

COMMUNITY ENGAGEMENT PROJECT:
The National Institute for Mental Health in England
Community Engagement Programme (2006/7)

REPORT OF THE COMMUNITY LED RESEARCH PROJECT FOCUSING ON:
Sandwell Bangladeshi Mental Health Needs Analysis Research

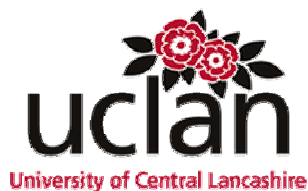
BY:
Smethwick Bangladeshi Youth Forum

COMMUNITY IN:
Smethwick
West Midlands

By:
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Background

We often hear the following words or phrases:

- Community Consultation
- Community Representation
- Community Involvement/Participation
- Community Empowerment
- Community Development
- Community Engagement

Sometimes they are used inter-changeably to mean the same thing. Sometimes the same word or phrase is used by different people in the same meeting to mean different things. The Centre for Ethnicity and Health has a very specific notion of Community Engagement, and this paper is an attempt to describe it. The Centre's Model of Community Engagement evolved over a number of years as a result of its involvement in a number of projects. Perhaps the most important milestone however came in November 2000, when the Department of Health awarded a contract to what was then the Ethnicity and Health Unit at the University of Central Lancashire to administer and support a new grants initiative. The initiative aimed to get local Black and minority ethnic community groups across England to conduct their own needs assessments, in relation to drugs education, prevention, and treatment services.

The Department of Health had two key things in mind when it commissioned the work; first, the Department of Health wanted a number of reports to be produced that would highlight the drug-related needs of a range of Black and minority ethnic communities. Second, and to an extent even more important, was the process by which this was to be done. If all the Department of Health had wanted was a needs assessment and a 'glossy report', they could have directly commissioned a number of researchers. These people could have gone into local Black and minority ethnic communities, talked to them about their needs, written up a report, and produced yet another set of reports that potentially do not have any long term impact. This scheme was different however. The Department of Health was clear that it did not want researchers to go into the community, to do the work, and then to go away. It

wanted local Black and minority ethnic communities to undertake the work themselves.

These groups may not have known anything about drugs, or anything about undertaking a needs assessment at the start of the project; what they would have is proven access to the communities they were working with, the potential to be supported and trained and the infrastructure to conduct such a piece of work. They would be able to use the nine month process to learn about drug related issues and about how to undertake a needs assessment. They would be able to benefit and learn from the training and support that the Ethnicity & Health Unit would provide, and they would learn from actually managing and undertaking the work. In this way, at the end of the process, there would be a number of individuals left behind in the community who would have gained from undertaking this work. They would have learned about drugs, and learned about the needs of their communities, and they would be able to continue to articulate those needs to their local service providers, and their local Drug Action Teams. It was out of this project that the Centre for Ethnicity and Health's model of community engagement was born.

The model has since been developed and refined, and has been applied to a number of areas or domains of work. These include:

- Substance Misuse
- The Criminal Justice System
- Sexual Health
- Mental Health
- Regeneration
- Higher Education
- Asylum

New communities have also been brought into the programme: although Black and minority ethnic communities remain a focus to the work, the Centre has also worked with:

- Young people
- People with disabilities

- Service user groups
- Victims of domestic violence
- Gay, lesbian and bi-sexual people
- Women
- White deprived communities
- Rural communities

In addition to the Department of Health, key partners have included the Home Office, the National Treatment Agency for Substance Misuse, the Healthcare Commission, The National Institute for Mental Health in England, the Greater London Authority and Aimhigher.

The Key Ingredients

According to the Centre for Ethnicity and Health model, a Community Engagement project must have the community at its very heart. In order to achieve this, it is essential to work through a **host community organisation**. This may be an existing community group, but it might also be necessary to set a real or virtual group up where one does not exist already. The key thing is that this host community organisation should have good links to the target community¹ (whoever this is) such that it is able to recruit a number of people from the target community take part in the project and to do the work (see section on task below). It is important that the host community organisation is able to provide a co-ordination and infra-structure (e.g. somewhere to meet; access to phones and computers; financial systems) for the day-to-day activities that will be undertaken once the project is underway. One of the first tasks that this host community organisation undertakes will be to recruit a number of people from the target community to work on the project.

¹ The target community may be defined in a number of ways – in many of the Community Engagement Projects that we have run we have defined it by ethnicity. We have also worked with projects where it has been defined by some other criteria however, such as age (e.g. young people); gender (e.g. women); sexuality (e.g. gay men); service users (e.g. drug users or mental health service users); geography (e.g. within a particular ward or estate) or by some other label that people can identify with or rally around (e.g. victims of domestic violence, sex workers).

A Host Community Organisation	With Good Links To The Target Community	To Provide Basic Infrastructure For The Project (Recruit And Co-ordinate Project Team; Provide Office Space, Phones And Computers; Look After The Finances)	To Recruit A Number Of People From The Target Community To Do The Work
A Task	Time Limited Meaningful Manageable	A Piece Of Research Into Key Needs/Gaps/Issues For The Community	Learning And Development Of Key Individuals; Access Hard To Reach Groups; Raise Awareness and Debate; Community Ownership
Support	Financial (Typically Up To £20,000)	Training And Workshops; On-Going Support And Guidance; Personal Tutor	Statutory Partnerships; Steering Groups; Sustainability

The second key ingredient is ‘the **task** that the community is to be engaged in’. According to the Centre for Ethnicity and Health model, this must be something that is meaningful, time limited and manageable. Nearly all of the community engagement projects that have operated have involved communities in undertaking a piece of research or a consultation exercise within their own communities. Sometimes this has been met with an initial resistance to doing ‘yet another piece of research’, but this misses the point. As in the initial programme that operated on behalf of the Department of Health, the process (i.e. of getting ordinary people involved in doing the work) was as important, if not more important, than the report that they produce at the end of the day. The task or activity is something around which many other things will happen over the lifetime of the project. Individuals will learn and new partnerships will be formed. Besides, it is important not to lose sight of the fact that it will be the first time that these individuals have undertaken a research project.

The final ingredient, according to the Centre for Ethnicity and Health’s model, is the provision of appropriate **support** and guidance. Community groups are not expected

to become involved for nothing. Typically in the region of £15-20,000 would be made available to the host organisation. It is expected that the bulk of this money would be used to pay people from the target community as community researchers².

UCLan then allocate a named member of staff from their Community Engagement Team as a project support worker. This person will visit the project at for at least half a day once a fortnight. It is their role to support and guide the host organisation and the researchers through the project.

UCLan also provide a package of training – typically in the form of a series of accredited workshops. The accredited workshops give participants in the project a chance to gain a University qualification whilst they undertake the work. The support workers will also assist the group to pull together a steering group for the project³.

The steering group is an essential element of the project: without one, it is difficult to see who the community are engaging with and it is unlikely that anything out of the project will be sustained in the longer term. The group will be doing a needs assessment or a consultation exercise, but for what purpose?

It is the role of the steering group to ensure that the work undertaken sits with local priorities and strategies, with a mechanism for picking up any findings and recommendations made. It is also their role to help to pick up the key individuals who are developed through the project process to help them to take their 'next steps'.

The Community Engagement Team

The Community Engagement Team comprises of 25 members of staff. They work across a range of Community Engagement areas of specialism, within a tight regional framework.

² This is not always possible, for example, where potential participants are in receipt of state benefits and where to receive payment would leave the participant worse off.

³ Very often we will have helped groups to do this very early on in the process at the point at which they are applying to take part in the project.

National Programme Directors			
Northern Team	Midlands Team	Southern Team	Senior Programme Advisors
Senior Support Worker	Senior Support Worker	Senior Support Worker	
Support Workers X 3	Support Workers X 3	Support Workers X 6	Drug Interventions Programme
			Regeneration
			Mental Health
Teaching And Learning Team			
Administration Team			
Communications Officer			

Programme Outcomes

Each group involved in any of the Community Engagement Programmes is required to submit a report detailing the needs, issues or concerns of the community that it consulted with. The qualitative themes that emerge from the reports are often very powerful, particularly when taken together with other reports produced by groups involved in the same programme. Such information is key to commissioning and planning services for diverse and 'hard to reach' communities. Often new partnerships between statutory sector and hard to reach communities are formed as a direct result of community engagement projects.

The capacity building of the individuals and groups involved in the programme is often one of the key outcomes. Over 20% of those who are formally trained go on to find work in a related field.

The Focus Of This Particular Report

Since 2000 over 200 community groups have taken part in one or other of the Centre for Ethnicity and Health's Community Engagement Work Programmes.

National Institute for Mental Health in England Community Engagement Programme:

Smethwick Bangladeshi Youth Forum (SBYF) is one of 40 community groups who took part in the National Institute for Mental Health in England's Community Engagement Programme in 2006. The objectives of the programme were to deliver improved equality of access to services, experiences, and outcomes for Black and minority ethnic mental health service users by:

- Building capacity in the non-statutory sector;
- Encouraging the engagement of Black and minority ethnic communities in the commissioning process;
- Ensuring a better understanding by the statutory sector of the innovative approaches that are used in the non-statutory sector;
- Involving Black and minority ethnic communities in identifying needs and in the design and delivery of more appropriate, effective and responsive services;
- Ensuring greater community participation in, and ownership of, mental health services;
- Allowing local populations to influence the way services are planned and delivered;
- Contributing to workforce development, and specifically the recruitment of 500 Community Development Workers.

The focus of the work in Sandwell has been the needs of the Bangladeshi community.

SBYF is keen to build its capacity as a community based organisation. Evidence based on secondary data indicates that Mental Health is a major issue and a cause for great concern within the Bangladeshi Community. SBYF recognise the hidden burden of mental health and the profound effect it is having on the community through the different generations, in particular young people and women. The

findings will enable SBYF to obtain an informed view on the issues of mental health and well-being and respond better to the needs of the community.

It will also enable SBYF to influence service providers, planners and policy makers to develop and provide appropriate services that meet with the cultural and religious needs of the Bangladeshi community. It would also enable service providers to make provisions more accessible and available.

The views expressed in the report are those of the group that undertook the work, and are not necessarily those of the Centre for Ethnicity and Health at the University of Central Lancashire

Community Demographics

Sandwell has a population of 282,750 (Census 2001). In the last decade the population has become more ethnically diverse. According to Sandwell Trends 2003 data, the BME population has increased by 5.6%. In 2001, 20.3% of the population is of BME origin as compared to 14.7% in 1991. The borough has the third highest BME population in the region and the eighth highest in England and Wales. The largest BME group in Sandwell are of Indian origin accounting for 9.1% followed by Caribbean – 3.3%, Pakistani 2.9%, Mixed 2.1%, and Bangladeshi 1.2%.

When dispersal or concentration of communities is examined, it is identified that the Bangladeshi residents were the least dispersed. As many as 80% were living in just 5 of Sandwell's 24 wards. These wards are identified as North Smethwick, West Bromwich Central/Greets Green, Tipton, Wednesbury and Blackheath.

All BME groups have large population of young people and fewer old people. 58% of black groups and 64% Asian groups are under 30 years as compared with only 39% white population. Sandwell population trend also demonstrate that there has been a 27% increase in the population of young. Specific trends in the Bangladeshi community in Sandwell are presently not available.

Economic Activity & Basic Skills

Unemployment rate is at 8.5% for the borough. In some of the deprived wards where BME communities reside, the unemployment rate is as high as 17.7% (Soho & Victoria). The unemployment rate may not be as high as might be expected due to the impact of the New Deal Programme even if participants do not find work. The largest increase in employment between 2000 and 2010 is expected to be in Business Services and Retailing by 26% and 14% respectively.

Sandwell economy is heavily dependent on the manufacturing industry. While on decline it represents 37% of the jobs compared to 18% nationally. The metal manufacturing industry is seven times larger in Sandwell accounting for 14% of employees compared to 2% as a whole for England and Wales. Employment in the

metal processing industries is expected to decline by 53% in Basic Metals and 15% in Metal Goods Sector.

The proportion of unemployed young people aged 18-24 is over 25% compared to the national average of 24.9%. However, the levels of unemployment amongst ethnic minority groups are higher. Long-term unemployed increases with age – only 2.8% of the unemployed are under 25 and have been out of employment for more than a year. The rate of unemployment for more than 1 year amongst 45-59 year olds is 34.4%.

The Bangladeshi community experiences significant barriers to employment and training, including lack of relevant and recent work experience, lack of appropriate qualifications and vocational skills. Sandwell has the 8th highest proportion of long-term unemployed out of the 36 Metropolitan District outside London. The Borough has high levels of deprivation generally. This is not unexpected when examining the basic skills needs of the population.

Sandwell has a high proportion of 16-60 year olds with very low and low literacy and numeracy skills. This rate is 11.6% above the national average level. People lacking basic skills qualification tend to be concentrated within the higher age range; however, the proportion of unqualified young people is also of concern. 41% of the population in Sandwell holds no qualification in English language (Sandwell Trends 2003).

Low family income is relatively common in Sandwell and characteristic of Bangladeshi single earner household. According to Sandwell Trend figures, 22.8% full time employees in Sandwell earn less than £250 per week, compared to 18% nationally.

Benefit dependency is also very high. In the ward with the highest dependence, Soho and Victoria, more than a third of the population (37.3%) depend on Income Support or Job Seekers Allowance – a much larger proportion than the next highest, St Paul's which has 25.2% of its population dependent (Sandwell Trends 2003). The largest cluster of Sandwell Bangladeshi community reside in these two wards.

Households & Housing

There are 115,428 households in Sandwell with 30% comprising of single person households. The regional and national average is 31% and 30% respectively. However, Sandwell has a higher proportion of lone parent households accounting for 8% as compared to a national average of 6%.

Owner occupation in Sandwell is lower than the West Midlands regional average of 69%. Owner occupation for Sandwell is 60% and rented accommodation from social landlords accounting for 31% of which 27% is rented from Sandwell Council. Only 5% are privately rented and a further 4% comprises of rent-free accommodation. Despite the low levels of owner occupancy, house prices increased by 70% (from £59,700 to £100,900). The average national increase over the same period is 48%.

Introduction

This project has numerous aspirations and intentions surrounding the field of awareness of mental ill health and take up of services.

Each set of questions used in the research had a specific rationale for being included in order to achieve an objective, seek an opinion or realise a recommendation.

The project has set out to reduce the taboo of mental health and make it more acceptable to use services and talk openly about mental health issues. It aims to address attitudes and their effects on lack of service uptake through questions that relate to how the community perceive mental illness, what the interviewee thinks are the causes of mental illness, how they feel those with a mental illness should be treated and their views on black magic, etc.

It will provide an insight into the need for services for the Bangladeshi Community either in an enhanced form of those already available or perhaps even others more specific to their needs. Therefore, the recommendations from this research should offer an increase in satisfaction amongst service users.

Both the community questionnaire and that for the service providers asks questions in relation to experience of mental health services; how the Bangladeshi Community are accessing services; what the barriers are to accessing services; and proposed improvements. These answers should serve as a focus for improving services in the future.

Another effect that this research hopes to achieve is to make available the services that are required specifically by the Bangladeshi service users and to increase uptake of current services and support, in order to enable recovery from illness. This will be accomplished by lobbying research findings to appropriate organisations to tailor services.

The questions used in this research ask what the problems are with mental health services and why they hinder recovery. It also looks at the service providers' knowledge of Bangladeshi culture to establish whether there is a need for mental

health staff to receive appropriate training to deal with this group and whether there is a need for service providers to employ Bangladeshi staff. The community are also asked/questioned about why other sources of help are sought before mainstream mental health services are accessed.

It is anticipated that the results will encourage services users and providers of services to become involved in self-help and to steer away from traditional therapies whilst developing culturally sensitive approaches that involve one-to-one, group and counselling therapies. The community questionnaire asks where people would go for help initially and why spiritual healers are generally a point of call for people with mental health issues in order to establish how effective this is for them and how they have found mental health service provision. In addition, service providers are asked about their awareness of the Bangladeshi community; how these users are treated; their own need for training on cultural issues; and what suitable changes they recommend.

The results should also advocate support for BME communities in Sandwell, specifically to Bangladeshi service users, through informing professionals of the need to be culturally sensitive, and will aim to influence local mental health policy, practice, planning and implementation. The field research will also provide an insight into current failings, reasons for this and how mental health service providers can be more sensitive to the needs of the Bangladeshi community.

