**Primary care and access to services**

Performance in this area will be monitored by for example, things such as access to psychological therapies, self-help groups and support services such as housing and employment, experience of service users, and carers, including those from the black and minority ethnic communities.

**Effective services for people with severe mental illness**

Performance in this area will be monitored by for example, things such as ensuring staff are competent to assess the risk of violence and self-harm, to manage individuals who may become violent, and to know how to assess and manage risk and ensure safety; integrated arrangements to prevent and manage crisis, including access to services around the clock; the engagement through assertive outreach and effective medication of service users who are at risk if they lose contact with services.

**Individuals who care for people with mental health problems**

Performance in this area will be monitored by for example, things such as carers' receiving easy to understand information about both the help available to them, and the services provided for the person for whom they are caring, including medication, other treatment and care, and what to do and whom to contact in a crisis.

**Action necessary to achieve the target to reduce suicides**

Performance in this area will be monitored by for example, things such as a reduction in suicide rates and local suicide audits

The Health Education Authority (HEA, 1997) state that about 1 in 7 people experience a mental health problem and the chance of being affected appears to be affected by various social factors including:

- Unemployment (rates up to 100 per cent higher)

- Being a lone parent or living alone (rates are between 26-80 per cent higher),

- Living in rented accommodation, particularly from local authorities and housing associations (rates are up to 50 per cent higher and

- Living in urban areas (rates are between 20-40 per cent higher) [5]

There are also gender differences in the diagnosis of mental illness. For example, in every 20 people identified with a mental illness, 11 are female and 9 are male. Local work in Islington also suggests that while more black and minority ethnic women are diagnosed as mentally ill, men are far more likely to be referred for specialist treatment (McKenzie and Weekes, 1994).

**3.2. Mental Health Services for Black and Minority Ethnic Communities**

There is a great deal of literature about black and minority ethnic groups' unsatisfactory experience of mental health services (Wilson, 1993). Research evidence also consistently demonstrates differences in their treatments and pathways into mental health services (Cole et al, 1995). These data strongly suggest inequity in treatment and poor management of mental ill health among black and minority ethnic communities (BMEC). Yet, there has been no systematic implementation of pragmatic changes in the delivery of care or in the training of professionals charged with providing care to BMEC. For example, the Mental Health Task Force, set up in 1992, focused its attention from January 1993 to December 1994 on the twelve inner London District Health Authorities and their associated social services departments. It also undertook a consultation exercise with black mental health groups and organizations and published, *Mental Health – A dialogue for change*, as well as a video, *Different Cultures – Different Needs*. However, there has been no strategic imperative to act on or build on the

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[5] Reference: OPCS Survey, (1995): The Prevalence of psychiatric morbidity among adults living in private households

work done by the Task Force, implementation of its recommendations have been done in an ad hoc way and dependent on the individual interests and motivation at a local level.

### 3.3. What do we know about the mental health of South Asians?

In London, almost half of all mental health admissions are from black and minority ethnic communities or those who were not born in the UK (Johnson et al, 1997). Whilst there is to date limited local and national research into the needs and issues for Bangladeshi communities, a number of common experiences among South Asians are illustrated by studies, which highlight:

- A pattern of Asian people entering specialist mental health services in acute crisis with low levels of GP referral (Bhui et al., 1993);

- An increased incidence of misdiagnosis and the greater likelihood of receiving medication and ECT as opposed to talking therapies such as counselling and psychotherapy (Campling, 1989; Ilahi, 1988);

- Suicide rates among Asian women aged 15-24 years are three times the national average and 60 per cent higher for those aged 25-34 (Balarajan and Soni Raleigh, 1993) and attempted suicide rates also high in young Asian women (Yazdani, 1998; Merrill and Owens, 1986);

- Young Asian women appear to have a higher risk of eating disorders such as anorexia and bulimia nervosa than their white peers (Mumford and Whitehouse, 1988);

- South Asians are more likely to be found in mental health services as in-patients rather than as users of preventive services (Cullen and Fernando, 1989);

- Measures of mental distress developed by western –orientated researchers and psychiatrists may not be sensitive to symptoms shown by Asian people, leading to a possible under reporting in prevalence studies (Williams, 1993);

- Asian women are particularly disadvantaged in both primary and secondary mental health services as a result of acculturation, language, social isolation, racial hostility and abuse, material difficulties, lack of childcare support, cultural and religious issues, and interpersonal disputes (Williams, 1993; Webb-Johnson, 1995;Upadhyaya et al, 1989).

In terms of service awareness and uptake, a number of studies, including local work done in Islington among Bangladeshi women have showed low levels of community awareness about existing support services and a subsequent low uptake of mainstream preventive support (Rahman, 1997, Beliappa, 1991). For example, in Islington, out of 25 women, all of whom listed symptoms associated with a depressive disorder, none were aware of any mental health services available to them (Rahman, 1997). For many of the women, their first and in many cases their only point of medical contact was with their GP (Rahman, 1997). In Beliappa's sample of 100 Asian women, again the finding was similar; the most frequently used services were those provided by their GP[6], reiterating the pivotal and central role the GP has in initially diagnosing mental health problems and subsequently making referrals to specialist agencies.

The important role of GPs becomes even more marked for black and minority ethnic communities because as Johnson et al., (1997)[7] indicate that the absence of shared meanings, lexicon, concept of self and world view will contribute to the emphasis on physical symptoms which are more directly amenable to undistorted translation. Somatisation as a term is often applied when, due to premature closure of assessments or of 'cultural distance', there is poor understanding of the therapeutic encounter (Bhui, 1994). Local work highlights that Asian women in particular express and talk about physical symptoms when experiencing depression or anxiety. For example, in Rahman's (1997) sample, over three quarters of women complained of recurrent headaches\migraines and over half of women said that they had general aches and were not feeling right.

Such a scenario has been more recently been demonstrated to be associated with non recognition of psychiatric disorder in primary care (Jacob et al., 1996). Wilson and MacCarthy (1994) demonstrated

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[6] However it is important to note that the majority of the sample viewed their GP as someone to approach for physical ailments that needed a medical cure and not for emotional and psychological problems.

[7] -in a report to the King's Fund London Commission.

that even when patients presented with psychiatric complaints, Asians were more likely to be diagnosed as suffering from physical illness. Where physical complaints were presented, more of the white group were identified to have psychiatric problems than the Asian group. Jacob et al (1996) confirmed that a sample of West London GPs correctly diagnosed less than a fifth of those identified by the questionnaire to be ill.

