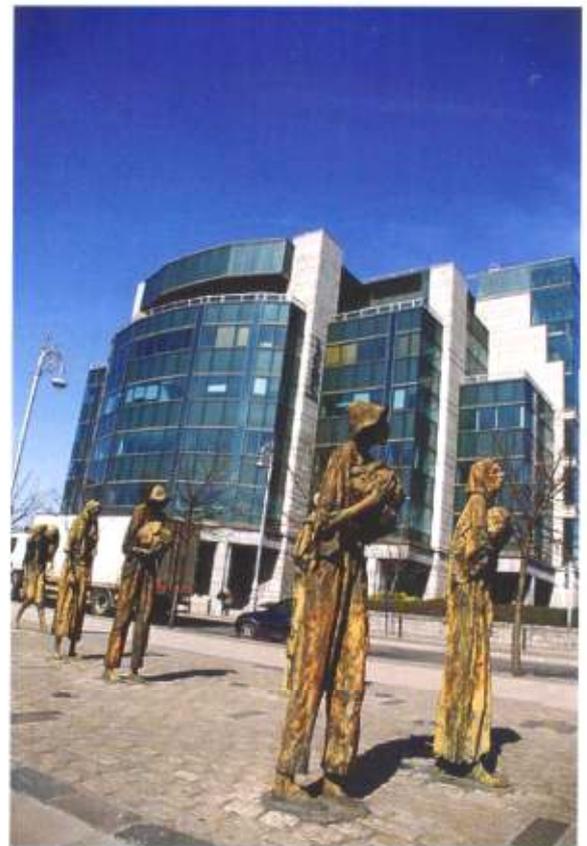


# CSIP COMMUNITY MENTAL HEALTH RESEARCH REPORT

## Inequalities and Cultural Needs in Mental Health Service Provision for Black and Minority Ethnic Communities in Liverpool



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## Researcher Profiles

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

### **Valerie Gray**

I am forty-five years old and was born in Liverpool. I worked in the catering industry for many years while my son was growing up. Following this I worked in a residential care home for the mentally ill. While there I completed a Level 2 Course in Health and Social Care and gained certificates in Working with Vulnerable Adults, Health and Safety and First Aid. I am planning to continue my education with a University course.

Two years ago I became a volunteer with ICCM and have found working within the community very rewarding. This is what has led me to become part of this project. I would like this piece of research to benefit all Liverpool BME groups including our Irish and Irish Traveller community. Culturally sensitive Mental Health Services can help reduce inequalities in the delivery and support of care.

### **Alex McCurdy**

I am thirty-five years old and was born in Belfast, Northern Ireland. My family and I moved to County Antrim to escape the troubles in Belfast. I have three brothers and two sisters. My youngest brother has learning disabilities and has used various Mental Health Services.

I have also accessed Mental Health Services whilst living in Belfast.

I moved to Liverpool in 2003 and became a volunteer for ICCM. I enjoy this work and the time I spend in the community. I am very interested in this project and would like to see changes and more cultural understanding in our Community Mental Health Services.

Our research work could make a big difference to all three groups involved in this important project.

### **Mary O'Reilly**

My name is Mary O'Reilly and I have been bi-polar all of my life. Many members of my immediate and extended family have the same condition. I am Irish and have lived in Liverpool for 10 years having come here to do post-graduate study. My background is in education and training.

I am committed to service user/carer involvement in all areas of health provision. I work with Mersey Care, our regional Mental Health Trust, and with Imagine, a Liverpool Mental Health Charity on many different projects. These include the delivery of Mental Health Awareness training to the general public, staff development training for Nursing Assistants and lecturing on Mental Health Nurse training courses at two local Universities.

My hope is that this research will not only identify the sources of inequality in both access to and delivery of mental health services to ethnic minorities, but that it can be a driver in effecting real positive change in attitudes and services.

### **Ginnie Ip**

At the moment I am working part-time as a youth and Community Worker at the Pagoda Chinese Community Centre. I also do private teaching in various

subjects-piano, English and maths. In the past I have worked as a book-keeper, a secretary for the Chinese Health-link Workers Project and an assistant in the Pagoda Chinese Youth Orchestra. I have been working with the Liverpool Chinese Community since 1984 and have contacts with lots of different people.

### **Zhen Ming Wang**

I have been working in the Pagoda Chinese Community Centre in Liverpool as a Bilingual Employment and Training Officer for 6 years now. My job role is to give information, advice and guidance service to people and help them to develop their career and learning goals. Recently, I am lucky to have a chance to engage with the CSIP Mental Health Project, as a researcher, which is a great opportunity for me to explore and understand more about the needs of our Chinese elderly, their difficulties and barriers and find ways to help them to overcome these. This is a very meaningful and exciting nationwide project.