SBYF aims to ensure that as an organisation, they build on their capacity in co-ordinating and delivering community needs-based mental health provisions that are culturally acceptable.

Aims and Objectives of the project.

The mental health need of the Bangladeshi community is a complex interrelationship between poverty, inequality, social and cultural values and norms. These complex and multi variable issues could create barriers to accessing mainstream mental health services.

Like other BME communities, perceptions and stigma associated with mental health stems from a lack of understanding of the range of mental health conditions and the lack of awareness of the support services available.

SBYF recognise that several opportunities and drivers for change exist at the different levels of national/local policy and service provision and development. The data and information collated will be used to challenge service providers care standards and planning framework to ensure that there is equality of access, experience and outcomes.

The primary aim of Delivering Race Equality in Mental Health Care is achieving equality and tackling discrimination in mental health services. The purpose of this project is to identify what mental health services are available to the Bangladeshi community in Sandwell, their appropriateness and how they can be improved.

The research will aid the Department for Race Equality (DRE) programme of change.

Furthermore, the research also supports the DRE agenda for action to bring about equality in health and social care and The Five Year Vision. The proposed research would also provide the basis for supporting and implementing Sir Nigel Crisp's 10-point race equality action plan in the NHS, and support NHS trust to fulfil their obligation under the Race relations (Amendment) Act 2000.

The six points of the DRE Action Plan that the recommendations from this research will seek to address include:

- Less fear of mental health care and services among BME communities and BME service users.

- Increased satisfaction with services
- An increase in the proportion of BME service users who feel they have recovered from their illness
- A more balanced range of therapies such as peer support services, psychotherapeutic and counselling treatments, as well as pharmacological interventions that are culturally appropriate and effective
- A more active role for BME communities and BME service users in the training of professionals, in the development of mental health policy, and in the planning and provision of services
- A workforce and organisations capable of delivering appropriate and responsive mental health services to BME communities.

In order to achieve any recommendations as a result of this work, the following Aims and Objectives were devised to give a focus for the Project. The analysed answers will form the basis upon which recommendations for future work can be commissioned, changed to meet need, or allocated to other agencies.

Aim 1: To gauge the awareness of the Bangladeshi Community in relation to mental ill health

Objectives:

- 1) To analyse the respondents understanding of mental health.
- 2) To investigate the effect the Bangladeshi culture has on the perception of mental ill health
- 3) To recognize how the Bangladeshi community view and understand mental ill health generally.

- 4) To comprehend how the Bangladeshi Community Participants view their own mental wellbeing at the time of interview.
- 5) To ascertain whether the Bangladeshi community are able to identify mental ill health.
- 6) To determine whether it is felt that mental ill health is a growing issue in the Community.
- 7) To establish why people in the Bangladeshi Community may have mental health issues and what outside factors may contribute to these.
- 8) To discover what the views of the Community are, regarding people with mental ill health.

Aim 2: To assess the correlation between the Bangladeshi community and mental health services.

Objectives:

- 1) To determine whether the Bangladeshi community are accessing mental health service provision.
- 2) To recognise who people would turn to for help and advice if they had a mental health issue, and whether people felt empowered to discuss their feelings with members of the medical profession.
- 3) To identify the current level of awareness amongst the Bangladeshi Community, of the services available to people with mental health issues.
- 4) To identify any issues arising from accessing mental health services.

Aim 3: To assess the impact of religious beliefs on the perception and treatment of mental ill health in the Bangladeshi Community.

Religion and culture has a major role in the identification, treatment and rehabilitation process. It is often perceived that mental illness is the result of black magic referred to as Jado. Religious figureheads and healers are consulted to treat the condition and not medical professional.

Objectives:

- 1) To understand the association between Jado, Jinn and Mental Health.
- 2) To identify the reasons why people choose to go to religious figureheads and healers rather than health professionals.
- 3) To determine the Community's opinion of the role and influence of religious figureheads (Imams) and healers have in the treatment of mental health and how effective this is.

Aim 4: To understand the issues and barriers facing a younger generation of Bangladeshi's in Sandwell with regard to their mental wellbeing.

(The following objectives will be integrated into the responses generated by the whole participating group rather than initiating a separate section. They will also be combined with some of the further queries listed below)

Objectives:

- 1) To identify the mental health issues amongst young people taking into account the variables that may affect this age group, such as socio-economic factors, peer influence, and dependency on drugs.

- 2) To ascertain the understanding and requirement of the younger generation for mental health awareness and services.

Through the above aims and objectives, the research hopes to address the following queries:

- Are people in the Bangladeshi Community able to identify mental illness at its onset?
- What is the communities' understanding of Mental Ill Health?
- What is the awareness level of existing services?
- What are the communication channels between service providers and the community
- How is the information being provided?
- Is the Bangladeshi community accessing current mental health provision in Sandwell? Is so the project will seek to identify:
 - Do current mental health services meet the needs of the community?
 - What are the experiences of Bangladeshi mental health patients, carers and families within the system?
 - Was there an opportunity for discussion; to ask questions; were they happy?
 - Were there appropriate provisions for interpreting, explanation of illnesses and conditions?
 - Was there adequate support from staff and were they signposted to support networks?
 - Were they given practical advice?
 - Does the location of the services hinder the uptake of the service?
- What are young peoples understanding of mental health?

Methodology

The Sandwell Bangladeshi mental health research project is a initiative that provide an unique opportunity to look at the reason or complex issues that act as barriers to accessing services and how this might be overcome.

In many respect this is the first research of its kind that looks at the Bangladeshi community needs as opposed to a generic study which often group this severely disadvantage group with other South Asian community. The Bangladeshi community is the youngest of the settled South Asian community. There are some synergies between the needs of the south Asian communities, however, some needs of the community are different and requires different considerations at different levels.

This study is a qualitative research project carried out by means of a partnership approach involving the-

- Mental Health Services
- Primary Care Trust
- Bangladeshi Voluntary Sector Organisations (Sandwell)
- Asian Counselling Service
- Sandwell Council

At the outset it was established that for the research to be successfully undertaken the project workers would have to come from within the community, which was also consistent with the community engagement model. Given the scope of the project, it was established that the project would require two male and two female researchers who can speak Sylheti.

These speaking researchers were proactively recruited from within the community, using adverts promoted through the networks of community organisations, community leaders and a personal approach to service users expressing interest in job opportunities.

As an Investor in People accredited organisation, all the new researchers were encouraged to identify and notify SBYF of their training needs to enable them to execute their duties to the standard expected by the organisation.

These project workers received 6 research training and workshop sessions provided by UCLan and were supported by the Project Co-ordinator and UCLan Support Worker.

A steering community was appointed to oversee the project. Bangladeshi Community representative organisations, CSIP, FIS, PCT Commissioners, NHS Mental Health Trust, Mental Health Practitioners and other stakeholders were invited to contribute and direct the research and share their expertise. This would ensure that the project fits with local and national strategic priorities. Furthermore, it will ensure that Sandwell policy makers and local planners develop sustainable and appropriate services targeted at the Bangladeshi community and accept the findings and the recommendations of the report. The steering group would also function as a further check against any ethical issues that may arise in the development of the project.

Terms of Reference for the steering group were drawn up to ensure that all members were aware of their roles and responsibilities.

Due to the apparent language barriers within the community, the research team adopted a questionnaire method study which were devised and developed based on the project proposal and aims and objectives. 2 semi-structured questionnaires were constructed to seek both community and service provider views. Once agreed, 3 methods of engagement with the research participants were established:

1/ Service providers views were sort through the distribution of the second questionnaire by the Mental Health Promotion Team in Sandwell.

2/ An Information Leaflet was designed to promote the project and seek participants and community views. These leaflets were distributed through community organisations and mosques etc and one to one meetings with community representatives were held to explain the purpose of the project in detail to seek their endorsement and approval.

3/ One to One interviews were held with participant members of the community at the different community venues.

Sample Size and Characteristics.

For the purpose of this research (consistent with the original project proposal), the aim was to conduct 150 interviews across 4 different age groups across the 5 (Smethwick, West Bromwich, Tipton, Wednesbury and Blackheath) locations in which Sandwell Bangladeshis are clustered and reside. Of the 5 locations, research was limited to Smethwick, West Bromwich & Tipton as these area's have established community engagement centres, where as the other areas do not. Furthermore, previous attempts to work in these areas have proven to be difficult due to the insular nature and the dynamics that exist within the community.

The target group all Bangladeshi living in Sandwell and the sample was selected objectively to ensure that a representative profile of the community was taken.

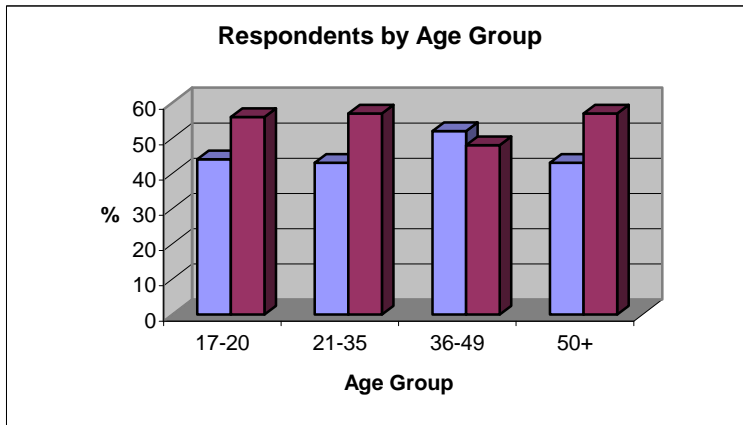
However of the 150 target size, only 131 one to one interviews were achieved. This may be due to the fact that there was a degree of reluctance to participate by the Bangladeshi community preferring to advocate responsibility and therefore the target number did not volunteer their services.

In line with Data Protection issues the participants names and addresses were not recorded on the questionnaires.

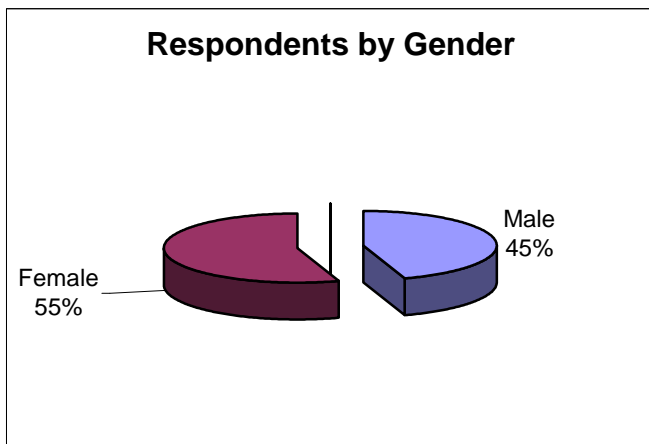
44% of participants were male and 56% were female distributed across 4 age groups. There were no transgender participants.

<u>Respondent by Age Group</u>					Total
	17 - 20	21 - 35	36 - 49	50+	
Male	8	28	13	10	58
Female	10	37	12	13	73
Total	18	65	25	23	131

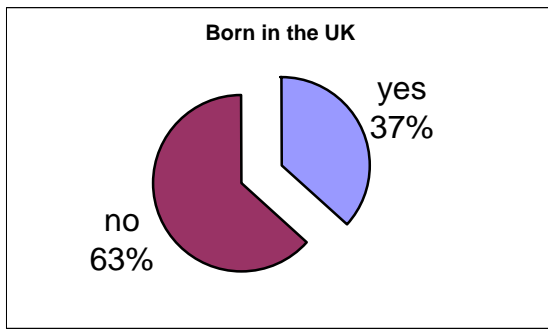
Of the female respondents, the target group 36-49 only had a fewer respondents than male, accounting for 48%. The other age groups had higher number respondents than male. As a percentage, the figures were consistent for target groups 17-20, 21-35 and 50+ accounting for 56, 57 and 57% respectively. It would be fairly accurate to assume that a balance between male and female was achieved.



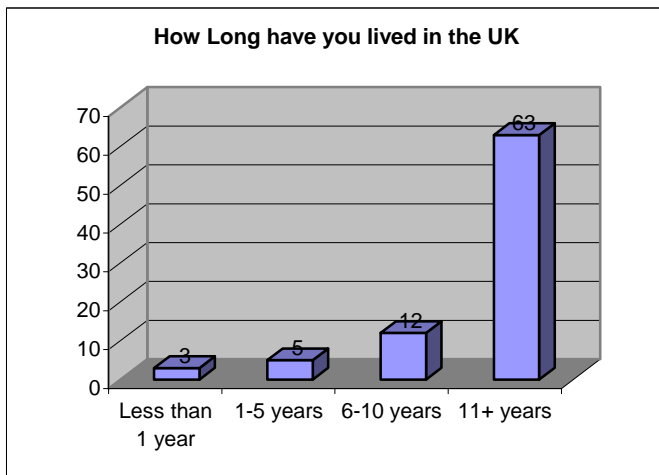
The chart below shows that the proportion of females account for 55% of all respondents as opposed to 45% for male.



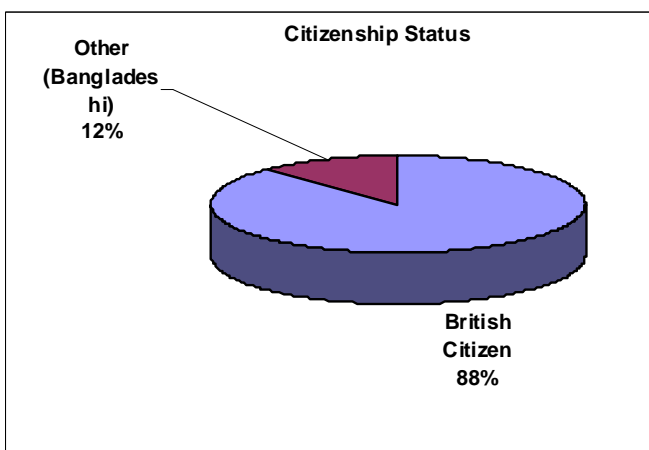
In respect of the respondent place of birth as shown below, 37% were born in the UK whilst 63% were born outside of the UK. This position is not surprising as the Bangladeshi community is the youngest of all South Asian communities in terms of migration and settlement patterns in the UK.



When the length of settlement of those not born in the UK is examined, 76% of the respondents have lived in the UK for more than 11 years, and only 3.6% have moved here in the last 12 months.



Given that large proportion of the respondents have been settled in the UK for over 6 years combined or were born in the UK, it is not surprising that 88% are British Citizen and only 12% have Bangladeshi Nationality, as shown below.



In respect of religion, 100% of the respondents were Muslim (appendix 1); 4 of the respondent reported as having a disability (appendix 1). One female respondent identified their sexuality as lesbian or gay and the remainder were either heterosexual (126) or did not answer (4).

Findings and Results

Aim 1

Gauging the Awareness of the Bangladeshi Community in relation to mental ill health.

Understanding the awareness and perception of mental health is a key aspect in addressing and discussing issues that affect individuals and communities. In addition, people's perception of mental health services or their actual experience of it may influence the whole community, especially if they are negative.

This section of the research aimed to identify how aware the respondents were about mental health, mental health services and their views on these issues. The sequence of questions relating to aim 1 and its objectives was designed to identify the following aspects:

- What the respondent understood about mental health;
- The effect culture had on the perception of mental ill health;
- The Bangladeshi Community's perception of Mental Ill Health.
- How the respondents rated their own mental health at the time of interview;
- Their ability to recognise and identify problems and illnesses;
- Whether it was felt that mental ill health is a growing problem within the Bangladeshi Community;
- Why people from the Community might have a mental health issue;
- What factors are thought to affect the mental health of community members;
- What the views of the Community are regarding people with mental ill health.

The data collected was analysed through tables and opened ended question comparisons to ascertain where the differences, similarities and concerns lay according to gender and age.

Understanding Mental health

According to the World Health Organisation (WHO), there is no one authorised or definitive definition of mental health. This is due to cultural differences, subjective interpretation and differing professional theories.