In all statutory sector services, time constraints determine the level of attention and degree to which a professional comes to really know the characteristics of any patient. Where a patient presents their distress in a manner which is unfamiliar to the health care professional, more time and attention to detail are required if the level of knowing that patient is to be comparable to that in a patient who shares (with the professional) the same language, social class, culture and world view about health, illness and help seeking (Bhugra and Bhui, 1996). Not only is such time not usually available, particularly in primary care and in emergency situations, but professionals are often unaware of the limitations of their assessment, making training in this area a key priority.

This body of research and needs assessment work indicates that in spite of poor ethnic monitoring, there is increasing evidence of the prevalence of mental illness within Asian groups. Groups such as young Asian women, and women in general appear to be particularly 'at risk' of experiencing particular mental health problems such as being at a higher risk of attempted suicide ( Merill and Owens, 1986 ) and eating disorders such as anorexia and bulimia than their white peers (for example, see Mumford and Whitehouse, 1988; Pendall et al, 1991; and Dolan et al, 1990 ). Further, it identifies that there are clear unmet needs at a number of levels within pathways to services and within existing service provision in terms of access and sensitivity of services in using appropriate diagnostic instruments, and in having appropriately trained and culturally competent service providers, as well as the conceptual models used to diagnose individuals.

### 3.4. Why mental illness is a concern for Bangladeshi communities in Camden and Islington?

The most recent ALG report '*Sick of Being Excluded*' (ALG, 2000) identifies that Bangladeshi communities in London are among the most disadvantaged, with higher levels of unemployment, nearly twice the rate of long term limiting illness compared with white people of that age group and are among the worst housed in the city. These findings are also echoed at a national level, in the 1986 Home Office Report, 'Bangladeshis in Britain':

> *"The Bangladeshis are the most recent arrived of Britain's major ethnic communities and are considerably the most disadvantaged. Their problems differ in degree rather than in kind from those of other ethnic minorities, partly reflecting their recent arrival, but the difference of degree is sometimes substantial. They tend to occupy the worst and most overcrowded housing, their recorded unemployment rate is exceptionally high (although some will be obtaining income from commercial activities within the home), average earnings are lower than for any other ethnic minority, there is considerable under-achievement among their children at school, fewer than in other ethnic minorities have a reasonable command of English…the language barrier and cultural factors restrict their access to health and social services, and they appear to be disproportionately affected by racial violence. These problems exacerbate each other".*

Whilst this picture of Bangladeshi people is negative and does not explicitly highlight the high achieving and successful individuals and professionals that also make up this community, it does put into sharp focus the multiple disadvantages and hence the greater degree of social exclusion faced by Bangladeshi people in general.

This cannot be dissociated with mental health as Meltzer et al (1995) have demonstrated a correlation between mental health and poor housing, poor education, unemployment, living in council accommodation, single parenthood and being alone in the general population.

Indeed, at a local level, Bangladeshi people further reiterate the hostile environmental, social and economic inequalities they experience as being key barriers to their well-being. For example, the Camden Bangladeshi survey highlighted that out of a random sample selected for interview, 62% felt that racial harassment was an issue for concern. One in three households had suffered some form of racial harassment and the fear of racial harassment had resulted in changes to the daily pattern of life for Bangladeshis, such as 34% only visit shops at certain times of the day (Camden Equalities Unit, 1995). This finding was mirrored in the Islington mental health research (Rahman, 1997), where all of the women listed at least one episode of experiencing racial harassment. In the majority of cases, women complained of abusive language. For many, this resulted in them not feeling safe to come out of their own homes.

Below are some examples described by women highlighting how this can often lead to individuals being excluded from community life and becoming more isolated:

*Rashida revealed that her younger brother had not been to school for two months as he was suffering racial harassment at school for not being able to speak English properly. She knew nothing about how to complain about this situation, she just stopped sending him to school.*

*Mumtaz said that she always felt scared taking her children to school as children that lived nearby often threw stones at her and her two children. As a consequence Mumtaz feels too frightened to travel alone, leaving her husband to take the children to school. Mumtaz is now totally isolated and has no social support as her husband works long, unsocial hours.*

The combination of socio-economic disadvantage and discrimination on the health and well being of black and minority ethnic Londoners is illustrated by data collected in The Fourth National Survey of Ethnic Minority and White people living in England and Wales (Nazroo, 1997). The survey showed significant independent relationships between the reporting of 'fair' or 'poor health' and 'perceived racial discrimination', 'experienced racial harassment' and 'socio-economic disadvantage'. For example,

- manual workers had 60% greater chance of reporting fair or poor health than those in non manual occupations

- people reporting experiences of racially motivated verbal abuse had 50% greater chance of reporting fair or poor health than those who had not experienced racial harassment

- people reporting experiences of racially motivated assault or damage to property were over twice as likely to report fair or poor health.

Housing conditions and financial hardship were also highlighted as a major source of anxiety in the Islington research. The most common problems mentioned were dampness, cold\draughts, overcrowding and the poor state of repair of houses. Dissatisfaction levels with the housing department were also very high in the Bangladeshi survey in Camden.

It is well established that good quality, affordable housing is a key determinant of health (Hunt, 1997; Ineichen, 1993 and National Housing Federation, 1997) and statistics show that Bangladeshi people in London are among the worst housed in the city, with high levels of overcrowding, sharing, children living above the ground floor level, and properties lacking basic amenities (London Research Centre, 2000).

The stresses of acculturation in terms of adapting to a new country, culture, life and way of thinking has been identified in national and local work as a major cause of mental distress (Summerfied, 1995). For example, the local Islington work identified that acculturation can not only be an issue for individuals , but also be a source of stress between generations. It identified that many Bangladeshi women suffered from total isolation compared to the lifestyle they led in Bangladesh, with the social support system and networks they had simply not existing in Britain. Nine women in the sample also revealed a constant state of fear that their children were becoming too westernized and conforming to the western way of life, worrying about their children losing touch with their religion and culture. This generation gap is perhaps to be expected in terms of the population profile of Bangladeshi communities in Camden and Islington which reveals that the majority of the population is made up of first generation settlers (parents) born in Bangladesh and the greatest proportion of the 16-24 age group were born and hence brought up in Britain.

## 4.    The Focus Group Findings

The consensus among the group of course participants was that overall the programme had been an empowering experience for them. They particularly appreciated the fact that its starting point had been to value them as individuals with a wealth of experience to share and build on. This section describes the specific aspects of the programme that workers had found useful and how they felt the programme could be improved in the future.