### **Essie Li**

I was delighted to becoming a member of the project which allows us to collate first-hand information from the community members hence to improve the public's quality of life, and to provide a more thorough understanding of different community groups. I joined Merseyside Fire & Rescue Service (MFRS) in 2005, started with the Community Fire Safety Department; then was seconded to the World fire-fighters Games 2008 (small Olympics for fire service personnel across the world to take part in over 70 events) team from October 2006, to deliver a series of novel and sports activities, to try to make the community healthier, stronger and safer.

Before joining MFRS, I was studying Psychology and Research Methods & Statistics (in Psychology), with the University of Liverpool. The courses and the placements gave me enormous experience and knowledge which highly benefit me in many respects, both at work and personally. I sincerely wish this project would be a great success.

### **Ruth C.Y. Chan**

As a Registered General Nurse and Registered Midwife, promoting health awareness among the Chinese community has been my interest since my arrival in the UK. I also hold regular health surgeries at the Pagoda Centre since 1982 and have helped to organise Health Fairs and Health related talks at the Pagoda Centre. Working as a Community Midwife has giving me the opportunity to have a good insight into the life of the Chinese community and better understanding of their isolated lives because of the language barrier. My involvement with the CSIP Mental Health Project will enable me to fully understand the needs of the elderly

At the moment I am working part-time as a youth and Community Worker at the Pagoda Chinese Community Centre. I also do private teaching in various subjects-piano, English and maths. In the past I have worked as a book-keeper, a secretary for the Chinese Health-link Workers Project and an assistant in the Pagoda Chinese Youth Orchestra. I have been working within Liverpool Chinese Community since 1984 and have contacts with lots of different people.

**Karen Li**

I am a busy mum, currently developing an internet based business, and studying Humanities and Classics part time. My career path has been varied and rather convoluted by design, as my family life has always been a priority.

I have a background in Nursing and Health Promotion. As a Health Promotion Officer, my remit was women's health issues pertaining to women from ethnic minority communities. This position also involved participating in a Department of Health funded study examining health attitudes and perceptions of women from minority communities.

I managed a busy medical office in Canada. I am aware of mental health issues, and have worked in the field of Psychiatry. I enjoy meeting and working with people from different backgrounds.

Having grown up and resided in the Liverpool area for over thirty years, and being a child of immigrant parents, I am cognisant of the many issues facing the Chinese community and Chinese seniors. My voluntary work experience has reflected some of my interests and social concerns. I have been an advisor with the CAB (Citizens' Advice Bureau), a Lay Visitor with Merseyside Police, a member of Wirral Community Health Council, a volunteer at the Pagoda Chinese Community Centre, and a volunteer with a mental health charity in Canada.

Other interests are travelling, hiking, skiing, boogie-boarding, snorkelling, reading, and trying different cuisines.

**Helen Yee-Hung Owen**

Helen Yee-Hung Owen, married with 3 children. Born in Canton, Quang Zhou, China and lived in Hong Kong until the age of 11 years old. Came to join father who was working in UK. Later was joined by mother and other siblings. Helen has been working in the Chinese community in Liverpool since 1980 as a Chinese Community Worker, soon after that, she became the Co-ordinator for the Vietnamese Refugee Resettlement Programme. The post involved assisting the Vietnamese Refugees in all aspects of relocation and settlement in Liverpool.

In 1985, the Merseyside County Council appointed Helen as a Senior Chinese Community Worker, and in April 1986 Liverpool City Council, Liverpool youth service employed Helen as Project Co-ordinator, up to the present.

Helen organised the 8th National Chinese Mental Health Conference in Liverpool in 2002. She is the Secretary of the UK Association for Chinese Mental Health and a Trustee member of the Merseyside Chinese Community Development Association, and a committee member of Pine Court Housing Association. Helen is a qualified bilingual counsellor, mentor and British Sign Language level 2 (B.S.L) signer. Her most recent research work is for the National Museum of Liverpool on the Moving Here Project, which is a national project. Helen is also a trainer for raising awareness of the needs of the Chinese Community

Helen is a member of the reference group for the Delivering Race Equality in Mental Health Care in Liverpool and a member on the Focussed Implementation Buddy Site. (FIS)

### **Breege McDaid**

I was born in Co. Donegal in the North West of Ireland. I have lived in Merseyside for over twenty years now. I have worked within the Irish voluntary sector for (dare I say it!) twenty years, working at Irish Community Care Merseyside (ICCM), firstly as a community care worker, then in a community development role. My current role is Director of ICCM.

I have been in the very privileged position of working in partnership with both the Irish and Irish Traveller communities, service providers and funders to develop a range of information, advice and outreach services at Irish Community Care Merseyside to meet the needs of our communities.