“Mental Health has been defined variously by scholars from different cultures. Concepts of mental health include subjective well-being, perceived self-efficacy, autonomy, competence, inter-generational dependence and self-actualization of one’s intellectual and emotional potential, among others. From a cross-cultural perspective, it is nearly impossible to define mental health comprehensively. It is, however sometimes used as a broader definition, and professionals generally agree that mental health is broader than a lack of mental disorders” WHO

Participants were asked to explain in their own words what they thought Mental Ill Health was. (Some of the results are listed in Appendix 3).

From the response’s given it was evident that there are variable levels of understanding, with the oldest generation displaying a poorer knowledge than the younger ones. However, the youngest male section of the community to be questioned also displayed a considerable ignorance on the matter in that the majority thought that people with mental ill health were ‘crazy’ or had ‘no idea what they were doing’.

Interestingly it appears that females have a better understanding of mental health than males. Most were able to express definitions or theories better and more appropriately than the male population.

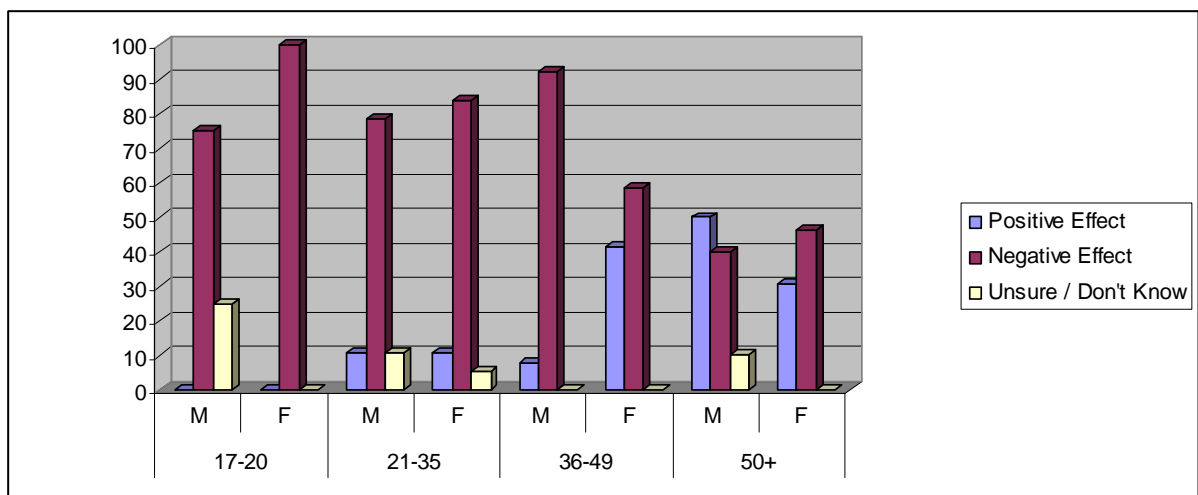
Despite this, the data also suggests that there is a considerable level of un-surety across the community, which could be open to misinterpretation and misinformation.

The effect culture has on the Bangladeshi Community's perception of mental ill health.

The issue of culture has profound effect and influence on the way in which we view and treat mental health. In any given culture, mental health is a difficult and challenging issue.

If the distinction between a mentally healthy person and one that is not is based on the theoretical perspective that psychological health depends on accurate perceptions of reality, then the question that arises is what is reality? What reality is, through the eyes and experience of one person, may not necessarily be the same as another with different set of experiences, values and of a different cultural, religious and social background.

Respondents were asked if they thought Bangladeshi Culture had a positive or negative affect on the way mental health is perceived.



This diagram shows that the majority of the respondents felt that Bangladeshi culture had a negative effect in the way in which we perceive Mental Health. None of the 17-20 age group, considered culture to have a positive effect, although 2 male respondents were unsure. Opinion was closer in the 36-49 female group and 50+ males. 42% of respondents of the former people considered culture as having a positive effect, which rose to 50% of males in the over 50's group..

The reasons given by respondents for Bangladeshi Culture's negative effect include -

- General lack of education and stigma.
- They think 100 out of 100 cases are either black magic or possession.
- Its gets disregarded, not seen as an illness.
- They don't understand that a person can suffer in such ways and think its all made up.
- Because they always give the impression that an outside being – a sprit, possesses a person. They don't recognise the illness as a illness.

The Bangladeshi Community's general perception of mental health issues.

Respondents were asked from a selection of provided statements, which ones they thought related to the community's views on mental health issues. They could pick as many statements as they thought related to the Community's feelings.

The statements were:

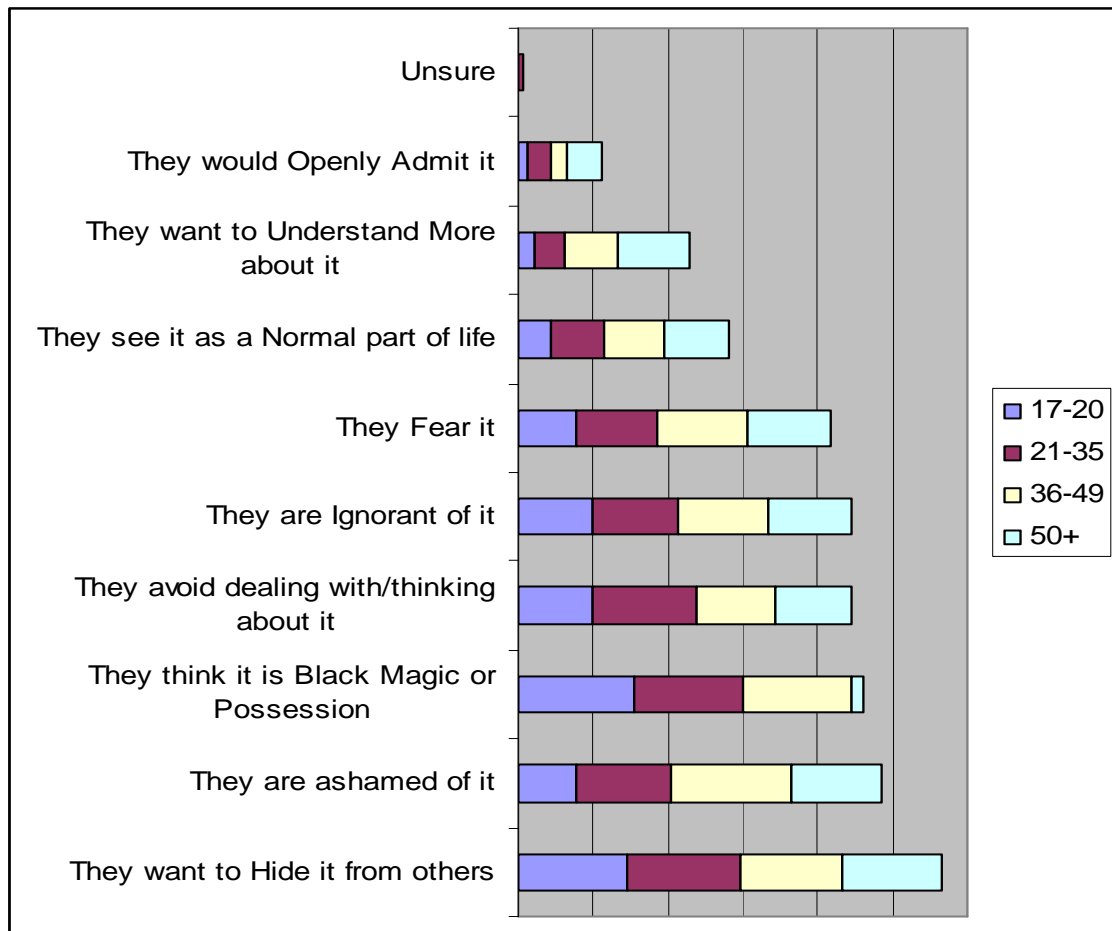
- They are ignorant of it.
- They think it is Black magic or Possession
- They are ashamed of it.
- They would openly admit it.
- They want to hide it from others.
- They fear it.
- They want to understand more about it.
- They see it as a normal part of life.
- They avoid dealing with / thinking about it.
- Unsure

Male respondents in the 17-20 and 50+ categories were less inclined to think that the community are ignorant of the mental health problems. However, a high proportion of all the respondents thought that the Bangladeshi community would want to hide it from others possibly because of shame as this statement also scored highly.

Furthermore, a high proportion of the 17-20, 21-34 and 35-49 group respondents thought that the Bangladeshi community perceive mental health as Black Magic or possession. It was not clear if this was due to cultural stereotype and bias against

mental health or as a direct result of experience. The respondents in the 50+ category did not think mental health is perceived as black magic or possession.

The respondents also perceived that the community were less inclined to want to understand more about mental health and more likely to avoid dealing with the illness.



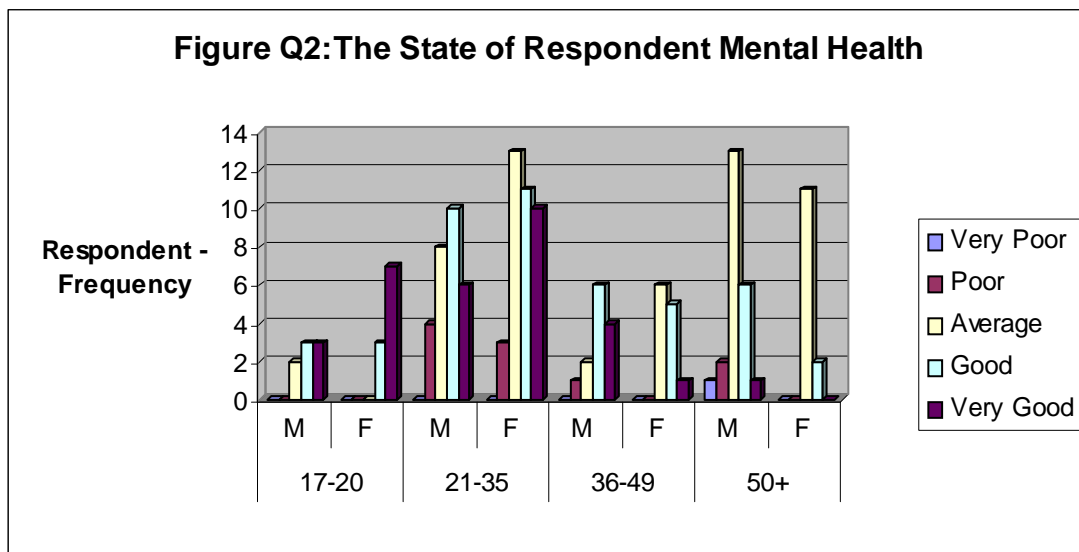
In addition to choosing statements, some individuals backed up their choices saying:

- There is a“ lack of education . Understanding exists between family members. They fear it because they think they will loose social status”
- “they think it’s destined to happen to them”
- There is a“lack of education. Uneducated people jump to the idea of possession. Most people are ashamed of it because their priorities are not in

order. Bangladeshi culture shuns the idea of communication with others, even spouses, to solve problems”

Respondent’s personal state of Mental Health (at time of interview)

When respondents were asked to describe their current state of mental health very few expressed it as very poor. As figure Q2, shows respondents feel either average, good or very good. There may be other reasons for these answers in that the culture of Bangladeshi’s may be preventing respondents from stating their true state of mental health due to the perceived stigma of having a mental health issue. As this is a purely individual perception it is difficult to say with a certain amount of conviction that respondents were completely truthful in their responses.



33% and 56% of young people within the 17-20 groups described their mental health as good and very good respectively. However, more female than male respondents feel very good.

In the 21-35 category 10.8% of the respondents reported feeling poor, however, for average and good the frequency is the same - 21 respectively accounting for 32.3% each. 24.6% (16) of the respondents felt their state of mental health is very good. A small variance can be seen between male and female responses. 35.1% (13) female

reported their state of mental health as average, as opposed to 35.7% (10) male who report theirs is good.

This result is not surprising given that despite the high levels of social disadvantage, young Bangladeshis (girls and boys) are found to be at a reduced risk of psychological distress as compared to their white counterparts. High levels of family support and high ethnic concentration provide protective factors for mental health (Stansfeld and Haines, 2004). It could be hypothesised that such protective factors permeates through the different groups and as such counterbalance the deprivation and disadvantage aspect.

Respondents in the 36-49 years category show similar patterns to that of the 21-35 age group. 44% reported good state of mental health followed by average and very good accounting for 32% and 20% respectively. Males report higher levels of good (46.2%) and very good (30.8%) mental health as oppose to 50% of women who say theirs is average with 41.7% for good.

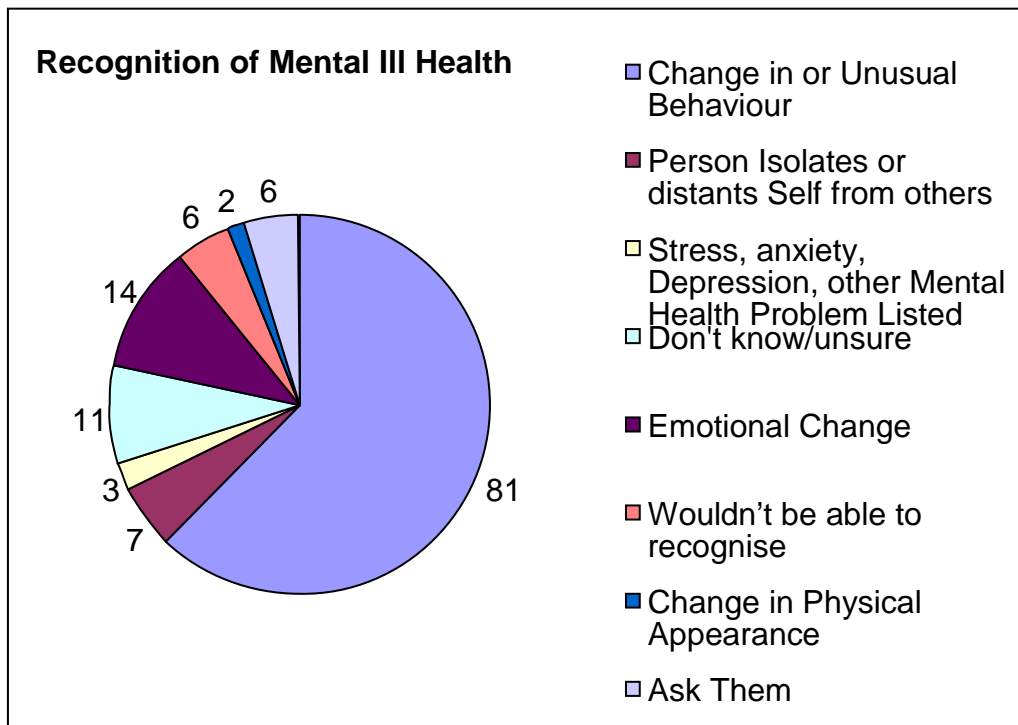
Within the 50+ category, 40% of the male respondents say their mental health is good as oppose to 84.6% who say theirs is average.

However, this Data needs to take into account that just under half of all the recipients disclosed that they have had a mental health illness. (See Section 2). If the majority of respondents claim to have average to very good mental health then this would suggest that they have either recovered from their mental health issue to the extent that they no longer recognise they have a mental health issue, or are symptom free.

Recognising Mental Ill Health in Other People

“Mental health problems can affect anyone, regardless of age, race, gender or background. Different disorders take different forms and affect people in different ways. Common mental disorders such as anxiety and depression can have a profound effect on the community and result in 1/3rd of days lost from work due to ill health and 1/5th of all consultations with GP's”(Weich and McManus, 2002).

Given that there are high levels of satisfaction amongst the Bangladeshi community about their state of mental health, respondents were asked how they would recognise if they or someone they know had a mental health issue. The chart below demonstrates the answers received.



62% of the respondents' felt that they would recognise that either they or someone they knew had a mental health issue through a change in their normal conduct including any unusual behaviours. This was by far the highest response, followed by an 11% recognition if there was an emotional change.