## 4.1. Benefits of mental health training programme

### 4.1.1. Development of personal and professional skills

Workers felt that the course had enabled them to develop more listening and problem solving skills. For example, one participant who was a doctor felt that before she just talked to patients without listening to them properly, she particularly learned that she needed to listen more. Another worker explained how she also felt that often in her work she didn't properly listen and hear what people were saying:

> "there's lots of times …when I go and face people…but I think I wouldn't listen and ignore [what they were saying] lots of times and maybe not pay attention as much"

For another participant, she felt that she found out other ways of approaching issues and situations she faced on a daily basis. One participant, felt that he was able to see things from a different perspective more readily than before, as a result of the training.

### 4.1.2. Stimulation of careers in mental health

A number of individuals felt that they were now seriously thinking about developing their careers in the mental health field as a result of the programme as explained by one participant:

> "this is a really new concept and it sort of opened our eyes ... in this field. A lot of us now are thinking…that yes there is a need for a Bengali psychotherapist…we would never have thought of it before…but now a lot of us are thinking about it in the future".

### 4.1.3. Focused time to address mental health issues

A few participants had been aware of some time of the mental health needs among Bangladeshi families they were working with, but that no one before had given them the opportunity to address it in a focused way. So they were very pleased about having the opportunity to have dedicated time to concentrate on it:

> "[this] must be the first initiative taken by Hasneen and the project to address it and I'm optimistic that at the end of the day something will come out of it, it's time overdue"

### 4.1.4. Awareness of mental health issues, causes and treatments

The majority of participants agreed that now they understood mental health issues better, the symptoms people might experience and the various treatment and care options available to people. Some people also identified that the programme enabled them to be better advocates in the future for how people might be able to use mental health services:

> "with the case studies and explanations of counselling, group therapy, psychotherapy, I could just really relate with the problem and the solution as well. Now, if I see any leaflets, it makes real sense to me".

For some workers, before the course, they had not made a connection between the work they did and their role in relation to mental health services. For these workers, they felt that they were now in a position to refer people who may come to them for help to appropriate mental health services. For other workers who were working with young people in particular, they felt they had become much more acutely aware of the various 'stressors' and triggers that young people were exposed to, that may make them more vulnerable to mental health problems.

### 4.1.5. Greater awareness of own practices, behaviour and attitudes

As part of the 'process' that participants experienced, they felt that they were able to examine their own behaviour, practices and attitudes and the types of changes they needed to make more readily. For example as two different participants explained:

> "before I used to just do my job, go home and that's it…but [the course] made me think how I felt and how I dealt with so in that way it helped me"

> "we learnt about ourselves in this group and that was quite good I think because we never had a chance to do that before".

### 4.2. Future changes to mental health training programmes targeted at community workers

All the participants agreed that they felt that the programme should be a beginning rather than an end and particular things that would improve future or a continuation of the programme would be:

#### 4.2.1. Greater practical application of theory to practice

In particular people felt that they would like to have more opportunities to relate mental health theory to their practice through role-play and exploring real life case studies with key points reiterated at the end.

#### 4.2.2. Course programme information and accessibility

Participants felt that future programmes should have course content and programmes under each module distributed in advance as a reference point for what they were learning and moving onto, with more course notes and handouts.

It was also felt that a Friday afternoon should be avoided in order to maximize the learning potential of participants.

### 4.3. Understanding Mental health issues for Bangladeshi communities in Camden and Islington

This section describes the range of mental health issues that this group of front-line community workers had experienced and come across over many years of working with Bangladeshi communities in Camden and Islington.

#### 4.3.1. Loneliness and social isolation due to language barriers

A number workers felt that the isolation and loneliness that people often expressed was compounded by not being able to speak English. Some workers felt that this often prevented people from coming forward to use services. One worker explained that people are often scared and confused and to go out to service providers and often end up staying at home rather than going somewhere where they do not know if they will find someone that they can communicate with or who will understand their cultural background:

*"so they feel that they won't be able to express what they want and no-one will know what they are looking for, so they think what's the point of going out".*

#### 4.3.2. Presentations of physical symptoms first

Health professionals and advocates in the group described how they often saw patients and clients who presented with physical symptoms and then it would emerge later that their key issues were emotional, financial, housing related or relationship related difficulties.

One person described how a woman came to see her, describing how she couldn't sleep, and sometimes she'd oversleep and often over eat. She came to the doctor describing these symptoms on four occasions and it was not until her third and fourth visit that she began to open up and talk to the doctor. It then emerged that she had a problem with her daughter's marriage and the divorce and that she felt she couldn't control the children. Yet the presentation of her initial symptoms were that: "she had pain all the time coming this way and that and here and there".

Another person described a different scenario of a lady who lost her husband on the same day she gave birth to her daughter. This lady always describes physical symptoms. For example, she thought she was having a heart attack when it was panic attacks and she always complains that the hospital doctors couldn't find anything wrong with her. Yet no one had bothered to spend the time with her and talk to her about how she was feeling and why she might reasonably be feeling that way after such a tragic incident.

These scenarios highlight that often the conceptual understanding of mental health and illness may be unfamiliar to individuals, and as Rack (1982) suggested, this is often compounded by the fact that many words to describe emotions and western descriptions of mental health problems do not exist in many Asian languages. Further, these examples reiterate how the GP may often be the first port of call for many patients and individuals often just associate going to GPs for medical symptoms and conditions.

A recent review of black and minority ethnic community's use of health services in London (ALG, 2000) indicated that GPs are the most familiar and well used practitioners, but that they also often act

as 'gatekeepers' to services, not making appropriate referrals, nor providing adequate explanations or information and users are often the least satisfied with primary care services.

### 4.3.3.    Reluctance to use services

Many workers identified how clients were often reticent to use mainstream mental health services because of a combination of factors such as the stigma of mental health and pressures to preserve the 'izzat' or 'honour' of the family, coupled with a poor understanding of mental health, illness and poor knowledge of what services could offer. One worker explained that often communities are only too aware that if there was gossip that there was depression in the family it would have an impact on things like the marriage prospects of daughters. Therefore, families have always got this in the back of their minds which often prevents them from seeking help. Another factor identified was the 'self sufficiency mentality' of many Bangladeshi people who often first try to solve their own problems.