My involvement in the UCLAN project has been a very interesting and thought provoking experience, working with people from different communities and agencies and many different life experiences. I would like to thank the fantastic people involved in the project:

- Our community researchers, administrators and research supervisors who have undertaken a mammoth task and have risen to the challenge very well
- Our Co-ordinators who have kept us on track over some quite fraught situations
- Our Steering Group members who have demonstrated commitment to taking forward the recommendations of the research
- UCLAN who have been central to the funding and ongoing support of the project
- Our communities who have given freely and generously of their time to share their personal experiences through the questionnaires and focus groups.

Go raibh míle máith agaibh go léir (Thank you all very much)

### **Ita Therese O'Keeffe**

I am from rural Ireland, and I've lived in Liverpool for 14 years. I've used mental health services in both countries. Depression was the bane of my life, but I've learned how to manage it and really enjoy life now. I'm glad that I've been able to use my experiences in a way that encourages other people who are going through some of the same stuff I went through.

I've worked at everything from farming to lecturing in sociology, and have done a lot of research into community and mental health issues. I'm self-employed, now which is great. And I have some fantastic friends. I'm a passionate environmentalist and have done a lot of campaigning in this. When I'm not working I love running, reading, cycling and, most of all, heavy metal.

**Ewan Roberts**

I am originally from Glasgow having moved to Liverpool in the early 80's and worked at sea for nearly 20 years before coming ashore to get a proper job. I have worked with Asylum Seekers since 2000 and managed ALM for the past 3 years.

Asylum Link sees around 2000 Asylum Seekers per year, many of them suffering deep seated anxiety and depression. The chance to find out more about the people we look after is something which can only improve the way we work and is one of the main reasons we engaged with the project. Meeting other groups and developing better understanding of the problems they face, is another positive outcome from the programme, which allows us to see people, not in terms of the labels society gives them, but as paid up members of the human race. The challenge is to enjoy the differences which make us the individuals we are, and not to be frightened by them.

**Sarah Senveewo**

My name is Sarah N.B. Senveewo. I am a Ugandan National. I am a Refugee and a volunteer at Asylum Link Merseyside. I have been with ALM since 2005 when I was an Asylum Seeker and they have been absolutely great with me.

I worked as a nurse in Uganda for over 15 years in Kampala for the City Council Health Department. I trained as a Health Educator working with communities from grass root/village along the district level. My duties were community mobilisation and education. The main aim of this project was to encourage people to realise their health problems so that they can willingly help improve the services that are provided. I also participated in the world immunisation programmes to eradicate polio and measles in children under the age of five. And I was also a data collector for health surveys in Uganda.

**Faridah Sentongo**

I am from Uganda. I have lived in the UK for almost five years. I have a diploma in Tourism, and a certificate in computer skills.

I am a mother of one. I enjoy listening to music, watching movies and spending time with my daughter. I am currently a volunteer at A.L.M. I am very much interested in this research about Mental Health as I believe it would benefit people from my background.

**Grace Florence Nazziwa**

I am from Uganda. I have a Bachelor of Arts Degree from University in Uganda in Economics and Sociology.

I participated in HIV/Aids Health Research in pregnant women and children. The main objectives were to protect the newly born babies and create awareness of HIV/Aids in rural areas. I have also carried out voluntary work with several churches dealing with young orphan girls.

I am extremely excited about taking part in this research as it will improve my knowledge and skills. I do hope that the knowledge acquired will bring about positive changes and improvement in the life of the BME community at large.

**Ben Kamara**

I am from Sierra Leone West Africa. My parents emigrated to United States where I grew up and attended High School and University. I came to the UK 5 years ago, lived and worked in London for about 3 years, then moved to Liverpool. At the present moment I am a case worker at ALM and a law student at Liverpool John Moore's University. I am also the co-ordinator for this research project. We see between twenty to thirty Asylum Seekers a day with problems ranging from accommodation, immigration and issues like finding a GP. This research has enabled me to look beyond surface issues like immigration, but explore more in depth problems that Asylum Seekers face from day to day. I am honoured to be a co-ordinator and hope this research project will change the attitudes towards Asylum Seekers and help enhance and improve services to the BME community.

**Pauline McGrath**

I was born in Germany, but raised in Dublin Ireland. I came to North Wales to study for my degree - a BA Hons in Sport Science - which I completed in 2001. In 2002 I moved to Liverpool and started to work for Irish Community Care Merseyside (ICCM) . My first post with them was as a Homeless Outreach Worker. Since then, with the support of ICCM, I have gone back into education to re-train as a Social Worker. I will be completing this four year course in June 2008.

I currently work as the ICCM Suaimhneas Project Co-ordinator. This involves co-ordinating two outreach projects and allows me to build on my management skills. I have been privileged over the past five-six years to work with our Irish and Irish Traveller communities. We have enjoyed the good times, coped with the bad and come out the other side living life to the full.