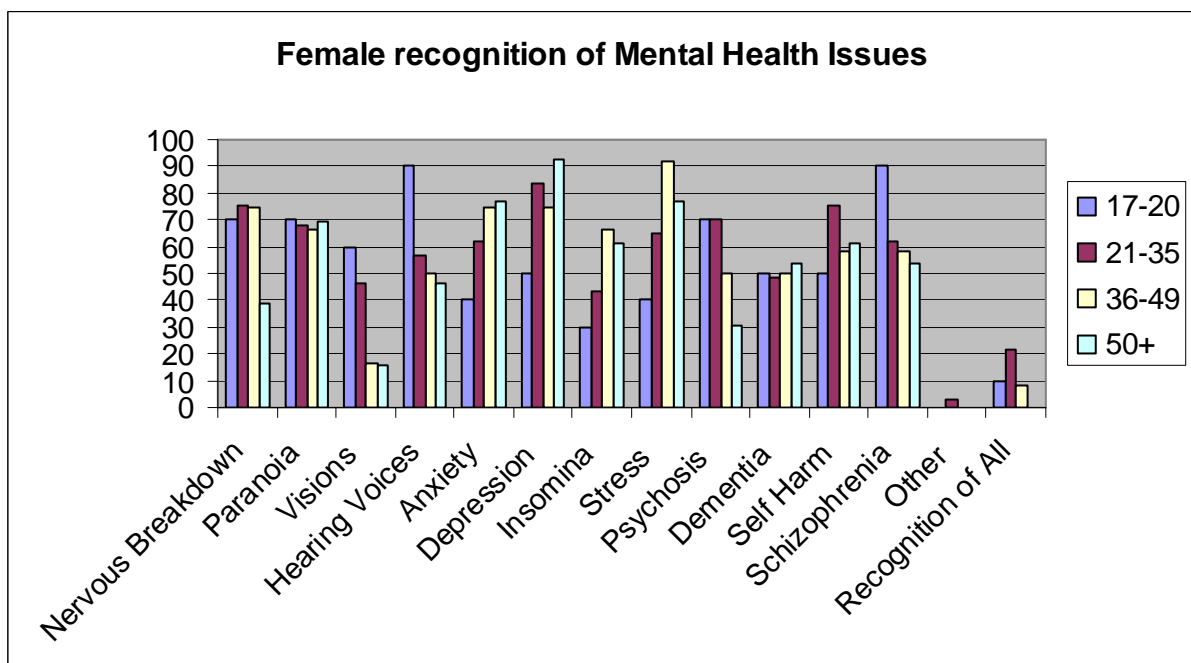
However, it was surprising that only 3% of the respondents said that they would recognise that a person (including him or herself) had a mental health issue if they were stressed, depressed or anxious. This may be down to cultural attitudes or societal attitudes around these illnesses, which deem them not to be a mental health issue but something that people just have and put up with.

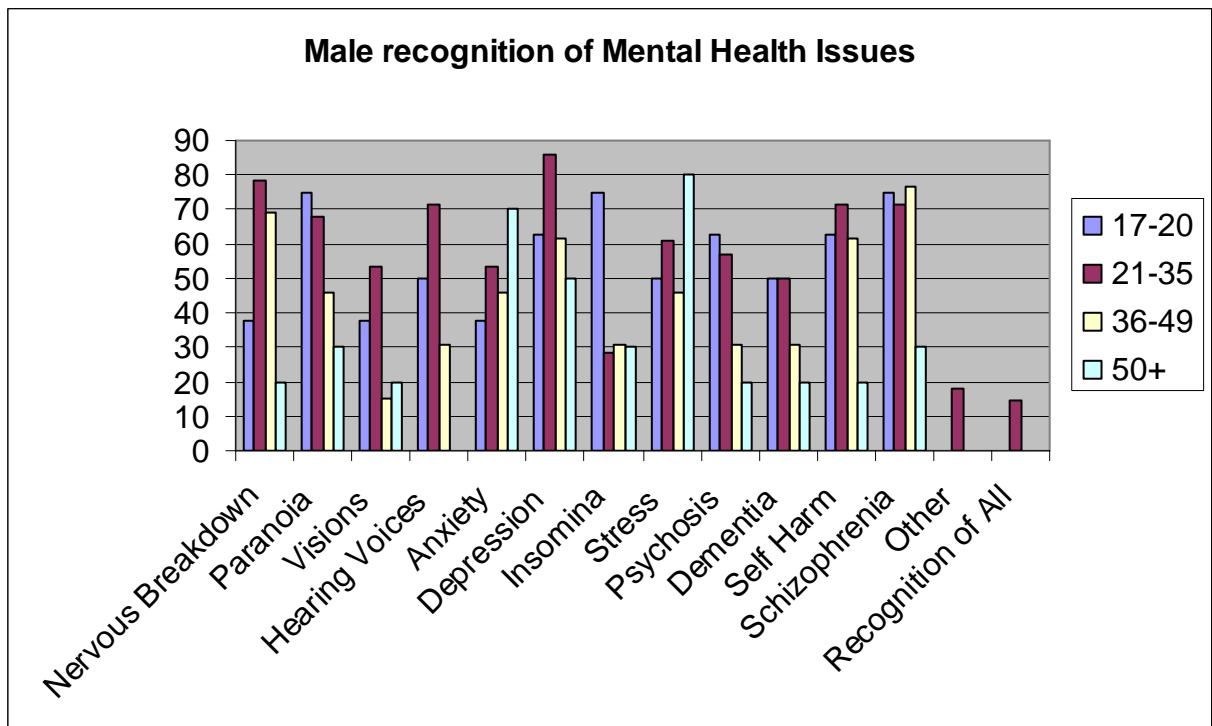
Significantly 13% of the respondents stated that they either would not be able to recognise someone with a mental health illness, or did not know (or were unsure) if they would be able to recognise someone with a mental illness.

Recognition of Mental Health Issues

Following on from this question, Respondents were shown a list of common mental disorders and psychiatric disorders such as schizophrenia and asked which ones they would recognise as a mental health issue.

Out of the possible 131 respondent's only 14 people recognised all the different disorders. In an ideal situation, this figure should be 100%. Overall greater numbers of female respondents than males recognised the illnesses; for example, in the 21-35 group recognition of all illnesses was 8 and 4 for female and male respondents respectively.





The diagrams above show the percentage of females and males in each age group that recognised the different mental health issues mentioned to them.

All respondents were able to identify one or more of the illnesses from the options provided. However, the hearing voices score was zero for male 50+, who did not consider it to be a mental illness, although there were no qualifying reasons for this.

Nevertheless, the older generation recognised two areas more than other age groups as being mental health issues: Anxiety and Stress, and the females of the older age group also recognised that depression was a key mental health matter for many people, whereas the males of this group were less inclined to see it as an issue.

This pattern of not recognising the ‘softer’ mental health issues such as stress, depression, anxiety and insomnia in the youngest age group is very telling of the society surrounding us today. Many young people view these as things people get which are commonplace and should be tolerated as part of living in this society.

Only the older generation failed to recognise self harm, but they may just not be aware that this occurs, as it is a relatively new issue that has been brought to the public’s attention.

Surprisingly both the males and females of the 21-35 age groups had similar results across the board with only a small percentage variation in each particular category. This may be due to increased awareness by this generation of mental health issues, to which the older and younger generations have not been privy.

Overall depression scored the highest with 76% of the surveyed participants recognising it as a mental health issue. Visions, insomnia and dementia were the least recognised, with between 53% and 65% percent recognising the other named symptoms.

However, some differences do exist. For example, within the 17-20 age group the percentage of female respondents recognition of Nervous breakdown as an illness was 70% as oppose to 38% for male and more females (52%) in the 50+ group think paranoia is a illness than male (12%).

One other significant variance is the in the recognition of stress. In the 36-49 group 92% of females compared to 46% of males considered it an illness. Within the same group a similar pattern can be seen for anxiety.

Perception of mental ill health as a growing problem within the Bangladeshi Community.

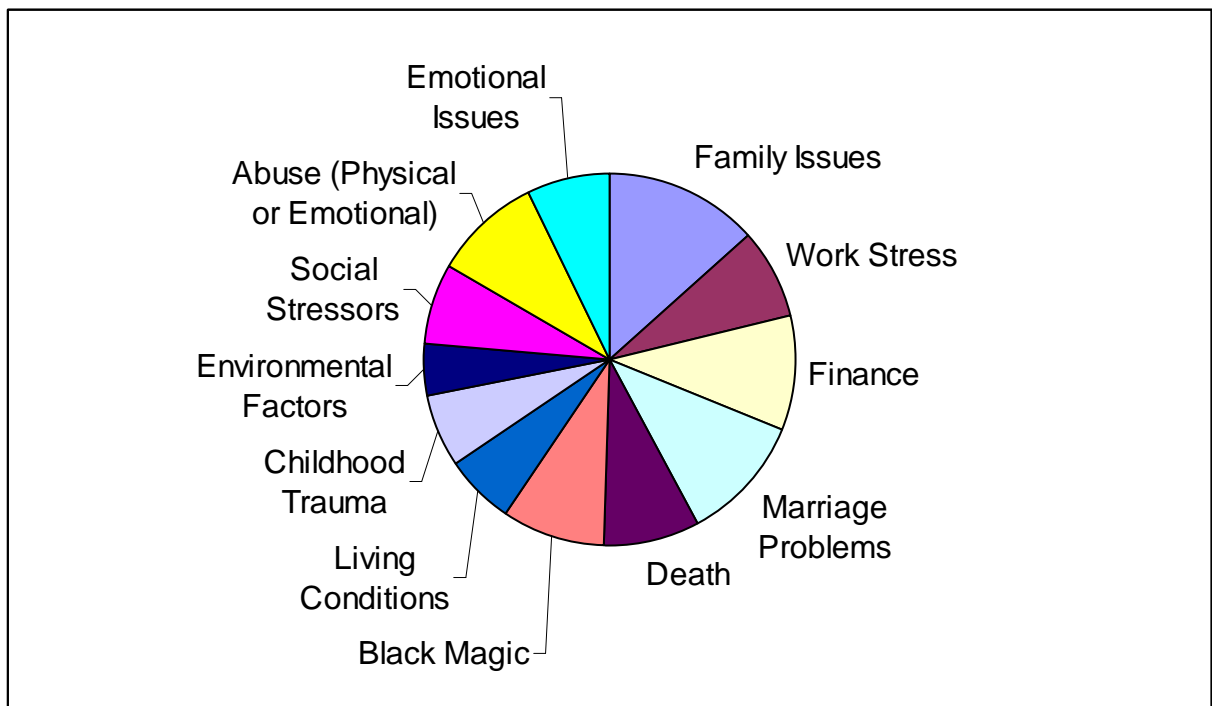
The underlying and true hidden burden of mental health within the Bangladeshi community is not yet known because of it secretive and hidden nature. When respondents were asked if mental ill health is a growing problem the opinion between genders and ages once again differed.

Nevertheless, overall the majority did feel that it is a growing issue, especially in the 50+ and 21-35 age groups.

Opinions were divided in the 17-20 and 36-49 age group. Half of the youngest males were unsure but the majority of those with a definite opinion thought there was. This contrasts with females of that age of whom 60% felt that there was no growing problem at all.

In the 36-49 age group the majority of females agreed with the over 50's about the increase but a small majority of males in the same age range did not (46.2% yes : 53.8% no).

Perceived reasons why people from the Bangladeshi Community have Mental Health Issues.



By far the most perceived causes of mental health issues in the Bangladeshi community revolve around the family unit with family issues and marriage problems coming top and finances following closely behind them.

Interestingly Abuse (physical and emotional) and Black Magic also have high scores, which demonstrate that they are recognised parts of the Culture of the Community. Environmental factors including living conditions, social and work stresses appear to play a less relevant part in causing mental health issues.

Lastly, only 44% of the respondents felt that childhood trauma played a role in the development of mental health issues, which is either indicative of healthy upbringings or a predisposition to deny anything traumatic occurred during childhood.

What Factors affect Mental Health in the Bangladeshi Community?

Respondents were asked what outside factors could influence people's mental health in order to gauge how much weight each issue had. The responses could be reflective of each generation's experiences of mental health and proved to be interesting.

Within the 17 – 20 age group the majority of females did not consider the area lived in; intergenerational conflict, or family friends and peers to have an impact of mental health. They did feel that racism, prejudice, religion and cultural influences played a part on accession along with school / college / work and the criminal justice system.

The males in this group on the other hand did feel that the area lived in, parents / family influences and school / college and work played a significant role. They also felt that peer pressure contributed as well. Surprisingly they were equally divided regarding the influence of bullying, and not one person was convinced that crime played any part at all.

75% of males felt that marital relations did not influence mental health as opposed to 50% of females and another 10% who were not sure.

In the 21-35 age group, again a high proportion of the females felt that the area lived in, school / college / work and the criminal justice system did not play a part in mental health issues, along with peer pressure, drugs and crime. Almost equally, there was divided opinion on marital relations and religion / cultural issues. They thought that the highest influence were parents and family.

The males in this age group felt that again, the area lived in, and peer pressure did not influence a persons mental health, but contradictingly that drugs most definitely did (58%). They also believe that parents / family and intergenerational conflict contribute to a person's mental ill health, but that religion and cultural influence did not.

Feelings were divided between those who believed that racism the criminal justice system and marital relations did play a role and those who did not.

In the 36-39 age group females appear to be almost equally split in all areas, except criminal justice and intergenerational conflict, from those who think they play a part to those who do not. In the two categories where there is a difference, a high proportion of women were unsure if they played a role. The least significant was school / college / work and a slight proportion considered the area and parent / family to have an influence.

Males in this group were equally split over the responsibility that marital relations has in mental ill health, but a high proportion overall considered that there are no outside influences in mental ill health or mental well-being. This appears to indicate that they consider it to be inherent or a physical disease.

This trend rolls over into the oldest generation, as they appear to conform to the feelings of the 35-49 age group in that the majority do not think there are any outside influences.

The only areas of difference fall into the over 50's males, who feel that parents / family and marital relations could contribute to a person's mental ill health.

The views of the Bangladeshi Community regarding People with Mental Health Issues.

According to the Department of Health (2006), one in six people experience mental ill health, ranging from distress to severe illness. This illness can be made worse by the way people with mental health issues are perceived and interact with people.

Sproston and Bhui (EMPIRIC report,2002) also state that '.....high levels of social support and social contact act to improve levels of well-being, or to enhance self appraisal and self esteem, thereby positively influencing mental health'

Therefore it is important that the thoughts and feelings of the Bangladeshi community are gauged through respondents own views.

Participants were asked a series of questions relating to how the community should treat people with mental ill health and whether they thought they could recover and lead 'normal' lives.

The following statements were included.

People with mental health issues.....

- Should be encouraged and supported
- Are able to be integrated into society.
- Are able to recover, live and work normally.
- Will not be able to recover at all.
- Can be treated effectively.
- Should be kept away from others.
- Are unsafe to be around.
- Have the right to be treated normally.

Results from this section of the questionnaire show that a high percentage of the respondents thought that people having mental ill health should be encouraged and supported. This view was held by all the males in both the youngest age group and the 21-35 age group. In fact, a larger percentage of the men felt this way than women.

However, when it came to being able to integrate back into society there were more varied views. The majority of both genders felt that this would be possible but there were two significant sectors where opinions were divided. In the female group of 17 - 20 year olds, there was a complete split (50:50) as to the possibility of integration and

in the 36-49 age group the men definitely felt that it would not be possible.

Respondents in this group felt that rehabilitation and integration was dependent on severity of the illness.

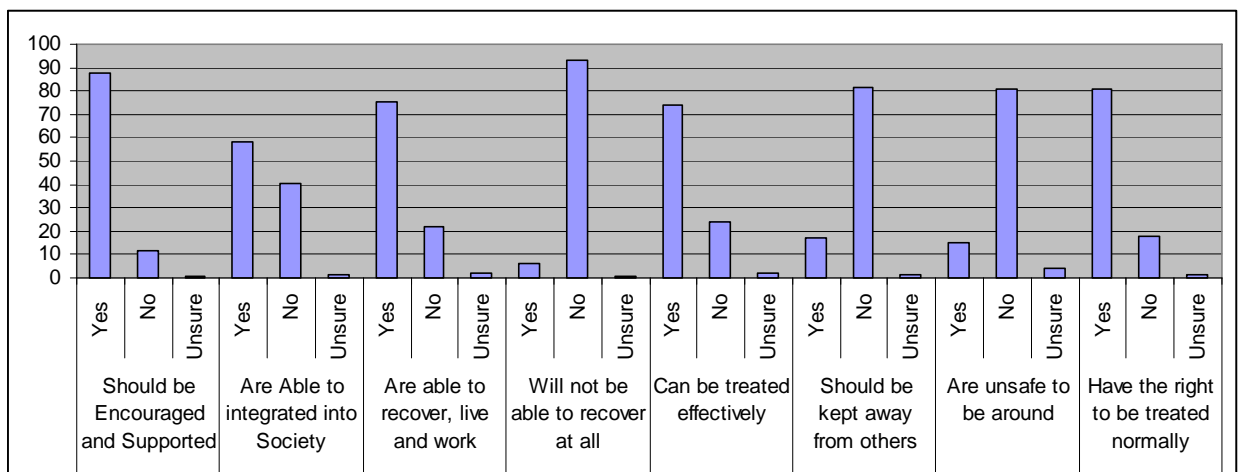
When comparing the results of this question to the previous question on encouragement, the percentages of people saying yes and no in this instance were closer than in the former.