For example, one woman who was very young when she got married in Bangladesh, at 16 or 17, then had two children in this marriage. Her husband had some problems like depression, but one day he just got up and left her. All her family is advising her to wait for her husband, as he will come back. However, the woman feels she can't explain her feelings to her family and feels that she needs someone to recognize her. The worker explained that it was quite clear that she didn't know where to go or who to turn to, but the pressure from the relatives was to 'keep it within the family'.

Workers also felt that there was little acceptance of services offered, so they felt more needed to be done to raise awareness and raise the profile of mental health and services in the community. This is highlighted in the case below:

> *One Bangladeshi woman who was referred to a psychotherapist in the hospital told the worker that a big doctor was coming to see her at home to treat her. It was clear that she felt very uncomfortable about the person coming to see her at home and had little understanding of his role.*

### 4.3.4.    The impact of poor housing, unemployment and low incomes

Many cases were cited by workers about the anxiety, stress and negative impact of socio-economic conditions faced by Bangladeshi communities such as poor housing conditions, unemployment and low incomes of many families. For some workers, they often saw people whose physical health was also affected by these factors:

> *"most of the patients that come to me have lots of housing problems, asthma, skin diseases… overcrowding, damp and other things are common in this area".*

Another case was cited by a worker of the stress that poor, inappropriate housing had caused one woman. This woman has 4 children who go to four separate schools, one of the children has Down's Syndrome and she lives in a fifth floor flat where she regularly has to manage the wheelchair and collect her children from different schools every day. This woman has been waiting to be re-housed for years and years for a house in a location where all her children could go to one school. The woman attends a parents' workshop for children with special needs run by the worker and she often bursts into tears.

For workers who worked with young people unemployment and low income was a key factor that (they felt) often pulled young people into the criminal system. Then, when these young people decide to return to their families, they are often rejected, which in turn increases their isolation and mental health problems. The low self esteem and loss of confidence associated with not being able to find a job was not confined to young people, as it was a common experience for a number of older male clients that workers had contact with.

Another example was described of how low income coupled with lack of access to appropriate support services had led one woman to try commit suicide three times:

> *This woman has three children who are all very active and she simply feels that she can't manage them on her own. Her husband is working, but does not support her at all and so she basically lives on whatever money she gets from social security. She is taking anti-depressants from her GP, but she feels pretty desperate. She has tried unsuccessfully to commit suicide three times and all attempts have been quite serious, as she has been hospitalized on all occasions.*

### 4.3.5. *'I'm nobody here'* – Lack of recognition of professional and academic qualifications

Loss of self esteem and depression was a common factor cited by workers among Bangladeshi professionals who are well educated and have had good jobs in their own country, but find on arrival to this country that their qualifications aren't recognized and they have difficulty getting any job. Below is an example of one individual, which is typical of many scenarios:

> *This man was a doctor in Bangladesh, but when he came here, he found out that he needed to do another course to be able to practice, which he had no money for. Now he works as a care assistant for people with special needs. His life has changed so completely.*

### 4.3.6. Unmet expectations of a new country

Workers described that a common experience of many individuals who come to the country is that their expectations are very different and they often expect a better life and conditions to be better than they are:

> *"no-one expects to be dumped in those blocks of flats… [with] 5 or 6 kids, overcrowded, they've never faced it and never expected it…I never expected … to live in a 2 bedroom flat with seven brothers and sisters!".*

Such a mis-match of hopes and expectations then leads to stress, a feeling of being let down and disappointed, and generally feeling dissatisfied and low.

### 4.3.7. A need to retain and preserve identity in an alien culture and environment

Many people felt that Bangladeshi first generation settlers in Camden and Islington as a result of differing expectations and unmet needs and experiences of a hostile environment often tried harder to preserve their religious and cultural identities. This factor was also identified in the Camden Bangladeshi survey, which highlighted that the majority of Bangladeshis in the sample identified themselves as 'Sylheti' first.

This notion of having to preserve and think about who you are all the time which is often a pressure from white British society, which reminds a Bangladeshi person through harassment and discrimination that this is not your country is simply not a 'stress' or an issue in Bangladesh. So workers highlighted that this can often lead families to become more orthodox in their religious and cultural practices which then presents problems and a huge 'divergence of thinking' with children, who have different expectations, a different upbringing and different needs.

Workers described how often parents then had very high expectations of their children and found it very difficult to understand the behaviours and attitudes of their teenage children, often as result of children being frustrated and poor communication (between parents and children):

> *"I always find parents emotionally stressed out with their children [through] lack of understanding and the western way of life. The parents just think that the children are not listening to them"*

> *"they want the youngsters brought up in their way or with the culture they had in mind when they came over here, but the circumstances and the situation and culture are different in this country … and they can't keep up with it".*

The relationship difficulties and the decisions that people make about their lives, which emerge, from these conflicts and factors are highlighted in the case study below:

> *"A girl who was brought up in this country was taken to Bangladesh and pressurized into marrying someone she didn't know. She had no one to talk to and got married without saying anything. When she got back, she continued to have an affair with her previous boyfriend and then had his child. Her husband didn't come to join her for another year. Once he came over, he found out about the affair and became very frustrated and moved far away from her. They are now divorced."*

### 4.3.8. Domestic Violence is a reality

Workers cited the existence of domestic violence as a daily reality for a number of Bangladeshi women and their families as a key factor in their mental health and well being. The case study below depicts how destructive this can be:

A woman who experienced violence from her stepson in her first marriage remarried and had a very violent second marriage, where the husband beat her and her children up regularly. Although she is now separated from her second husband, he still visits her to beat her up. The woman finds that she now can't sleep at night, she always wants to keep a child with her all the times and has to communicate with her social worker through a worker she knows.

### 4.3.9.    A need for family centred models of care

A real need was identified to develop more family centered models of care to support families who have low levels of awareness of mental health and illness, poor knowledge of existing services and various systems and a real fear of the stigma of mental illness. A number of case studies were cited where services did not involve and inform families of what was happening, leaving families confused and frightened about what was happening:

> *For example, in one family, a girl was sexually raped and subsequently has depression. The family at the time was equally distressed and was providing support to her, but they were not told what was happening by any of the professionals they came into contact with, such as the doctor. The family at the time just wanted someone to sit with them and tell them what to expect and what was going to happen in the future.*

For another family, whilst their daughter was a teenager she was sectioned because she tried to kill herself. The family was very shocked as she was taken by the police and when they came into hospital, they weren't told anything, so they were very scared as they didn't know if she was going to get better or what was happening to her. In this situation, as well as information, the family just wanted some support also to help them to deal with the situation.