**Denise Wong**

I have two children and I am polite and friendly and enjoy roles where I can meet new people. I think it is very important to treat people with respect and I get a great deal of pleasure from my work as a researcher for the Chinese Community. During the research project I learnt a lot and it was very enjoyable. Now the project is complete I would like to do some charity work or obtain a job in the Chinese Community.

## Acknowledgements

**The Liverpool project would like to thank the following agencies and individuals who supported the work of the project:**

- The National Institute for Mental Health in England for funding the Community Engagement Programme
- The Centre for Ethnicity and Health at The University of Central Lancashire for managing and supporting the project.
- Nadia Ahmed – Support Worker for the Centre for Ethnicity and Health, University of Central Lancashire
- Jan Uddin – University of Central Lancashire
- Manjeet Singh – CSIP Regional Lead for race equality
- Doctor Joseph O’Neil-Liverpool GP with a specialist interest in the groups involved, and who brokered the original partnership
- All the men and women who gave up their valuable time to complete the questionnaire. Without them this project would not have been possible.

**The Steering Group members who have supported and guided us.**

- |                       |                                    |
|-----------------------|------------------------------------|
| • Nadia Ahmed         | Support Worker/UCLAN               |
| • Ben Kamara          | Coordinator/ALM                    |
| • Breege McDaid       | Director/ICCM                      |
| • Pauline McGrath     | Suaimhneas Project Coordinator     |
| • Melusi Ndebele      | PCT Community Development Manager  |
| • Ita O’Keefe         | Project co-ordinator/ICCM          |
| • Dr Joseph O’Neill   | Medical advice and PHQ9 training   |
| • Helen Owen          | Chinese Project Co-ordinator/MCCDA |
| • Jackie Patiniotis   | Joint Forum Development Worker     |
| • Afrah Qassim        | PCT Community Development Worker   |
| • Ewan Roberts        | Manager/Asylum Link Merseyside     |
| • Peter Trigelgis     | Volunteer ALM                      |
| • Philomene Uwamaliya | PCT Community Development Worker   |

**The work was undertaken by the community researchers who were also members of the steering group.**

- |                  |                   |                  |
|------------------|-------------------|------------------|
| ❖ Ruth Chan      | ❖ Valerie Gray    | ❖ Ginnie Ip      |
| ❖ Essie Li       | ❖ Karen Li        | ❖ Denise Wong    |
| ❖ Alex McCurdy   | ❖ Pauline McGrath | ❖ Grace Nazziwa  |
| ❖ Ita O'Keefe    | ❖ Mary O'Reilly   | ❖ Zainab Saleh   |
| ❖ Farida Sentogo | ❖ Sarah Senveewo  | ❖ Zhen Ming Wang |

### **Our special thanks to**

- Maggi Green – Volunteer coordinator at Asylum Link Merseyside - for organising food and refreshments
- Amir Ebrahim and Shaban Taher – service users at Asylum Link Merseyside - for cooking.
- Father Peter Morgan for providing the premises at Asylum Link where most of the meetings took place and for being so much more than just a landlord.

## **Executive Summary**

This project engaged three widely differing community organisations i.e. Asylum Link Merseyside (ALM), Irish Community Care Merseyside (ICCM) and Merseyside Chinese Community Development Association (MCCDA). It tasked them both collectively and individually with working together to identify the difficulties associated with accessing mental health services. It also sought solutions to these difficulties. The project was challenging, time consuming and rewarding. The aims have been realised and are set out briefly in this summary.

This Community Engagement Project (CEP) we undertook was one of forty national projects undertaken in 2007/2008 under the initiative of Delivering Race Equality in Mental Health Care funded by NIMHE and managed and supported by the University of Central Lancashire (UCLAN). The projects, carried out by Service Users themselves, provide detailed needs assessment information to steering groups comprising key local stakeholders. This enables service improvement as part of local delivery plans. The overall aim is to effectively improve the design and delivery of mental health services in accordance with the 12 key areas highlighted in the Delivering Race Equality in Mental Health Care Action Plan (DoH 2005).

Our project looked at the mental health experiences of specific Black & Minority Ethnic (BME) communities living in Liverpool i.e. Asylum Seekers and Refugees, Irish and Irish Travellers and Chinese Elders. It was unique as it involved three different community organisations presenting a collective voice through the research report.

What was obvious at the beginning of the project was how few, if any, of the Service Users in the respective communities had ever been consulted on their experiences of mental health services including access and suggestions for improvement. The experiences of the three groups, with one or two exceptions, were very similar, despite the huge differences in background. This is not to say, however, that it is possible to have a 'one size fits all' approach. In fact the opposite is true.

Another startling fact was that many individuals, who according to the Mental Health Screening Tool PHQ9 score indicated an existing mental health issue, yet had not sought help. Clearly the needs of these individuals have not been addressed, and many distressed people continue to slip through the net.