When asked about recovery the majority of participants felt that people with mental ill health would be able to recover and live 'normal' lives. The exception to this were the female 50+ group, 54% of whom felt that they wouldn't be able to do this and 46% who thought that they would. 100% of the youngest generation felt that everyone with a mental health issue would be able to have some sort of recovery, and overall a high percentage of every age group and gender felt this way.

The results continued in a positive light with people generally feeling that mental ill health can be treated effectively and those who have the disorders are not considered to be unsafe. In addition, the majority also think that people with mental ill health have the right to be treated normally.

The respondents also feel that over time they will be able to integrate and recover from their illness through effective treatment. Additionally people with mental health problem are not considered to be unsafe and have the right to be treated normally.

Overall percentage of respondents views regarding people with mental ill health.



Conclusion to Aim 1

The findings show that people feel that the Bangladeshi culture has a negative effect on the perception of mental ill health due to lack of education and the belief in black magic and procession. Overall, the respondents felt that the community would hide mental ill health or avoid the topic, as they are ashamed of it. This all points to a general ignorance of what exactly mental ill health is and the symptoms of different conditions.

The latter point is backed by the presumption that everyone with a mental health issue would change his or her behaviour, as this was the highest scoring area of how to recognise if someone had mental ill health.

Of all the mental health conditions listed, the majority recognised depression as a symptom, with visions, insomnia and dementia being the lowest scoring. This may be due to lack of knowledge regarding visions and including the latter two symptoms as being normal conditions that happen as a physical problem.

In all cases it was agreed that there is a growing problem with mental ill health in the Bangladeshi community, with family issues, finances, marriage problems and death being contributory factors.

However, despite the lack of knowledge displayed about mental health the majority of respondents were very positive about having people with mental ill health living in the community. They felt that these people should be encouraged, supported and integrated and have the right to be treated normally.

Aim 2

Assessing the relationship between the Bangladeshi Community and Mental Health Services.

Previous data collated demonstrated that few respondents felt that their own mental health was below average. However, there is a need to determine whether people had in fact had mental ill health in their lives and if so, what services they had accessed and the experiences they had had with that service.

In addition, the research needed to determine who people in the community would go to for help and advice; whether they felt able to discuss their feelings with the medical profession; and the general awareness and experience of mental health services available.

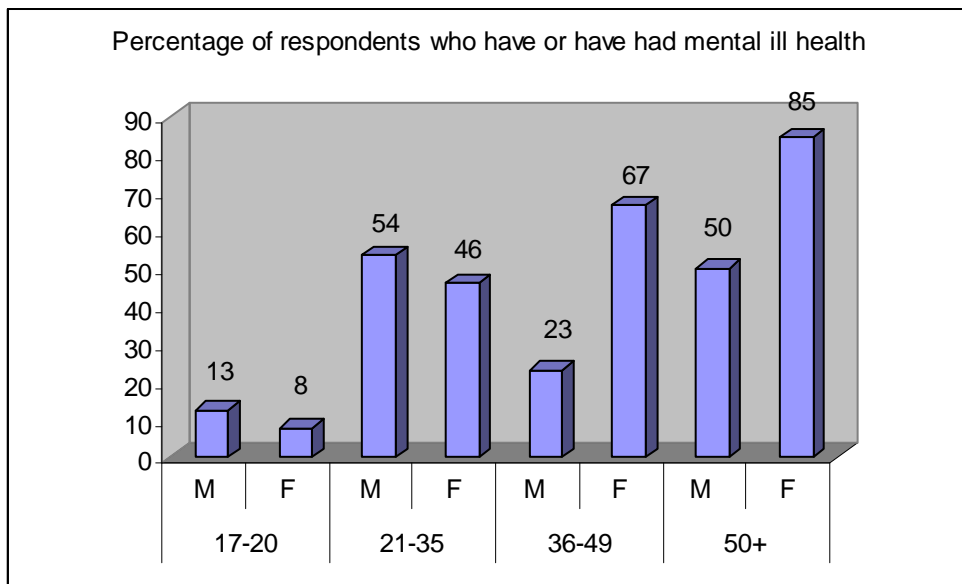
Personal experience of Mental Ill health and Mental Health Services.

“Evidence from studies of treatment rates suggests that the prevalence of mental illness among population broadly described as South Asian, appears on balance to be lower. It has been suggested that these lower detected rates could reflect language and communication difficulties, or a general reluctance among some South Asian groups to consult with doctors over mental health problems” (J Nazroo and William O’Conner 2002).

Relating back to the list of common mental health disorders, respondents were asked if they had ever had any of the ailments.

Overall, 47% stated that they either had or had had a mental health issue in their lifetime. Of these the greatest percentages were females over the age of 35.

However, a total of 11% of the 17-20 age group, 49% of the 21-35 age group, 44% of the 36-49 age group, and 70% of the over 50’s had either had a mental health issue now or had had one in the past.



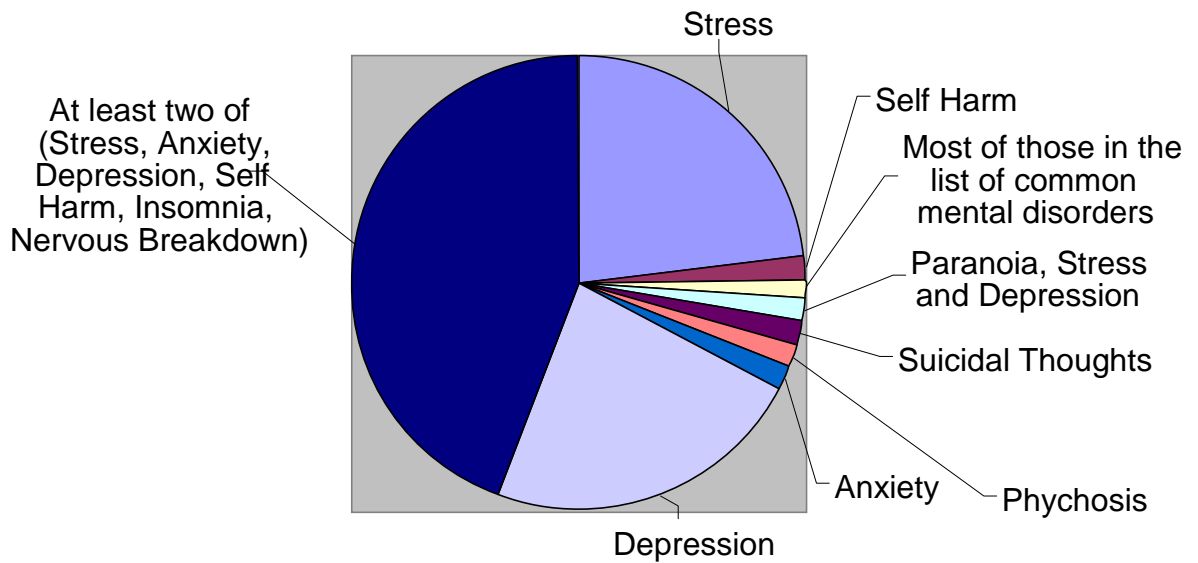
Given these results, respondents who replied that they hadn't had a mental health issue in their lifetime were also asked if they knew of anyone who had.

The results of this question demonstrated that the younger age groups knew of people who had (17-20, 28% & 21-35, 12%), but the older generations did not. In the 36+ age groups, only the males recognised mental ill health in other people that they knew. This would imply that the older generation were able to recognise their own mental ill health but not that of other people.

The diagram below shows the different illnesses that respondents claimed to either have now or have had in the past.

It demonstrates that stress and depression were the most common and identifiable illnesses across all age and gender groups, and that the majority of people had had episodes where two or more symptoms were present.

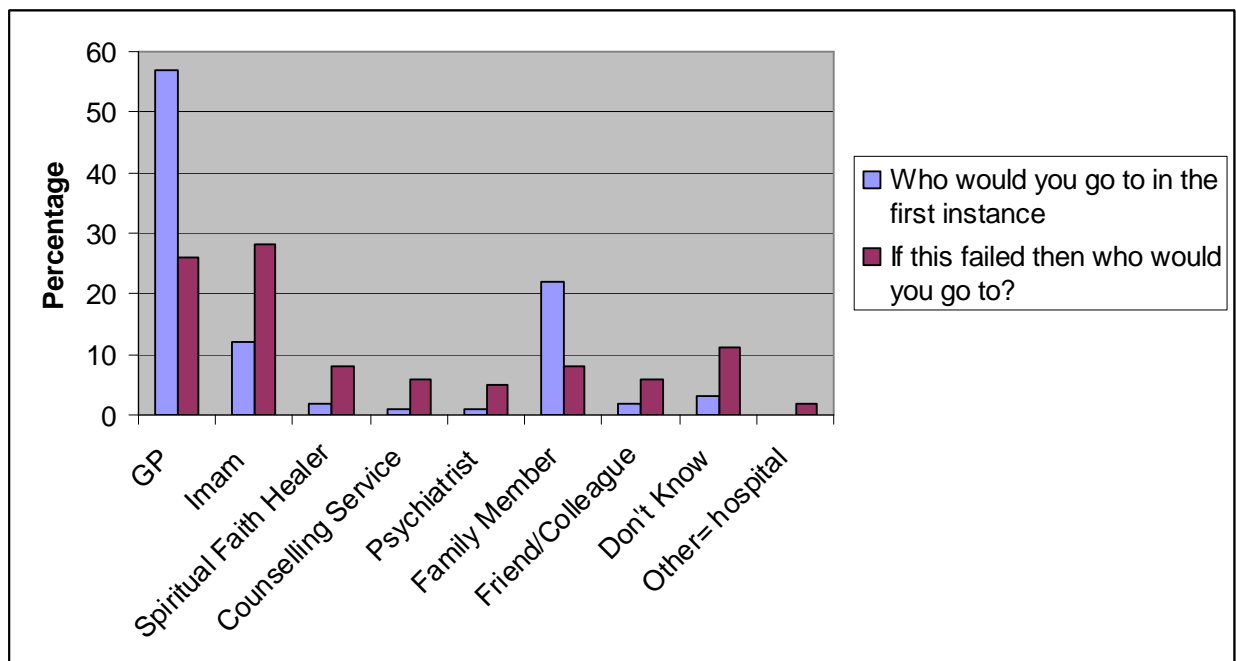
% of people with Mental Health Issues



It is common practice for people with mental health issues to consult spiritual healers and be less dependent on Eurocentric medication and treatment of mental illness.

It was surprising then that when respondents were asked whom they would go to first if they had a mental health issue; the majority stated that they would go to their GP for advice and treatment. However, in the 50+ age group 60% of male respondents said they would go to an Imam and 35.1% female respondents in the 21-35 age group say they would go to a family member. Language barriers could be a factor in this as the majority of older generation Bangladeshis do not speak English, thus communication would be an issue.

Significantly, very few say they would go either to a spiritual faith healer, counselling service or psychiatrist. However, when respondents were asked who they would seek help from if their first choice failed, the response was varied and no clear pattern emerged.



It is evident from the above findings and knowledge of the community that there is an underlying dependency on Imams and to some extent spiritual healers to cure mental health where Gp's are deemed not to have given effective treatment or response.

Of those respondents who stated that they had had personal experience of mental ill health 54% (33) said that they had sought help with the condition. Of these 33, the majority had not been prescribed medication for a mental health issue diagnosed by their GP and when broken into the different age groups, none of the 17-20 year olds had. This has two connotations:

- 1) The majority had not been to see their Gp, which could support Nazroo and O'Conner's findings over communication difficulties and other reasons for being reluctant to seek medical advice.
- 2) The Gp does not support the prescribing of medication for specific issues such as depression. The latter theory may in this case be the most predominant as the previous findings show that given the choice most people in the community would visit their Gp first.

People were also asked if they had had a say in their treatment options and whether they had been offered additional services. Interestingly the majority stated that they had had little or no say in what treatment was given, and were not offered additional

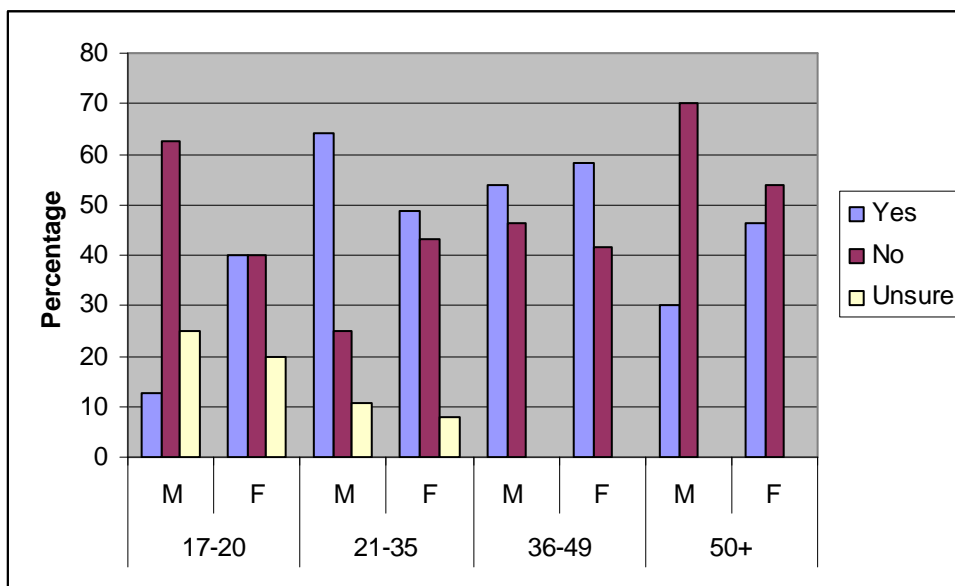
therapies alongside medication. The only exceptions to this were the Females in the 36-49 age group, 25% of them had a say in their treatment and had been offered the additional therapies.

Of the people who had been offered a treatment option and additional therapy this was in the form of informal counselling by Gp, behavioural therapy and formal counselling. It appears that the majority of people were happy with the treatment that they received, whether that was medication or additional therapies or both.

Given the fact that few people had been given an option of treatment for their mental health issue, it was important to gauge whether people felt that they were able to explain and discuss the emotional difficulties they were experiencing to their Gp or Mental Health Professional.

The question was asked of all respondents and the results are shown in the chart below.

Ability to talk to Gp or MH professional about their emotions.



The results demonstrate that males in both the youngest and oldest generations strongly feel that they are unable to explain or discuss emotional issues openly with any medical professional. In addition, this feeling is also reflected in the older females too. However, the middle generations have a more positive attitude whereby the

majority do feel enabled to talk about their feelings. Only the under 35s showed that some of them were unsure about it.

Somatization is the name given to explain the reasons why mental factors such as stress cause physical symptoms. Somatoform disorders are a severe form of somatization where physical symptoms can cause great distress, often long-term. However, people with somatoform disorders are usually convinced that their symptoms have a physical cause.

This is a hidden issue, which cannot be ignored as a possible factor for high responses to the inability to explain and discuss the emotional difficulties.

The inability to distinguish between physical distress and emotional distress is often a contributory cause for severe mental health problems. Language barriers particularly amongst the elderly and the newly arrivals would be high, and lifestyle change and access to adult learning provision would be necessary to overcome such problems. It is also possible to surmise from previous results that ignorance of mental health issues may be a contributory factor and that symptoms are simply not recognised as disorders. Therefore, they would not be discussed openly.