Some service providers have now begun to recognize the need for a family orientated approach to the services they provide such as Nafsiyat, an intercultural therapy centre in North London.  Z Guerina from the centre describes a case study, which helps to explain why such an approach is paramount in meeting the needs of minority ethnic communities, especially in dealing with acculturation issues:

> *Fouzia was referred by her teacher for her increasing lack of motivation in her school work. She suffered from severe asthma attacks. Fouzia is 14 years old, of British nationality and of Pakistani parents. She was dedicated to her studies and always wanted to learn. Suddenly, her achievement dropped and she became withdrawn and unhappy. When she came for therapy, she was suspicious and reluctant to talk about her difficulties. Gradually she was able to talk about her anger and confusion. She revealed because she dressed up differently from the other pupils and always wore a scarf and long clothes, she was laughed at and abused by her peers and teachers. She found it difficult to share her worries and anxieties with the school counsellor or teachers because 'they all think I'm mad to wear a scarf'. Also she finds it difficult to talk to her parents in case 'they will prevent me from going to school'. As a result, Fouzia became depressed and isolated and felt between two conflicting social demands. She could not please her peers by taking off her scarf and at the same time she was unable to upset her parents.*
>
> *In therapy, Fouzia was very suspicious of the referral and kept on asking why she came to therapy. She felt embarrassed to admit that she was beaten up by her school mates. Although her parents were aware of individual and institutional racism, they could not make sense of the fact that wearing a scarf was so problematic for the teachers and pupils. Even the school counsellor suggested change of attitudes to them 'when you are in Rome, do as the Romans do'. In each of the ten sessions in therapy she talked about her inability to make sense of 'human stupidity'. After her suicide attempt, her parents came with her to therapy. They did not realize that wearing a scarf was a major problem for Fouzia, her peers and her teachers. During the therapy, both Fouzia and her mother talked about their difficulties and worries in trying to adjust to a different culture. Her mother talked about her painful feelings of isolation in Britain, as she did not speak English very well and felt rejected by people. Relevant strategies on assertiveness, problem solving and ego strength were given to the family. Fouzia felt confident in the end to wear the scarf and showed to her friends that reciprocal respect between herself and her friends is necessary in a relationship. She was more assertive to report any harassment to her parents and teachers.*

### 4.3.10. The myth of extended family support

Whilst it was acknowledged that a number of Bangladeshi families may physically live as part of an extended family, for a whole range of reasons including economic 'need', the reality was that many do not. So, the notion of individuals then receiving support from the extended family was a myth. In fact, workers sometimes felt that the transition for many Bangladeshis of suddenly coming into an environment where they are responsible for meeting all the emotional, financial and physical needs of children was daunting and an area where some parents or carers may require more support to develop their skills. This area has also been identified in other research, for example, Yazdani (1998) found that many young Asian women she spoke to felt that their parents were not able to deal with their emotional needs and hence support them in this area.

### 4.3.11. Lack of appropriate support and pro-active support to Bangladeshi communities from mainstream service providers

Workers identified that a number of problems arose because individuals and families simply did not understand how various systems work, such as the education, legal and mental health care systems and services were simply not proactive in explaining mechanisms or giving information that would help individuals to make sense of what was happening to them and empower them to manage their situation. The consequences of simply not providing the right support and information at the right time are illustrated in the case study below:

> *This woman had faced a lot of abuse in her first marriage and re-married and had two children with her second husband. Her second husband then started treating her badly so she got out of that situation through social services for the sake of her two children. As the children were under twelve, she had three solicitors dealing with her case, to represent the children as well. There was no Bengali worker attached to her case and she felt that she couldn't raise many of the questions and issues she wanted. The Social Services panel decided to take her children away from her and have her sanctioned because she became violent towards the social worker that came to take her children away. She was in a psychiatric hospital for three weeks and during that time, her children were taken away. In the assessment, the hospital found that she was just emotionally stressed and that there was nothing else wrong with her. Her husband in the meantime has gone to all her family and told them that she has mental problems and now they have decided not to support her.*

## 5. Ways forward

This previous section emphasized that the mental issues and needs of Bangladeshi communities in Camden and Islington do not simply result from the relationship between socio-economic status and health, as underlined by the Independent Inquiry into Inequalities in Health (Acheson, 1998). Indeed, they are the result of a broader and more complex set of relationships between poverty, inequality, social and cultural identity and democracy, which are the key components of 'social exclusion'. Duffy (1995) identifies that *"to the individual this means, being able to participate effectively in economic, social, political and cultural life and in some cases, (reducing) alienation and distance from mainstream society"*.

This review also supports the consensus which emerged from workers in the focus group that improvements are required at a number of levels if the mental health and well-being of Bangladeshi communities is to be improved in the long term and if current HImP and Mental Health National Service standards/targets and HAZ values and priorities are to be realized in a meaningful way, rather than being paid just 'lip service' to.

Indeed, other reviews (Moffic and Kingie,1996) also highlight that mental health services need to develop more effective outcomes for black and minority ethnic communities and in order to do this, service planners and providers should first and foremost listen to, acknowledge the insights of users and carers, in order to:

> *'Develop innovation in service structures and styles of care delivery such that the service optimally manages distress in the targeted cultural groups'.*

The ultimate aim being to develop a range of independent, targeted and generic service responses, which are funded through mainstream mechanisms and tap into central sources of funding rather than specialist, limited or marginalized and hence vulnerable sources of funding.

The richness and range of issues and case studies highlighted in this review also underlines the very significant role that a range of Bangladeshi community workers in Camden and Islington have in providing emotional support to their clients. Without this support, many Bangladeshi community members would not be accessing any service.

### 5.1. A Time for Action

At a **national policy level**, there are a number of opportunities for local mainstream service providers in Camden and Islington to promote the mental health and well-being of Bangladeshi communities and to make services more responsive. For example, at a policy and guidance level:

The *NHS Patient's Charter* (1992) outlines certain basic rights that patients can expect the NHS to respect and their right to privacy, dignity and respect for religious and cultural beliefs at all times in all places is a key area identified;

*The National Health Service: a service with ambitions* stresses the need for the NHS to be *"a high quality integrated health service which is organized and run around the health needs of individual patients, rather than the convenience of the system or the institution"* (White Paper, November 1996);

*Our Healthier Nation* (February,1998) sets out proposals for concerted action to be taken in partnership to improve peoples' living conditions and health. In addressing inequalities, it highlights that attention should be focused on prevention rather than cure.