This report identifies three main areas for improvement:

### **1. Provision of Information**

Information needs to be universally available, in translated form if required, and suited to the needs of the community accessing it. It needs to be available in a wide variety of places and should describe the services offered and details on how to access them. The information should be tailored to local services in each area.

Proper account needs to be taken of people's need for spoken information. This applies to people who prefer and can assimilate information this way, people who may have literacy difficulties and people for whom English is not their first language. This could be facilitated through face-to-face contact with support workers and also through video in waiting rooms and community spaces. Many people requested information via TV and radio. There is a need for further research into the most effective ways of disseminating information.

The information needs to be widely available at all points in a journey through life from the most casual to the most critical scenarios and encounters i.e. transition, arrival, meeting places, or where people naturally go to access support, advocacy or help.

## **2. Access through Community Based Support**

All the research teams uncovered a need for:

- Quicker and more flexible ways of accessing services
- Making people aware of systems of referral and access to services
- Knowledge of what services are available

The consensus view is that this can best be achieved by health professionals, working in partnership with community organisations. This will ensure immediate access to care, support and advice for Service Users. Advice and guidance can also be provided to staff and volunteers working alongside the health workers.

It is essential that people have immediate access to services at time of need. A system of self-referral needs to be available through a 24/7 Crisis Service - one which is not based merely on access to Accident & Emergency Departments in local acute hospitals.

## **3. How Care is Explained, Planned, Delivered and Followed Up**

People need to have their illness and treatment clearly explained to them. They need to know the possible side effects of medication and be made aware of alternative treatments. Service Users must be integral to the drawing up of care plans and need to fully understand what their care plan means. When all these things happen, unsurprisingly, people's experience and perception of their care is vastly improved.

Health care professionals i.e. psychiatrists, psychologists, GPs, nurses, secretaries and receptionists, need to develop a much better understanding of the specific cultural needs and experiences of BME communities they provide services to. There are no shortcuts and all health professionals must be prepared to take more time to understand, empathise and work competently with BME communities.

Mental Health Trusts and Service Providers need to embed quality cultural awareness, sensitivity and competence training as part of both their staff induction and ongoing professional development programmes. The impact of comprehensive quality training cannot be over emphasised.

This research project has been an adventure into the unknown. This applies not only to the researchers from the three community organisations - consider how people from Kampala, Cork and Kowloon, all sit down together to work out the common questions to be asked of their communities - but also for the managers, staff and volunteers who have hitherto concentrated on their own communities.

The partnership work across the communities has built friendships and developed understanding. This could be mirrored in the way our society meets the needs of BME communities. It has also been very hard work. This project would not have been undertaken if there had not been a screaming imperative for change in the way mental health services are delivered to take account of the needs of vulnerable groups or individuals who are voiceless within our society. Given the day-to-day requirements of serving their communities, the effort made by the organisations to complete the report has been extraordinary.

The recommendations made by the communities have Equal Opportunities and Empowerment at their heart. For us this does not mean treating all people the same, but addressing differences and providing individuals with appropriate support to allow them equal access to the services available to the rest of society.

What has become clear, as the research has progressed is that we are not covering new ground. The research has highlighted that the Black and Minority Ethnic communities involved want to see actions from consultations with positive outcomes. There comes a point where it is no longer appropriate to ask questions of people, without some form of concrete action taking place. We have long since reached that point.

# Summary of Research Background and Findings

## The Focus of this particular report

The focus of this report on the Community Engagement Programme is the experiences of Asylum Seekers and Refugees, Irish and Irish Travellers and Chinese Elders. The objective of this work is to improve the quality of access, experience and outcomes for the above communities accessing mental health services.

Through the project teams experience of working with our communities we have gained understanding of and gathered information on their needs. We have also highlighted the skills, qualities and resources necessary to our individual organisations in order to deliver services that are culturally appropriate and accessible to the diverse groups.

## Aims and Objectives of the work

Our research set out to examine the extent to which the issues identified in the 'Delivering Race Equality in Mental Health Care' action plan (Department of Health 2005), had relevance for BME communities in Liverpool and if any concerns were specific or different. Our intention was to examine these by collecting data from BME communities to ascertain:

- Access to mental health services in Liverpool
- Attitudes to mental health services in Liverpool
- Level of satisfaction with mental health services
- Experience of the range of therapies, support and treatment available in Liverpool

## Project start-up and Researcher background

The 14 researchers represented three groups within the BME communities and were recruited from within those communities. Their cultural background fell into one of the following experiences:

- Born or came to Liverpool with parents or family seeking new opportunities
- Came as adults, from home country, seeking refuge from war, conflict, or persecution
- Came as adults with husbands working in professional occupations in the UK, or for further education

The Community Research Group met regularly in the summer of 2007. We made several trips, as a group, travelling together to the University of Central Lancashire (UCLAN) and also to training in Wigan. We attended workshops, networking events with other research groups, group learning, training and

development sessions with the researchers eventually attaining research qualifications. At the start, the researchers came together to agree the research focus, develop questions and agree a format for gathering and recording data. Later, the data we collected from the research was analysed and shared, to arrive at our recommendations for promoting change. We learned the procedures and protocols of academic research during the workshops.