Explanations offered by respondent as to why they cannot explain and discuss the emotional difficulties shed new light on the issue. Some people felt that they simply did not trust their Doctor and did not have a relationship with them. Others identified language barriers and lack of translation facilities as issues, whilst some were too embarrassed or wished for the same sex Gp to discuss things with. In one case, a respondent confirmed the Communities belief in Jado and Jinn, which are discussed in the Religious section and stated that Doctors do not believe in the same things and only think of it in scientific terms.

Awareness and Experiences of Mental Health Services in the Community.

The research aimed to identify how the Bangladeshi community can be made more aware of mental health services and how they currently access such services. In addition there was a need to establish how appropriate and responsive the services are at targeting and meeting the needs of the community.

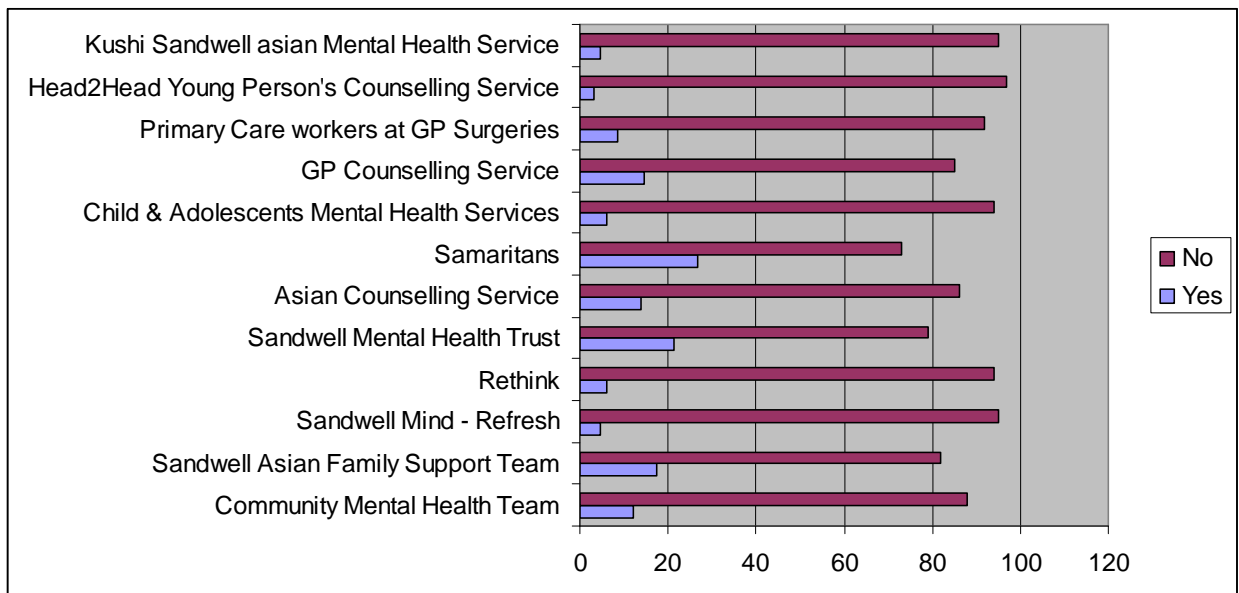
Awareness is an important element in bridging inequality in mental health. When respondents were asked if they were aware of the mental health service provision in their area, a significant majority answered no across all age groups and genders.

This demonstrates a huge void in providing adequate information and services to the community. This finding also hinders progress in achieving appropriate and responsive services and equality in access.

In order to address these issues service providers need to work more closely with Bangladeshi led voluntary sector organisations to disseminate information on their services. Urgent action and strategies would be necessary correct the current position.

When respondents were asked how they were made aware of the mental health provision in their area, it was not conclusive that one method of communication prevailed over others. The majority had not received any form of communication at all. Of those who had received information the sources varied from GP services, posters and leaflets, local community centres and word of mouth

Respondents were also asked if they knew or have heard of organisations delivering mental health provision in Sandwell. The results showed that the organisations/services respondents were most familiar with are the Samaritans, Sandwell Mental Health Trust, Asian Counselling service, Sandwell Asian Family Support Team and GP counselling service. Despite the familiarity the frequency of identification of services is quite poor and would require redress if the services are to be inclusive.

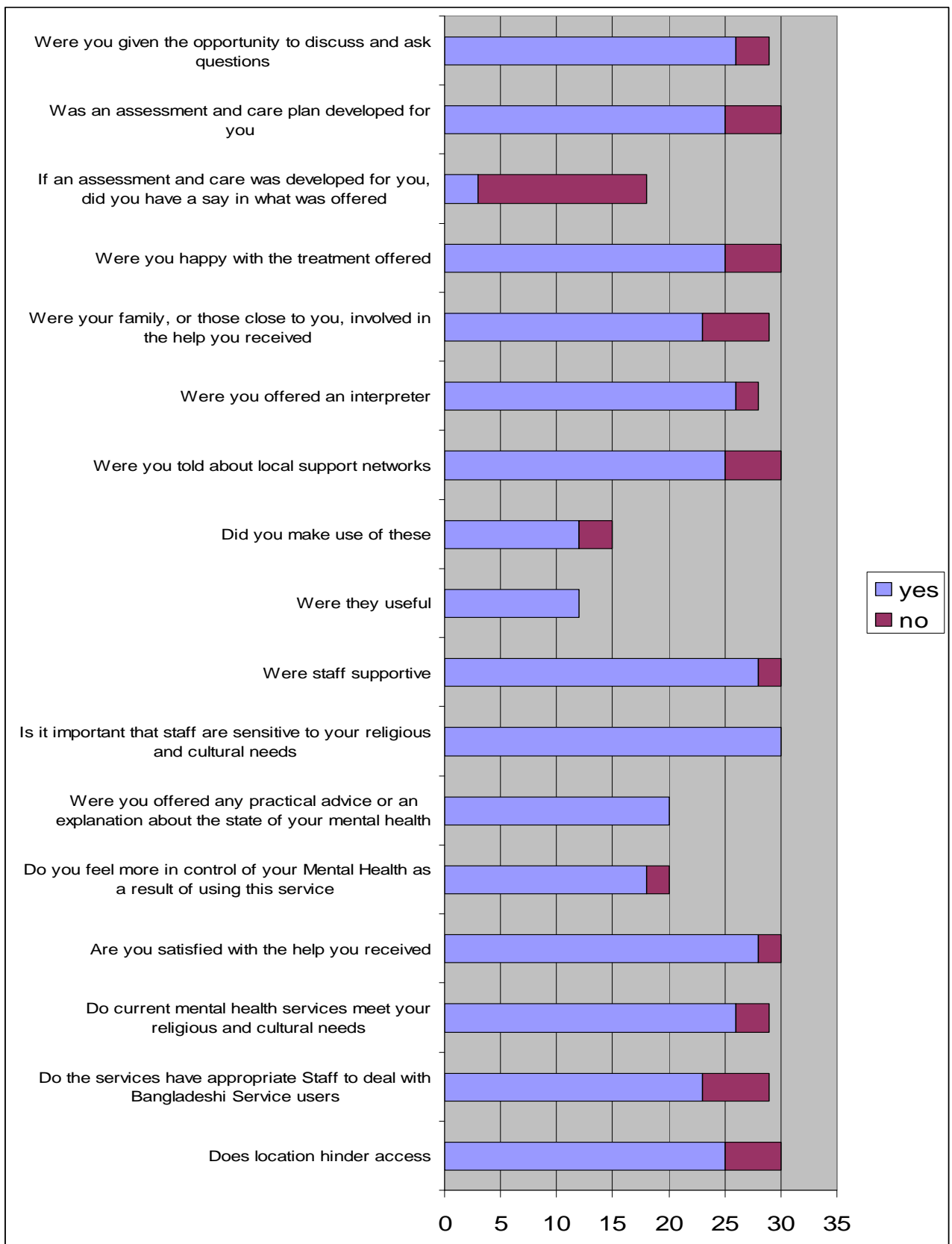


Of the respondents who said they have heard of services, very few have been in touch with the service. Only 12.5% of males in the 17-20 group claim to have accessed the service and 16.2% of females in the 21-35 group have accessed services. The data demonstrated that overall, more men than women have accessed the services.

The services used included:

- Gp
- Counsellor
- Child & Adolescent Mental hEalth Service
- Head to Head – Sandwell Mind
- Asian Counselling Service
- CAMHS
- Gp Counselling Service

When Respondents were asked how they were referred to other services, it was apparent that they were either self referred or referred through Gp services or the hospital.



The diagram above shows that the majority of people attending services were happy with the provision given. However, a high percentage (25%) felt that location hindered access, and very few actually received a care plan as a result of the intervention.

Nevertheless, it must be noted that only a small number of people responded to these questions and further work in this area may be needed to verify these findings.

As has been noted in the previous section, respondents from the Bangladeshi community think there is a growing problem of mental ill health within the Bangladeshi community and little recognition of services available. In addition, often, for various reasons, medical professionals are not the first choice for people to go to for help.

When the respondents were asked if these issues need to be discussed within the Bangladeshi community, the majority of the respondents recognised the need. Only the males in the 36-49 age group demonstrated a difference in opinion with 53.8% deciding that there was not need to talk about it.

Therefore there is a willingness from across the ages to be more open about mental health issues and become more aware of both the conditions and services available.

Conclusion to Aim 2

The findings show that a fair majority (47%) of the respondents had had a mental health issue during their lifetime ranging from stress and depression to insomnia, nervous breakdowns or self-harm. However when it came to recognising mental ill health in others the research found that although the younger generation demonstrate a fair ability in being able to do so, the older generation struggled to identify anyone else that they knew who may have poor mental health.

When questioned as to who respondents would go to for help if they had a mental health issue, the majority identified their GP, followed by family and then their Imam. If this method failed to assist them they would then go to another source, ranging from Gp again, to a higher number of people who would then see their Imam instead of a medical professional.

54% of those people who had stated that they had had a mental health issue had sought help for it, but the majority had had no say in their treatment following this.

It was vital then that people's beliefs in their ability to talk to medical professionals was gauged and the reasons for being unable to identified. 49% of respondents felt they could talk to their GP or other professional but 44% could not. This negativity stemmed from their own beliefs that their Gp could not be trusted or did not have the same beliefs or there were language barriers that prevented them from expressing their feelings.

Few of the respondents had also heard of mental health services in their locality, which suggests a void in information provision, but of those who had actually heard of or access services the organisations used varied from the Mental Health Trust / Community Mental Health Teams to the Samaritans and Asian Counselling Service. The people who had received services stated that they felt happy with the service they received, although they did feel that location could affect that access and that not many of them had received care plans as a result of contact.

Because of these responses, the majority of people felt that there are issues that need to be discussed in the wider community forum.

Aim 3

Assessing the impact of religious beliefs on the perception and treatment of mental ill health in the Bangladeshi Community.

Understanding the association between Jado, Jinn and Mental Health.

Jadu or Black magic is commonly believed and practised by practitioners across many cultures. Jadu has no religious precedence yet within the Bangladeshi community belief system it is applied for personal gain, as a vendetta or in spite and many Bangladeshi's believe that Jadu can and does affect a person's state of mental health.

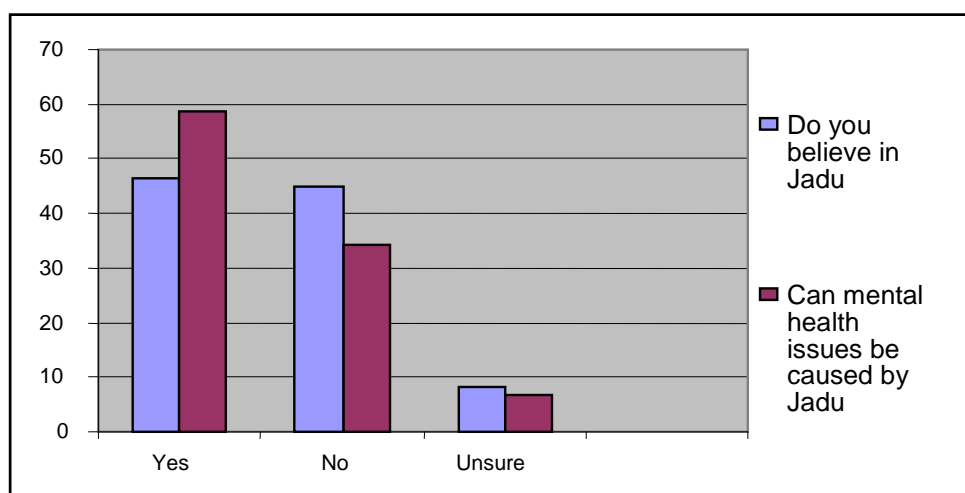
All the respondents were of the Muslim faith and Islam as a religion forbids the practice and belief of Jadu. However, the Quran mentions Jinn in many ways and this belief is acceptable within the religious parameters.

Black Magic or Jado is described as 'Magic used for evil often with the intent of injuring or killing someone. It may also be done for the personal gain of the practitioner.'

Jinn is far more complicated and is described as being 'created from fire whereas the human beings are created from clay. Although they are invisible to human eyes, the jinn can see us. Like human beings, they are also entrusted with responsibilities (careers, family life, etc.). They too will be rewarded for their righteousness and will receive punishment for their wickedness.'

Jinn are believed to be able to be controlled for the benefit others and detriment of the victim. It is alleged that they can and do cause harm to people.

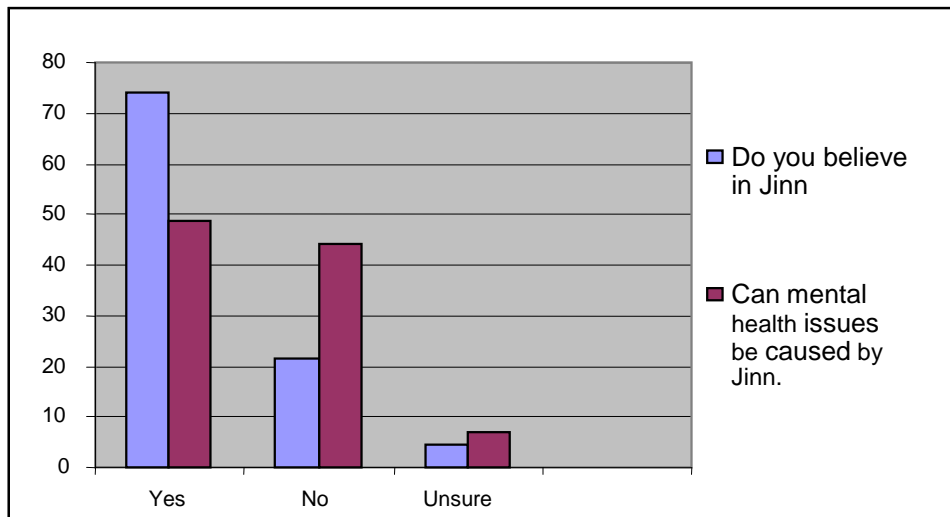
Due to the religious connotations of belief in these beings and practices, respondents were asked various questions of both principles.



When respondents were asked if they believe in Jadu, the different age group opinions were divergent. Respondents in the 17-20 and the 36-40 age group were either less inclined to believe in Jadu or less likely to admit to believing, although differences between believers and non believers were less significant. Prevalence to believe in Jadu was higher in the 21-35 age group and more males than females were likely to believe in Jadu accounting for 57.1% and 48.6% respectively. In the 50+ category 60% male respondents say they believe in Jadu.

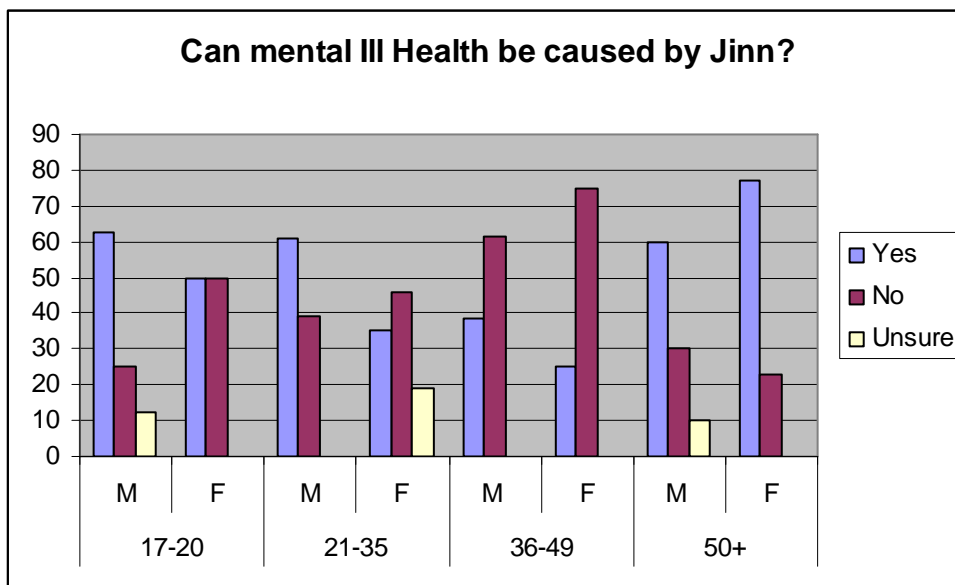
Nonetheless, overall there was little difference between believers and non-believers.