*The New NHS* (White Paper, December, 1997) promotes partnership working across the broad range of health and social care providers, with users, carers and the independent sector.

At a **service provision and development level**, a number of drivers, structures and mechanisms exist such as:

#### National Priorities Guidance

The Government's Modernising Health and Social Care Plan emphasises that fast, fair and convenient services are what is required by those who use and work within the NHS and social services. Mental health is a key theme within the ten-year modernisation programme, which commenced in 1998 and a key priority area at a regional and local level offering significant scope for addressing black and minority ethnic communities' health needs.

#### Health Improvement Programmes- (HImPs)

These were introduced to the NHS in 1998. A review by the London Regional Office (LRO), (1999), highlighted that most Health Authorities (HAs) had identified the needs of black and minority ethnic communities as an area to be addressed within their HImPs.

> HAZ boards were established to oversee a programme of promoting local initiatives, which were committed to:
> - identifying and addressing the public health needs of the local area;
> - increasing the effectiveness, efficiency and responsiveness of services;
> developing partnerships for improving people's health and relevant services, adding value through creating synergy between the work of different agencies.

#### National Service Frameworks

The National Service Framework for Mental Health sets out a strategic context and priorities for a range of mental health services, with specific performance assessment criteria in relation to a number of standards which will be measured by the experience of black and minority ethnic users and carers.

#### Health Action Zones

The first Health Action Zones (HAZs) were established on 1 April 1998 to bring together all those contributing to the health of the local population to develop and implement a locally agreed strategy for improving the health of local people. HAZs have key objectives of reducing health inequalities, improving services and securing better value from the total resources available. Camden and Islington is one of four HAZs in London which has identified improving services for black and minority ethnic communities features as a cross cutting theme in all its programmes.

## Local Government Policy and Initiatives

There are a number of key strategic initiatives from central Government, which deliberately shift the focus from tackling equality to core strategic priorities for local Government. The Best Value programme of the Department of the Environment, Transport and the Regions (DETR) has specified a comprehensive set of performance indicators to drive the agenda for local authorities towards making continuous improvements in the way they carry out their functions.

The majority of the best value performance indicators specify 'fair access' amongst its core standards. These link closely with other central government policy initiatives such as Agenda 21, which, focuses on regenerating local communities and building capacity of local organisations. Although key strategic initiatives afford opportunities to tackle inequalities, the focus on visible minorities needs to be addressed if large sections of the population are to have equity and equality.

## Quality Protects and Sure Start

These are the government's strategic drivers to improve management and quality of Children Services. These identify specific developments to address culture and diversity in providing and managing children's services. Sure Start has a direct focus on working with the youngest disadvantaged children.

## London Health Strategy

The London Regional Office was established in April 1999 when the geographical boundaries of the NHS in London were changed. The LRO will play an important strategic role alongside the new Mayor and the Greater London Authority in creating an environment where health and social care, housing; employment and economic regeneration can develop.

At a local level...

"Investing in the Future" – plan sets priorities for work with children, young people and their families in Camden for 1998-2001. It provides a framework to develop services that will enhance the health, welfare and life chances of these groups. It involves the local health authority, main health care providers, the voluntary sector, police and the community. Examples of projects which can support promoting the mental health and well-being of Bangladeshi communities include:

- Hopscotch Asian Woman's Centre - providing a range of services; information; advice; support groups; a toy library and a playgroup for families with special needs children.

- A Home Support Service, a counselling service for families with children with special needs.

- Camden and Islington Health promotion Unit and Bengali Women's Health Project- Bangladeshi Development Worker- focusing needs analysis, identifying service gaps, and ways to improves services.

- Supporting Parents – developing parenting support in minority ethnic communities.

Camden Interpretation service - for all community languages

### Role of PCGs
- Improve the health of the population
- Tackle inequality
- Manage budgets to pay for care from community and hospital health services
- Develop services
- Work with social and community services
- Develop public and user involvement.

The London Health Strategy was launched in May 1999 as a partnership between key local government organisations, NHS bodies and the voluntary sector. The draft strategic framework document published in December 1999, addresses key concerns for tackling race and social exclusion. Tackling inequalities, working with communities and partnerships are the guiding principles of the strategy, which identifies regeneration, education, employment, housing, homelessness and crime and disorder amongst its key priorities for 'working to improve London'. The health of black and minority ethnic health people and refugees and asylum seekers are key priorities.

## Primary Care Groups and Trusts

PCGs and PCTs are ideally placed to create change where there is poor practice and to target services to meet specific needs, as primary care is where most people need services and primary care settings offer multiple points of access to encourage the use of services. The small scale nature of primary care services offers the potential for meeting needs flexibly and creatively.

This section highlights that many local and national policy directives now exist and offer opportunities for local health and social services in Camden and Islington not only to improve service provision and delivery to black and minority ethnic communities, but also to ensure that equality issues do become embedded within the culture and functioning of the organisation.

## 6.    Services and developments needed to promote mental health and well-being among Bangladeshi communities in Camden and Islington

In terms of the initiative undertaken by the Bengali Women's Project and Camden and Islington Health Promotion Service, the review has highlighted that it has been extremely successful in enabling a group of sixteen Bengali community workers in various roles to understand mental health issues and needs. This has already allowed a number of them to feel more empowered to promote mental health in their work as well as developing a number of good practice skills which they can use in all the work they do. For some, the training has even stimulated them in pursuing careers in the mental health field. Workers found the process of coming together as a group, sharing experiences, and having the time and opportunity to network very supportive.

The enthusiasm and motivation of individuals and the rich access they have to local Bangladeshi people offers providers and purchasers in Camden and Islington many opportunities to utilise their skills and valuable experience. For example, this group could be linked to:

- mainstream service providers and purchasers as a group of 'advocates' for Bangladeshi communities who can make a positive, informed and valuable contribution to mental health planning mechanisms

- any research initiatives

- consultation events and processes

- rolling out further initiatives to develop 'peer educators' as they can potentially act as important role models and mentors for others.

This emphasises the clear need for this network and group of individuals to be supported and developed further in order to sustain the momentum of the work done and their motivation to contribute to the mental health service development and the mental health of local people.