## **Data Sample**

Questionnaires were completed by 104 members of the BME communities aged 18 – 97. There were (47) male and (57) female. Apart from the Irish or Irish Travellers, only one respondent had English as their first language. All Irish or Irish Traveller participants had a previous known history of mental illness. Asylum Seekers and Chinese participants did not necessarily have a previous recorded history of mental illness.

The interviews were carried out with 33 Irish or Irish Travellers, 33 elderly Chinese people and 38 Asylum Seekers and Refugees, from a very diverse set of backgrounds. Focus groups were also conducted by ICCM and MCCDA. People's ages ranged from 18 to 97 and participants came from 29 different language or dialect groups. Within the religions, Christianity predominated, however Islam, Buddhism, Taoism, Ancestor Worship and Paganism were all present.

## **Key Findings**

### **GP Services**

The research results indicate that GPs are the first point of contact with mental health services. The rapid allocation of a GP is therefore crucial.

GP's and primary care staff do not always have up-to-date knowledge on the impact of stigma and discrimination around mental health issues in BME communities. Knowledge of culturally appropriate services in their area is often lacking making appropriate referrals for support and treatment problematic.

It was also found that persistent physical ailments were not always identified as being linked to mental illness.

### **Delays**

There are considerable delays between being referred by the GP and actually seeing a mental health specialist.

### **Feelings of shame and stigma**

Shame, cultural differences and stigma play a major part in the way BME communities view mental illness. Specific stigma around immigration status, language barriers, fear and cultural differences, were the greatest barriers to

the Asylum Seeking and elderly Chinese communities. With both the Irish and Irish Traveller population the quality of the services available, difficulty of access to them and the manner in which they were treated on both a social and clinical level were problematic.

The research suggests that lack of empowerment and knowledge perpetuate negative attitudes towards mental illness, and its identity as a 'taboo' or 'unmentionable' subject.

### **Lack of knowledge**

Few participants had knowledge of mental health services or how to access them.

### **Broader issues**

Separation, employment and accommodation issues, poverty, status and threats of deportation all contributed to feelings of being anxious, depressed, isolated and lonely.

## **These are a selection of comments from research participants:**

### ***Memories of Experiences***

*'When I was 16 I went to my GP. He put me on anti-depressants. I did not go back. He did not seem interested and was not helpful. I did not know that I was depressed. I had no energy, and I did not know that he prescribed me anti-depressants. I took them for 28 days and the feeling eventually went'*

*'I tried to kill myself – coping with a sick mother and brother – running to meetings about the site and incomers – going to court against the council.'*

*'No one had time to listen to my problems in the hospital. The only ones who got attention were the ones who were on close observation or who were very disruptive. There was one really nice nurse who did listen but she was generally too tied up with the hectic ward life to have time to listen to the quieter patients. I never saw the consultant the whole time I was there'*

*'I was brought into the Royal later as an emergency, they decided because of my strange presentation (disordered balance and speech due to epilepsy and Acquired Brain Damage) that my problem was solely drink related. They had security escort me out of the hospital at 10 past midnight with my injured face only half treated and without any money to get back to the hostel.'*

*"I had a bad experience, been 5/6 times to A & E (suicide attempts) they gave me loads of leaflets, but I cannot read or write. I was referred to a GP, seen as an alcoholic'*

*'Talking, talking, and more talking. No help at all, seeing different people all the time and explaining over and over again'.*

*,..... as an outpatient, during a period of two years I saw 6 different locums. One of these sent me back out on to the streets in a suicidal state. For the past couple of years I've been lucky enough to have an excellent consultant.'*

*'Did not see stress as a mental health problem'*

*'Fear of others, and cannot speak English'*

*'Fear of possession by evil spirits'*

*'Belief in alternative medicine'*

*'Being judged by my past drug history'*

*'Had a bad experience in the past - I was afraid of looking for professional help'*

*'Stigma of being an Asylum Seeker'*

*'Thought that I had asked for so much, I couldn't ask for anymore'*

*'Doctors didn't understand me when I told him I was anxious, thought it was normal, almost committed suicide upon receiving my refusal letter from Home office'*