Although Jadu is unproven or unsubstantiated, for many including the Bangladeshis the association between Jadu and mental health is interlinked. When respondents were asked if Jadu can cause mental health issues, 70% females in the 17-20 age groups said yes compared to 50% for male respondent. However, in the 21-35 age groups more male respondents compared to female respondent considered Jadu as a cause for mental ill health. In the 36-49 age group 46.2% male and 50% female respondent believe that ill mental health cannot be cause by Jadu. However, more significantly within the 50+ age group respondents believe that Jadu can cause mental ill health accounting for 80% and 92.3% for males and females respectively. This could have significant ramifications given that the head of households within Bangladeshi community are in this age category. This may have an impact on the help sought for mental ill heath in those families, with preference given to spiritual healers and Imams over medical advisers.



Whilst many believe in Jadu, a higher proportion of respondents believe in Jinn. This is not surprising given that it is mentioned in the Quran and the Hadith. The differences in belief is not significantly different across the age groups except in the 50+ age group where the belief is the strongest at 80% and 92.3% for males and females respectively.

Despite this belief, there was only an overall 4.5% difference in the conviction that Jinn can cause mental health issues. When this is investigated further the age groups differ in opinion greatly.



Females in the 17-20 age group were equally split but Males in this category along with males from the 21-35 age group felt strongly that Jinn could cause mental ill

health. This is also reflected in the older age group of 50+. Only the 36-49 group and the Female section of the 21-35 group and felt that there was no influence. This latter result was surprising given that the same group considered Jado to be able to cause mental health illness.

The justification for belief in Jinn's, which may explain some reasons for the differing results included:

- Jinns are spiritual beings.
- In the Quran Allah refers to good and bad Jinns.
- Jinns can only possess humans if they are woken or interrupted.
- Jado is an act, which requires the jinn.
- Islamically there are good and bad jinn's. If a bad Jinn possesses one then it can affect ones mental health.
- People are more afraid of black magic than Jinns.

Identifying the reasons why people choose to go to religious figureheads and healers rather than health professionals.

When the respondents were asked if they had faith in the positive effects of Imams/spiritual healers on mental health the results differed. In the 17-20 age group 62.5% of the male respondents said yes, whilst 37.5% were unsure, however, 60% female respondents said yes and 30% said no.

In the 21 – 35 age group, more males (75%) than females (45.5%) believed in the positive effects that Imams and Spiritual Healers had on mental health.

However, in the 36-49 age groups neither the male or female respondents believed in their positive effects of imams and healers on mental health accounting for 53.8% and 50% respectively.

In the 50+ age category satisfaction was high; 90% of males and 61.5% of females had faith in the Imams and healers. It appears that the impact of treatment provided by Imams and faith healers is subjective dependent on the experiences of the individuals.

Some of the views of respondents included:

“I have seen it used on family members”

“When they do their treatment I find it helpful to me”

“they in my opinion know more about the religion than me so I’d put more of my faith in them”

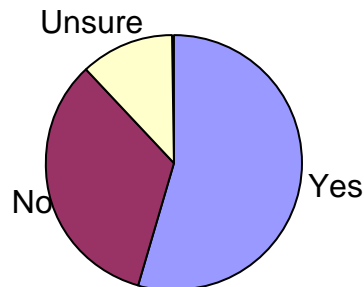
“if the imam is good then its possible and you respect their decision. However, if the Imam is bad then it can lead to improper conduct”

“what the doctors can’t diagnose and effectively treat we go to alternative solutions”

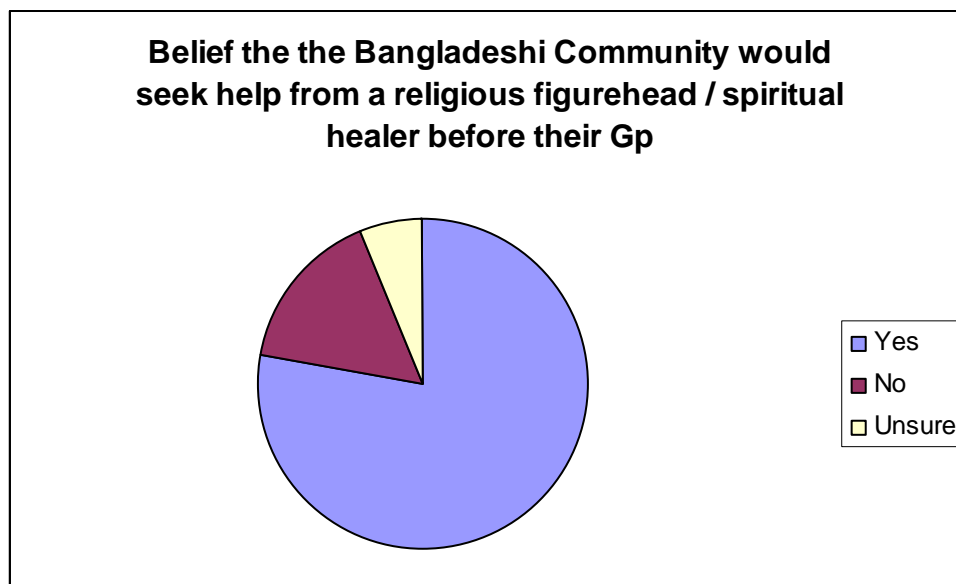
“we need help from both GP and Imam”

Out of all the age groups only the 36-49 age group felt that imams and healers would not have a positive effect on mental health but overall 52% of the respondents did had faith in the constructive effects they could have.

Faith in Positive Effects of Imams/Spiritual Healers on Mental Health



Despite earlier findings that many people interviewed for this research would go to their GP for help with mental health in the first instance (57%), 78% of respondents believe that the Bangladeshi community would seek help from religious figurehead/spiritual healers before their GP. Only 16% felt that people would not and 6% were unsure.



Interestingly the older females (41.7% and 30.8% female respondents in the 36-49 group and 50+ group respectively) were the highest groups of interviewees who said that the Community would go to the Gp in preference. These two groups were also two of the highest groups who would visit the Gp first, although across all age ranges the responses had been high.

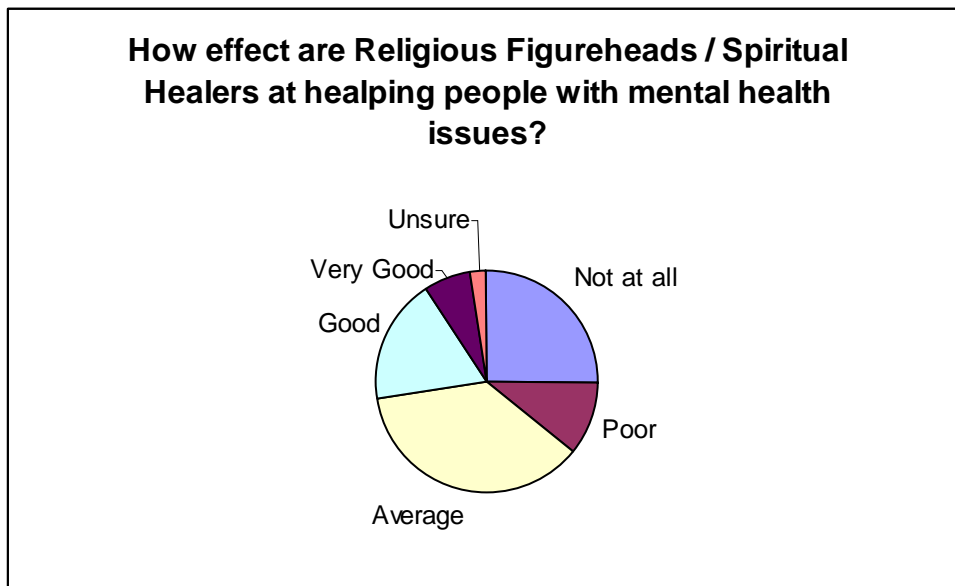
The reasons why respondents believed that the Community would seek help from Imam's and Spiritual Healers above Gp's included:

- "They believe Imams are more effective"
- "because they might be cursed by black magic"
- "because the individual doesn't distinguish a medical problem maybe they go for peace of mind, at least they've tried everything"
- "because the Bangladeshi community see mental health problems as Jadu related in the first instance, therefore, they would visit imam's who have more knowledge about this than the medical profession"
- "they may understand the Imam/spiritual faith healers more than their GP and get more help from them rather than being prescribed medication, which may help them to cope but not cure them"

From these findings, it is apparent that the perception of the level of dependency by the Bangladeshi community on spiritual healers is considerable when attempting to cure mental health problem.

This then leads onto the question of how effective the religious figureheads and spiritual healers are at helping people with mental health issues when they are consulted.

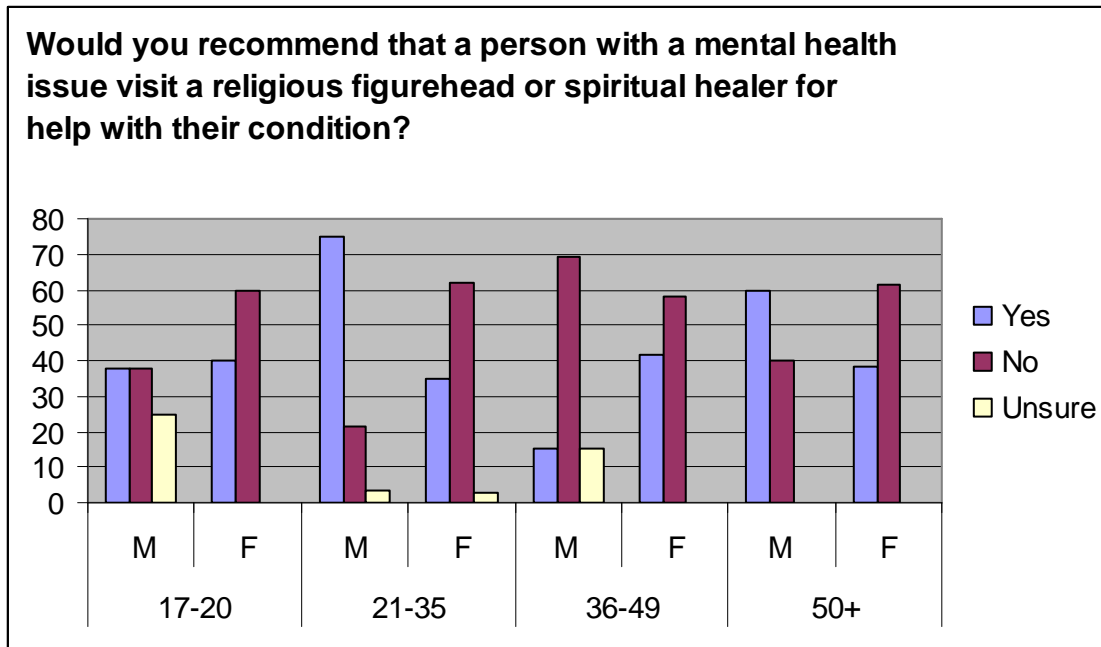
When this question was asked, the results were divergent with the majority rating the efficiency as average, but a significant number feeling that they were poor or ineffective.



Almost two thirds of the respondents felt that the help was either average or above average, but more people rated it as poor or not at all, than good or very good. Only two percent of the interviewees were unsure of the effectiveness of the help.

There was almost an equal split in the 36-49 aged males in those who felt the healers and figureheads were ineffective and those who felt they were effective, but few of either gender in the 17-21 group classed the help as below average. In the same middle age group 50% of the females felt that the help was below average. This reflects the findings of previous questions regarding whom they would go to for help, where the majority of women in this age group chose the Gp over the Imam's or Spiritual Healers.

Following on from these questions, the respondents were asked if they would personally recommend a religious figurehead or spiritual healer to someone with a mental health issue to go to for help.



From this chart it can be surmised that the majority would not give a recommendation, but on closer examination the results show an almost equal split; 45% would, 50% would not and 5% are unsure.

By far the highest number of people who would recommend them comes from the 21-35 males and 50+ males, whereas the 36-49 age group disagree. Since 46.2% of the males in this age group felt that religious figureheads and spiritual healers were effective in helping people with mental health issues this result is surprising. Similarly 80% of 17-20 age females felt the same way yet 60% of them would not give the recommendation.

Given the high numbers of unsatisfied women with the effectiveness of the leaders and healers, the results in this section for females aged 21-35, 36-49 and 50+ were anticipated.

Conclusion to Aim 3

Religious beliefs, and cultural attitude towards other factors such as Jinn and Jadu, have been shown to play a large part in the Community's perception of Mental Ill Health and the role they have in treating these conditions.

Although there was little difference in the respondent's belief in Jadu with only 0.5% more stating they did not believe in it, 58% of them do believe it can cause mental ill health. Belief in Jinn was higher at 74.1% yet only a small majority thought these beings could cause problems (48.8% to 44.3% respectively)

When it came to people's belief in the effectiveness of religious figureheads and spiritual healers in assisting in the treatment of mental ill health, the majority thought they would have a positive effect. They also believe that the Community would seek the help of these people before a medical professional. Despite this, half of the respondents would not recommend someone with a mental health issue actual visit a religious figurehead or spiritual healer for help with their condition, which conflicts with their previous answers and no reasons for these answers were forthcoming.

Aim 4

Understanding the Issues and Barriers facing a younger generation of Bangladeshi's in Sandwell with regard to their mental wellbeing.

11% of the respondents in the youngest generation claimed to either have or have had a mental health issue, but they were reluctant to state which ones. This may be linked to their observations of how their culture and community perceive mental health.

The majority of this age group felt that the culture had a very negative effect on mental ill health and that many in their community consider it 'Black Magic' and wish to hide it from others.

They consider that the factors which contribute to mental ill health include work, college, and school, with the males also listing the area lived in; parents and family; and peer pressure as playing a role too. The females disagreed, feeling that in their opinion racism, prejudice, religion, culture and the Criminal Justice System are all part of the causes of mental ill health.