Whilst Camden and Islington has a draft mental health strategy and a local implementation plan for the National Service Framework for Mental health, neither of these documents identify using any specific actions, or measure how the mental health needs of Bangladeshi communities will be met, nor do they present a co-ordinated mental health promotion strategy. Standards 1.3.6, and 9.1 to 9.4 of the National Service Framework for mental health indicate particular actions for meeting the needs of black and minority ethnic communities, but to date progress on these is often described as requiring more work. The black and minority ethnic (BME) reference group is the only group cited which will be consulted in developing standards. It is important that the Bangladeshi community workers have an opportunity to affect changes in services by feeding into any work that the BME reference group undertakes.

The next section presents the views and ideas which emerged from the group of community workers about specific developments which they felt would help to promote the mental health of local Bangladeshi communities.

## 7.    Recommendations

### 7.1. At a structural and organisational level

#### 7.1.1.    Specific mental health promotion strategy for black and minority ethnic groups

The current draft mental health strategy and local Mental Health National Service Framework implementation plan should specify particular health promotion and service development work to improve the health of Bangladeshi communities within the context of a co-ordinated strategic approach.

#### 7.1.2.    Introduce systematic 'ethnicity monitoring'

Ethnicity Monitoring in required to be undertaken consistently and systematically at a primary care level where Bangladeshi communities present most often to service providers, but also by mental health service providers.

In order for such monitoring to be effective in improving the quality of services, as well as addressing and identifying the linguistic and religious needs of communities, data needs to be collected on ethnicity, written and spoken language needs and practicing religious needs.

### 7.1.3. Set accountable targets and performance indicators for mainstream services

Mainstream services need to take more responsibility for measuring whether their services are accessible to and meet the needs of Bangladeshi communities. Executive and Non Executive Board members should be identified by Trusts, Primary Care Groups and Primary Care Trusts, the Local Authority and Health Authority to take a lead on specific, measurable and practical targets to improve services. Such individuals should then be accountable for meeting these targets.

## 7.2. At a service provision & development level

A number of specific practical service provision and development measures were identified to improve the cultural and linguistic appropriateness of and access to services, such as:

### 7.2.1. Bengali telephone helpline

This could be used by a range of individuals in the family and would preserve the anonymity and confidentiality that many users are concerned about in terms of the stigma of mental health.

### 7.2.2. More Bengali professionals and advocates

Individuals who have a professional training and can understand the cultural and religious needs of individuals are able to meet language needs should be employed. Bi-lingual Bengali advocates with an understanding of the mental health system were felt to be better placed to meet the needs of Bangladeshi people with mental health needs rather than interpreters whose roles are to be impartial in any communication and not to represent the service users in any way, or enable them to get the best out of the services.

### 7.2.3. An inter-agency multi-disciplinary service in King's Cross

Individuals often have to go to ten different places for different aspects of their services and the ideal vision for the community was a one stop mental health shop with a range of professionals from different disciplines who could provide a more holistic package of care for the individual. Team members could comprise of some Bangladeshi professionals, advocates and outreach workers as well as culturally trained non-Bangladeshi professionals to offer a choice in services. It was felt that a 'centre' such as this would be a reference point that could undertake pro-active health promotion and community development work as well as crisis management and specific case work.
The catchment could be for all residents in Camden and Islington and the service could also be offered in the evenings and at the weekend.

### 7.2.4. Equality and cultural awareness training for professionals

All mental health providers should undertake training, which familiarizes them with cultural specific issues and needs which can cause and impact on the mental health of Bangladeshi people. Any such training should not fall into the trap of encouraging professionals to stereotype communities and their needs, but simply heighten awareness of issues they need to take into account and the different types of questions they may need to ask to provide more sensitive and appropriate care. Training should also provide individuals with a clear context of the wider socio-economic inequalities and discrimination and alienation experienced by Bangladeshi communities.

### 7.2.5. Family orientated models of service provision

A number of cases were cited by workers where interventions needed to involve the whole family in order for them to be effective. Thus, it was felt that mental health providers should use more models of family–orientated interventions and have more family workers to address this need and gap.

### 7.2.6. Mental health link workers or 'co-ordinators of care' in primary care teams

GPs were felt to be key individuals in identifying and promoting the mental health needs of Bangladeshi communities. Workers recalled instances of people being referred by GPs, sectioned and discharged and going through repeated cycles of being admitted to hospital without any communication or follow up by the GP.

The time constraints that GPs often work under were well recognized and so with the employment of mental health 'linkworkers' or 'co-ordinators', they could take the role of referral and co-ordination of the care of the individual as well as spending time with the individual to raise awareness of mental health, explain how the system works and answer any questions the individual or their carers might have.

### 7.2.7. Continuity of care

The experience of workers was that even though many services claim to work on a key worker basis, clients did not appear to receive continuity in their care and sometimes this fell apart at the primary care level and discharge into the community as well as in hospitals. Thus, the monitoring and effectiveness of community and hospital based workers needs to be improved by getting qualitative feedback from clients about how it is working for them.

### 7.2.8. Targeted work with young people

It was felt that there is a great need to target young people as a 'sub-group', who may be using drugs and involved in criminal activities due to various pressures and needs, which have not been met or overlooked. Specific awareness work, support work and rehabilitation work were identified as priorities.

### 7.2.9. Outreach work by mainstream organizations

It was felt that mainstream organizations need to change their 'mind set' from complaining that people do not want to use their services or are not using their services to being more pro-active in improving access to their services and promoting understanding of their services. Outreach workers were felt to be central to such a process working and should be attached to all major mental health services.

## 7.3. At a community development, capacity building & health promotion level

### 7.3.1. Community Peer Educators

As a result of the stigma of mental health, low levels of understanding of mental illness and fear and confusion about what mental health can provide or offer, a useful model to adopt would be Bangladeshi 'community peer educators' who have received mental health training in a form provided by the mental health training course who could be available at a range of access points in the voluntary and statutory sector, attached to youth services, at GP practices and in hospitals, with education and social service departments..
Further, a 'team of peer educators' could raise awareness and understanding of mental health as well as doing activities to promote mental health.

### 7.3.2. Public awareness raising events at particular target groups

The awareness raising events that have been run by the Bengali Women's Health Project and Camden and Islington Health Promotion Service were evaluated as being very positive and successful with communities. This model could be extended to target young people, older people and men, however, rather than being one-off events they could be run more often, thereby providing continuity and incrementally tackling more issues and information needs.

### 7.3.3. A simple guide to mental health services

A simple guide to knowing your way around services does not currently exist. This could be used in a range of settings by various service providers as one way of increasing knowledge and empowering people.