*'I was too upset to talk about anything'*

*'Did not know how to access GP, NHS and statutory services'*

### **Expressed Wishes**

*'Information of routes into mental health services'*

*'Have my illness explained to me'*

*'To see the same person each time as they already know my problem'*

*'Side effects of medication explained'*

*'Proper care planning'*

*'24 hour mental health crisis service'*

*'Self referral when help is urgently needed'*

*'Interpreters who speak a range of Chinese dialects'*

*'To advertise services on TV and radio'*

*'Less time waiting for appointments'*

## Key Recommendations

- Local Commissioners to resource the development of appropriate and responsive services.
- Well publicised easy to access mental health services.
- Comprehensive training for people working in community organisations regarding services available and the access route to those services.
- Ongoing comprehensive training for all health professionals involving all aspects of cultural awareness, sensitivity and competence.
- Partnership work between professionals working in mental health services and community organisations working with Service Users, to deliver appropriate mental health services to minority communities.
- Information that is universally available in easily understood written, spoken and translated form.
- Community counsellors or support workers, who are easily accessible, culturally sensitive and based in the community.
- Services need to recognise the individuality of each Service User, whilst acknowledging the possible impact of their ethnic history and experience. Treatment needs to acknowledge this individuality and be tailored accordingly.
- Partnership work with Service Users to design and develop appropriate Mental Health Services.
- Proper engagement and consultation with Service Users in the shaping and delivery of their care plans and treatment.
- Urgent provision of appropriate treatment for those with Dual Diagnosis.
- An embedding of the Recovery Model into all treatment.
- A good, effective Homeless Outreach Service.
- The development of a Mental Health directory, listing all culturally appropriate services in Liverpool for BME men and women, including community organisations able to offer support. This can be distributed to all Mental Health service providers and voluntary organisations.
- Care packages designed to meet the unique needs of the individual offering a range of treatments and support, which are socially, culturally and spiritually appropriate.
- Health care professionals based within community organisations.

- Mental Health workers with a greater awareness, understanding and sensitivity towards BME cultures.
- Support to grow counsellors from BME communities.
- Services that listen and understand

The recommendations reflect the commonality across the 3 groups. One of the main differences however between the 3 groups was the rapid transit of Asylum Seekers and the need for better reception facilities. Homelessness was not an issue for the elderly Chinese community however this had a significant impact on the Irish community and Asylum Seeking groups.

The priorities for each group are indicated by top responses to question 2:1

What makes you feel happy?

Irish and Irish Travellers	Feeling Safe
Asylum seekers and Refugees	Immigration Status
Elderly Chinese	Family and Friends

## Conclusion

This report highlights the lived experiences of Asylum Seekers and Refugees, Chinese Elders and the Irish and Irish Traveller communities in Liverpool in relation to mental health and access to services. It is not a report purely for academic reference - too many of these already exist. The time has come for real committed action. It is absolutely imperative that **all local stakeholders** make use of this report. Consideration needs to be given to the findings that have emerged to address the urgent mental health and well being needs of Liverpool's Black and Minority Ethnic communities.

Our report recommendations are for the urgent attention and the shared responsibility of:

- Commissioners of Mental Health Services in Liverpool
- Liverpool Service Providers across both statutory, voluntary and community sectors
- All Stakeholders

# The Centre for Ethnicity & Health's Model of Community Engagement

## 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 interchangeably 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 section is an attempt to describe it. The Centre's Model of Community Engagement has 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 (DOH) awarded a contract to what was then the Ethnicity and Health Unit at the University of Central Lancashire (UCLAN) to administer and support a new grants initiative. The initiative aimed to get local Black and Minority Ethnic (BME) community groups across England to conduct their own needs assessments, in relation to drugs education, prevention, and treatment services.

The DOH had two key things in mind when it commissioned the work: first, it wanted a number of reports to be produced that would highlight the drug-related needs of a range of BME communities; second, and to an extent even more important, was the process by which this was to be done. If all the Department had wanted was a needs assessment and a 'glossy report,' they could have directly commissioned a number of researchers who could have gone into local BME communities, talked to them about their needs, written up a report, and produced yet another set of reports that potentially would not have any long-term impact.

This scheme was different, however. The DOH 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 BME communities to undertake the work themselves. These groups might not have known anything about drugs, or anything about undertaking a needs assessment at the start of the project. What they would have was 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 BME 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 bisexual 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 Aim Higher, Scotland Yard and Welsh Assembly.

## **The key ingredients**

There are four essential ingredients or building blocks to the UCLAN community engagement model.

### **1. An issue about which communities and other key stakeholders such as commissioners and policy makers share some concern**

The issue can be almost anything, but frequently involves a concern about inequitable access to, experience of or outcome from services. The community and other stakeholders may not agree about the causes of inequity or what to do about it-the key however is that they share a concern. Usually the concern will be framed within some kind of local, regional or national policy context (e.g. teenage pregnancy reduction).

### **2. A Host Community Organisation**

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 up a group for this specific purpose of conducting the community engagement research. The key thing is that this community organisation should have good

links to the defined target community, such that it is able to recruit a number of people from the target community to take part in the project and to do the work.