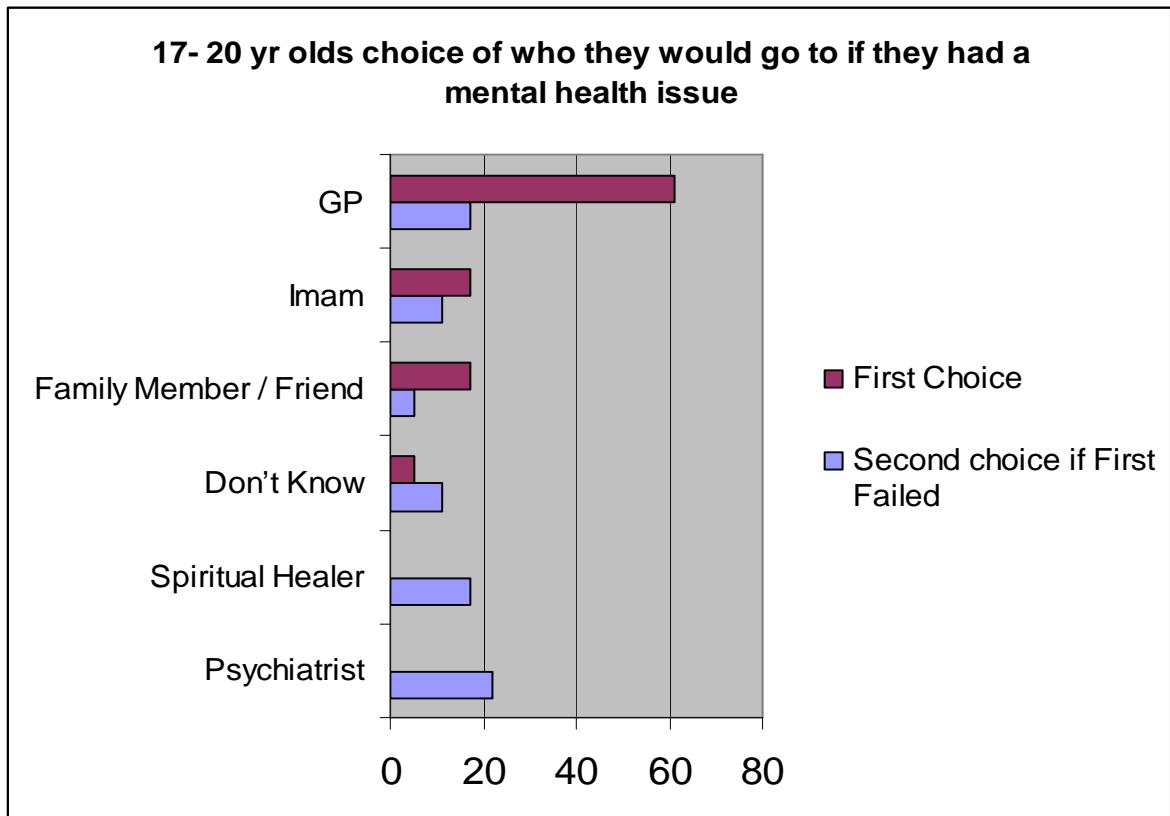
These findings demonstrate that the male and female genders differ in the majority of reasons of the causational factors pertaining to mental ill health.

If they personally had a mental health issue, the majority felt that they would visit the GP first and if this failed then the next port of call would generally be a Psychiatrist.

The results of this are detailed in the chart below.

In both instances, the Imam seems to also be an option for the respondents showing a faith in their effectiveness. However, despite a positive response to the effectiveness and the thought that the community would seek their help anyway, they also felt that they personally would not recommend visiting one with a mental health issue. This could reveal a more open approach to the medical profession from this generation.

This generation does not appear to generally believe in *Jadu* or are reluctant to admit their beliefs as the majority do think that *Jadu* can influence a person's mental health. Conversely, they are willing to admit to believing in *Jinn* possibly due to the acceptance of this belief from their culture and religion. They also state that *Jinn* can cause mental health issues.



When questioned about specific mental health conditions, the younger respondents did not recognise stress, depression, anxiety or insomnia as symptoms of poor health. This could be linked to the perception of these symptoms, by many people, as issues everyone has to deal with on a daily basis.

Given that none of the respondents sought help for their mental ill health, it is impossible to gauge the experiences of this generation of services provided for them. However, a small minority did admit to accessing some of the identified services but failed to say which ones. The reasons for this may be due to the fact that 50% of them feel unable to talk to anyone in the medical profession about their emotions or mental health.

It may be presumed from this, that an awareness raising of both mental ill health and services provided is vital for this age group, with safe forums in which to discuss any issues arising.

Service Provider Response

A service provider questionnaire was developed to obtain an informed view of how the needs of the Bangladeshi community are being met and what the channels of communication are. These questionnaires were disseminated through the Sandwell Primary Care Trust – Mental Health Promotion Team.

Statistical analysis and data grouping could not be achieved as a very low number of questionnaires were returned.

Consequently if further research is not completed on this, Commissioners will be requested to take the Community respondents views into consideration when reviewing new contracts. This will make part of the recommendation resulting from the work.

Awareness / Perception

From the information received, it would be accurate to conclude that the service providers do acknowledge the mental health needs of the Bangladeshi community. Some of the organisations provide direct services, not specifically to Bangladeshi community, but the whole south Asian community, whilst statutory service providers provide a sign-posting service through link workers.

However, the statutory service providers acknowledge that the communication channels with the Bangladeshi community are poor.

Evidence suggests that Bangladeshi community are accessing mental health services in very low numbers. This position could be improved by facilitating surgeries in community centres with interpreters. Service providers also think that prior intervention could decrease the severity of illness and some GPs' have not responded appropriately. Furthermore, those Bangladeshis that don't have members of family who speak English are at increase risk of late referral.

Service providers do think that the Bangladeshi community face specific barriers in accessing mental health service due to:

- Culture
- Language skills
- Poor service / responses from GP
- Social Isolation

To overcome these barriers and improve service provision, service providers have used interpreters to talk to individual families and GPs' and by identifying community locations where satellite surgeries may take place. Furthermore, service delivery providers do not think location hinders access to services (which conflicts with evidence from the community respondents) and that the community needs do not differ from other south Asian communities. This could be accurate as generically they are one people with similar needs. However, their services do not specifically meet the needs of the Bangladeshi community

Knowledge /Experience

Bangladeshi people are appropriately signposted to support agencies for services, and where necessary linguistic support is provided through an interpreter. If the client record is retained by the referral agencies then they are followed up.

Service providers do believe that somatization has a detrimental affect on the identification of mental illness amongst Bangladeshis especially by non mental health professionals such as doctors. Not being able to communicate emotions is an issue amongst the Bangladeshi community as well as other communities. The need for cultural awareness and somatic issues training exists especially for GP's

Youths

The factors that affect the mental health of young Bangladeshis are multi variable. Crime and drugs are particularly prevalent fuelled by lack of education and social mobility as well as employment opportunity. The mental health needs of the young Bangladeshis are not adequate as staffing the mental health workforce does not reflect the community.

Recommendations

The research has thrown up some areas for possible further work including that amongst the younger generations' experience of and specific needs for mental health services. Despite the lack of response on the personal experiences of services, it has been possible to determine other recommendations based on the responses to other questions.

1. Increase the Community's awareness of mental health.

It was apparent from the research finding that the community is not aware of the range of illness' and symptoms associated mental health; what might cause them; and how the symptoms can be recognised. A range of information sessions would target lay members of the Bangladeshi community including young people and older people. There should be a greater emphasis on health promotion to reduce the problems of somatisation.

2. National Advertising/promotion of mental health on Bengali Community TV Channels.

This is the quickest means to a mass target market. This form of communication is now preferred by the community and is much more effective than paper base promotional products

3. Community Champions – Mental Health

It is proposed that resources are targeted at developing mental health champions in the community including one for older people. These people would work across different agencies targeting specific peer groups.

4. Anonymous Bengali Helpline -

A Bengali telephone helpline could be developed, offering advice on wide range of issues concerning mental health and appropriate signposting. It would be advantageous to have Sylheti speaking advocates/advisors.

5. Local service guide to mental health – English and Bengali

Awareness of mental health issues and services across the Bangladeshi community is relatively poor. A local service guide would enable the

community to learn of the variety of services for people with mental ill health ranging from the acute to the severe form. It will advise on what action to take and the process to follow. The document will serve a dual purpose of capacity building and emotional wellbeing

6. More Bengali speaking mental health professionals

The make up of mental health teams and link workers should reflect the community (bilingual workers), thus ensuring health professionals refer people from the Bangladeshi community to the appropriate form of services. This would also enable interventions to take place in early stages of mental illness development, advocating prevention and cure.

7. Equality and cultural awareness training for professionals-

Trust between GP and patients from the Bangladeshi Community in Sandwell is very low, as demonstrated by the research finding. GPs' need to build trust with patients. GPs' and health professionals should undertake training in cultural competence and mental health issues to enable this trust to be developed.

8. Service Provision Development-

Closer ties should be fostered between link workers, front line staff and Community Mental Health Teams. The Bangladeshi led voluntary sector organisations in Sandwell could act as intermediaries. This would also enable community organisations to refer people to mental health services breaking down the barriers to access. This would be an innovative approach to access development.

9. Greater working relations between community and statutory sector agencies-

There are a number of voluntary and statutory sector organisations delivering mental health projects. However, in the Sandwell area none are very proactive in attempting to improving access to their service. Community and Voluntary organisations, with the support and backing of the statutory sector, should promote outreach as the central theme to promote mental health services. This would ensure that people know what type of services are available and

their location. This would address the issue of lack of awareness amongst potential service users or carers.

10. Religion orientated models of service

The belief in Jinn's and Jadu is quite strong within the community. Whilst many may not acknowledge their existence, the belief is very strong. The proposal is to develop a culturally sensitive outreach project to disseminate information on Jinn possessions and Jadu through the Mental Health Trust, with a dedicated and knowledgeable worker in post. The project should be able to take referrals from doctors and health professionals for those individuals who wish to talk about these issues and advise on appropriate courses of action. The aim would be to pick up people at early stage of developing common mental disorders, which leads to isolation resulting in severe forms of mental health problem.

11. Respite care for Bangladeshi elders through community organisation- Day Care Centre.

Developing a respite care programme would enable the older generations to come out of their environment and meet and talk to others about concerns and issues. This could be then be used as a means of support group whilst releasing carers to either become economically active or progress in to learning. This will address some of the issues surrounding family problems and other such related issues. Furthermore, it could act as a vehicle to providing care in the community.

Appendix 1

UCLan Core data

<u>Respondents by Age Group</u>	<u>Male</u>	<u>Female</u>	<u>Total</u>
17-20	8	10	18
21-35	28	37	65
36-49	13	12	25
50+	10	13	23
Total	58 (44%)	73 (56%)	131 (100%)

<u>Respondents by Age</u>	<u>Total:</u>
15 or under	0
16-18	9
19-21	13
22-24	16
25-29	18
30-39	41
40-49	11
50+	23
Total:	131

<u>Gender</u>	<u>Total No:</u>
Male	59
Female	72
Transgender	0

Were you born in the UK

<u>Yes</u>	<u>No</u>
48	83

If not, how long have you lived in the UK

	<u>Less than 1 year</u>	<u>1-5 years</u>	<u>6-10 years</u>	<u>11+ years</u>
<i>Number of respondents</i>	3	5	12	63

Citizenship Status

	<u>British Citizen</u>	<u>Asylum Seeker</u>	<u>Refugee</u>	<u>Other (Bangladeshi)</u>
<i>Number of respondents</i>	115	0	0	16

Religion

	<u>Number of Respondents</u>
Muslim	131

Do you have a disability

	Yes	No
<i>Number of respondents</i>	4	127

Sexuality

	Lesbian or gay women	Homosexual or gay man	Heterosexual or straight	Bisexual	Not answered
<i>Number of respondents</i>	1	0	126	0	4

Appendix 2

Respondents understanding of Mental Health; A selection of responses:

Age Group 17-20:

Male

- “it’s the way you think, the way it affects your normal life”
- “when someone is not fully able in their mind”
- “ when someone is not in control of their mind and they have no idea of what they are doing”
- “everyone has got a part of mental health in them just can’t see. Physical health –break arm , you can see, but mental health you can’t. I am ware of it”
- “someone who is crazy, has a problem with controlling their emotion”
- “Crazy”

Female

- “it is a state of mind that may develop due to major problems one is/has experienced. Some cases of mental health may be due to hereditary cases or disease and can be treated accordingly”
- “any illness occurring from within”
- “mad people”
- “stability of the mind”
- “mental health is certain behaviour that are associated with the mindset. It has a negative association to it.

Age Group 21-35:

Male

- “an incapacity to process thoughts properly or what is considered normal” 34 yrs
- “how happy or stressful a person is feeling Mental health is a wide range of things from not being able to cope with day to day living to more severe forms as harming your self”
- “someone who is ill”

- “someone who is physically well but not well in the mind who suffers from depression”
- “not very much”
- “Don’t Know”
- “its god given and will heal or will get better in due course”
- “I’ve never thought about it”
- “it’s a shock in life”
- “people with problems – mentally and physically”
- “what creates it. Symptoms. Cause of mental health are many. All relate well-being and health. Vast area, can not be answered concisely. Very difficult to talk about its not like a headache don’t you know”

Female

- “if you have a peace of mind everything is well”
- “being unwell. More pressure of family”
- “I am a carer. Everyone different. Some are one way, others feel different way. Family stress”
- “tension and pressure”
- “worries and problems”
- “like a brain disorder, people act weird and different from everyone else”
- “mental disorder resulting from stress, anxiety and most likely financial difficulty and inability to cope with the day to day life”
- “bad things”
- “someone who has special needs”
- “Someone who might be depressed or in extreme cases, schizophrenia. I believe that any mental health issue originates from not being able to talk about problems or in severe cases start from childhood”

Age Group 36-49

Male

- “someone who suffers from the disease of the brain”
- “mad, slow, deranged”
- “I don’t know. I don’t understand the term”
- “its not good”

- “it can be something which originates in your head”
- “problems associated with the mind, stress, worries, anxiety etc.”

Female

- “depression”
- “not very much”
- “tension. Way people feel. Everyone has different mental health issues. Mine relates to my home, family. This falls on women. A man doesn’t know what is in the home”
- “its linked to your mind. How you deal with And see things. Sometimes people worry so much they fall ill. They loose faith in getting better”

Age Group 50+

Male

- “I think it more to do with Black Magic”
- “I have liver problems which causes me a lot of worries regarding health. My understanding of mental health I think is caused mainly by physical health”
- “a persons brain problems”
- “good”
- “its something very bad. Worrying, stress is very bad”

Female

- “some people have worries. Lead to illness”
- “I think it is an illness in your head or mind because you can’t see the signs. People may think it doesn’t exist or you are making it up. Because the can’t see it like if you broke your leg for example”
- “don’t know”
- “it is an illness that affects your mind and your ability to function. From this illness many other illness form”

The PROJECT TEAM:

The following people were involved in the development, delivery of this project:

AJIB HUSSAIN – 23 years old. A recent graduate of Wolverhampton University with a degree (BSc [Hons]) in Computing Information Systems for Business. Ajib was employed on this project as a community researcher for his bilingual ability, IT skills and his desire to learn and acquire new skills. He has excellent communication skills and also wanted to contribute and develop his understanding and needs of the wider community. Ajib had no previous experience of working in or with the community. Through his involvement on the project Ajib has gained valuable experience such as developing the questionnaires, making public presentations, translating and undertaking field research. Ajib has also undertaken the university's accredited qualification in Community and Mental Health Research. In addition to his employment on the project Ajib works for House of Fraser. He has also worked in IT with Perceptive Informatics and IBM.

SALEHA BEGUM – 29 years old. Was unemployed after working on the SHEBA project – a community based women's empowerment project based in North Smethwick. She has also been involved in running some young girls group at the North Smethwick Resource Centre. Saleha is a mother of 3 children and a member of the Smethwick Bangladeshi community. She brings with her experience of community engagement work and locality knowledge. Her command of the Bengali (Sylheti) language was of significant value. Although she had no previous experience of health or social care but had knowledge of the community and their needs. She has been involved in developing questionnaires, conducting interviews and field research. She is also undertaking NVQ level 3 qualification in childcare.

NICOLA BEGUM – 26 years old. Nicola is a Graduate of Coventry University with a Degree in Psychology and the project lead researcher. Although Nicola had limited experience of community engagement work she understood the concept and adapted to the role very quickly. Nicola was primarily responsible for the day to day running and updating everyone with developments. As the lead researcher, she assumed the responsibility (with other members of the team) for developing the questionnaires and writing the ethics proforma. She was also given the responsibility for communicating with UCLan support worker, CSIP lead.

DUNU MIAH – 36 years old. Much of Dunu's work involve the day-to-day management and co-ordination of research and information gathering, contributing to strategy and policy development, delivery planning, stakeholder engagement, mapping, evaluation studies and preparing funding applications.

Presently Dunu is employed as a Community Development Officer (with responsibility of health development work) at SBYF with considerable experience of business and management. Over the last 8 years he has also acquired experience of working in the community and voluntary sector organising a number of seminars and conferences to discuss the role of Bangladeshi community in contemporary British society and the contribution and role of statutory agencies. He is presently involved with several projects; Benchmarking and Analysis of Bangladeshi Hospitality Sector

Training Needs, Sandwell PCT-CHN: BME Strategy, Health Promotion and Needs Analysis for Sandwell Bangladeshi community and developing successful funding applications.

His contribution to this project has been in co-ordinating and managing the research team, analysis of the data and writing of the report, liaising with the statutory and voluntary sector agencies to seek support and endorsement of the project and arranging interviews.

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