### 7.3.4. Radio and TV publicity

This is currently under-utilised in raising public awareness and it was felt to be a more effective way of reaching Bangladeshi communities than leaflets and posters as many people may not use services and may not be able to read Bengali or English.

## 8. References

Acheson D. Independent Inquiry into Inequalities in Health report. The Stationery Office, London, 1999.

Aldous J, Bardsley M, Daniell R, Gair R, Jacobson B, Lowdell C, Morgan D, Storkey M, Taylor G. Refugee Health in London. The Health of Londoners Project, 1999.

Balarajan R, Soni Raleigh V. Ethnicity and Health- a Guide for the NHS. London: DOH, 1993.

Beliappa J. Illness or Distress? Alternative models of mental health, Confederation of Indian Organisations, 1991.

Bhui K. London's ethnic minorities and the provision of mental health services. In: Johnson et al (eds), 1997. London's mental Health. London: Kings Fund Institute, 1997.

Bhui D, Strathdee G, Sufraz R. Asian inpatients in a district psychiatric unit: an examination presenting features and routes into care. *International Journal of Social Psychiatry* 1993: **12**: 195-206.

Bhugra D, Bhui K. Cross-cultural assessment advances in psychiatric treatment (In press 1996). Cited in Johnson S Ramsay R Thornicroft G et al. London's mental health: The Report to the King's Fund London Commission. London: King's Fund, 1997.

Camden Equalities Unit. Valuing Diversity: Camden Bangladeshi Residents Survey, 1996.

Cole, E, leaven G, King M, et al. Pathways to care for patients with a first episode of psychosis: a comparison of ethnic groups. *British Journal of Psychiatry* 1995: **167**: 770-776.

Department of the Environment, Transport and the Regions. Modernising local government: Improving local services through best value. The Stationery Office, London, 1999.

Department of the Environment, Transport and the Regions. Sustainable local communities for the 21$^{st}$ century: why and how to prepare an effective local agenda 21 strategy. The Stationery Office, London, 1998.

Department of Health. The New NHS, Modern, Dependable. The Stationery Office, London, 1997.

Department of Health. Modernising Social Services. The Stationery Office, London, 1998.

Dolan B, Lacey JH, Evans C. Eating Behaviour and Attitudes to weight and Shape in British women from Three Ethnic Groups. *British Journal of Psychiatry* 1990: **157**: 523-528.

Health Education Authority. Mental Health Promotion, A Quality Framework, London: HEA, 1997.

Healthy Islington 2000 & Islington Zairean Refugees Group. Islington Zairean Refugees Survey report. London: Healthy Islington, 1995.

Hunt S. 'Housing-related disorders'. Chapter 10 in Charlton J & Murphy M (eds) Health of Adult Britain 1841-1994. London Office for National Statistics, 1997.

Ineichen B. Homes and Health: How housing and health interact. London: E & FN Spon, Chapman and Hall, 1993.

Jacob K, Bhugra D, Mann AH, et al. The use of the General Practitioner by Indian females with psychiatric morbidity: recognition of the disorder and the role of social and cultural factors in help seeking. Brief report of preliminary findings. Cited in: Johnson S, Ramsay R, Thornicroft G et al. London's mental health: The Report to the King's Fund London Commission. London: King's Fund, 1997.

Johnson S, Ramsay R, Thornicroft G et al. London's mental health: The Report to the King's Fund London Commission. London: King's Fund, 1997.

Joubert, Raeburn. *International Journal of Mental Health Promotion,* Inaugural issue, September, 1998. Pavilion Publishing (Brighton) Limited, 1998.

London Research Centre. Taking stock of what we know: A statistical assessment of black and minority ethnic housing needs. London: London Research Centre, 2000.

Mckenzie H, Weekes J. Black mental health service clients in Islington: A survey of issues and needs, 1994.

Merrill J, Owens J. Ethnic Differences in Self Poisoning: A comparison of Asian and White Groups. *British Journal of Psychiatry* 1986: **148**: 708-712.

Mumford DB, Whitehouse AM. Increased prevalence of Bulimia Nervosa among Asian schoolgirls. *British Medical Journal* 1988: **297**: 718.

Pendall P, Hamilton M, Holden N. (Letter). *British Journal of Psychiatry* 1991: **159**: 441.

Modernising Health and Social Services HSC (98)159.

NHS Executive. Health Improvement Programmes Planning for Better Health and Better Health Care. HSC 1998\167, Leeds, NHS Executive, 1998.

NHS Executive. The National Priorities Guidance 1999/00 - 2001/02, 1997.

NHS Executive. Annual Planning Guidance 1999 - 2000. The London Regional Office, London Health Strategy in May 1999.

NHS Executive. Health Improvement Programmes Planning for better health and better health Care. HSC 1998/167. Leeds, NHS Executive, 1998.

NHS Executive. Addressing black and minority ethnic health in London - A review and recommendations. NHS London Regional Office, 1999.

NHS Executive. Health Action Zones Executive Letter EL(97)65, dated 30 October 1997.

NHS Executive. The London Regional Office, London Health Strategy, 1999.

National Housing Federation. Housing for Health, London: National Housing Federation, 1997.

Nazroo J. The Health of Britain's Ethnic Minorities: Findings from a national survey. London: Policy Studies Institute, 1997.

Rack PH. Race, Culture and Mental Disorder. Tavistock: London, 1982.

Rahman, R. Mental Health and Bangladeshi Women. Healthy Islington 2000, London, 1997.

Webb-Johnson. A cry for change: an Asian perspective on developing quality mental health care, C10, 1995.

Williams, R. Health and length of residence among South Asians in Glasgow: a study controlling for age. *Journal of Public Health Medicine* 1993: **15**(1): 52-60.

Wilson, M. Britain's Black Communities. London: NHS Management Executive. Mental Health Task Force, 1993.

Wilson M, MacCarthy B.  GP consultation as a factor in the low rate of mental health service use by Asians. *Psychological Medicine* 1994: **24**: 113-119. Cited in: Johnson S, Ramsay R, Thornicroft G et al. London's mental health: The Report to the King's Fund London Commission. London: King's Fund,1997.

Upadhyaya, A, Creed F, Upadhyaya, M. Psychiatric morbidity among mothers attending well-baby clinic: a cross cultural comparison. *Acta Psychiatrica Scandinavia*,1989: **81**: 148-151.

Yazdani, A.  A mental health needs assessment of young Asian women in Newham, East London. A Qualitative Study. Newham Innercity Multifund and Newham Asian Women's Project, 1998.