It is important that the host organisation is able to co-ordinate the work, and provides an infra-structure (e.g. somewhere to meet: access to phones and computers; financial systems) for the day to day activities of the project. One of the first tasks that this host community organisation undertakes is to recruit a number of people from the target community to work on the project.

### **The Task or Tasks**

The third key ingredient is the task or tasks that the community undertakes. According to the Centre for Ethnicity and Health model, this must be action orientated. It should be something meaningful, time limited and manageable. Nearly all of the community engagement projects have involved communities undertaking a piece of research or a consultation event within their own communities. In some cases there has been initial resistance to doing 'yet another piece of research', but this misses the point. As in the initial programme run on behalf of the DH, the process and outcomes have equal importance. The task or activity is something around which lots of other things will happen in the lifetime of the project. Individuals will learn; awareness will be raised; stigma will be reduced; people will have opportunities to volunteer and gain new qualifications; new partnerships will be formed; and new workers will enter the workforce besides, it is important not to lose sight of the fact that it will be the first time that some individuals will have undertaken a research project.

### ***Support and Guidance***

The final ingredient according to the Centre for Ethnicity and health's model, is the provision of appropriate support and guidance. It is not expected that community groups offer their time or input for free. Typically a payment in the region of £15-20,000 will be made available to the host organisation. It is expected that the bulk of the money will be used to pay people from the target community as community researchers. A named member of staff from the community engagement team is allocated as a project support worker. This person will visit the project for at least half a day once a fortnight. It is the role to support and guide the host organisation and the researchers throughout the project. The university also provides 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 form an appropriate steering group to support the project. Very often we will have helped groups to do this very early on in the process at the point which they are applying to take part in the project.

The steering group is an essential element of the project, it helps the community researchers to identify the community they are engaging with, and can also facilitate the long term sustainability of the project recommendations and outcomes. The community researchers undertake a needs assessment or a

consultation event. However the steering group ensures that the work undertaken sits with priorities and strategies; also that there is a mechanism for picking up the findings and recommendations identified in the research. The steering group can also support individuals' career development as they progress through the project.

### **The UCLAN Community Engagement Team**

The Centre for Ethnicity and Health has a large and experienced community engagement team to support the work. The team comprises of two programme directors, senior support workers and support workers, teaching and learning staff, an administration team and communications officer. They work across a range of community engagement areas of specialisation, within a tight regional framework.

### **National Programme Directors**

<b>Northern Team</b>	<b>Midlands Team</b>	<b>Southern Team</b>	<b>Senior Programme Advisors</b>
<b>Senior Support Worker</b>		<b>Senior Support Worker</b>	
<b>Support Workers</b>	<b>Support Workers</b>	<b>Support Workers</b>	<b>Drug Interventions Programme</b>
			<b>Regeneration</b>
			<b>Mental Health</b>
<b>Teaching And Learning Team</b>			
<b>Administration Team</b>			
<b>Communications Officer</b>			

### **Programme Outcomes**

Each group involved in any of our 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.

In 2005/06 the substance Misuse Community Engagement programme was externally evaluated. This concluded that:

- The community Engagement Programme had made very significant contributions to increasing awareness of substance misuse and understanding of the substance misuse needs of the participating communities. It also raised awareness of the corresponding specialist services available and of the wider policy and strategy context.

- The community Engagement Programme had enabled many new networks and professional relationships to be formed and that DAT's appreciated the links they had made as a result of the programme (and the improvements in existing contacts) and stated their intentions to maintain those links.
- Most commissioners reported that they had gained useful information, awareness and evidence about the nature and substance misuse service needs of the participating organisations.
- All DATs reported positive change in their relationship with the community organisations. They stated that the Community Engagement Programme reports would inform their plans for the development of appropriate services in the future.
- A significant number of the links established between DAT's and community organisations as part of the Community Engagement Programme were made for the first time.
- The majority of community organisations reported their influence over commissioners had improved.
- Training and access to education was successful and widely appreciated. 379 people went through an accredited University education programme.
- A third of community organisations in the first tranche reported that new services had been developed as a result of the Community Engagement Programme.
- The vast majority of participants and stakeholders expressed high levels of satisfaction with the project.

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.

## National Institute for Mental Health (NIMHE) in England Community Engagement Programme

Work undertaken by Irish Community Care Merseyside (ICCM), Asylum Link Merseyside (ALM) and Merseyside Chinese Community Development Association (MCCDA) is one of 40 projects community groups who took part in the National Institute for Mental Health in England's Community Engagement programme in 2007. The objectives of the programme were to deliver improve equality of access, experience 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 Community Development Workers.

The main focus of our work was to undertake a community based research project focussing on the mental health and mental health services needs amongst Asylum Seekers and Refugees, Irish people and Irish Travellers and Elderly Chinese in Liverpool

The views expressed in this report are those of research team at ALM, MCCDA and ICCM, and are not necessarily those of the Centre for Ethnicity and Health at the University of Central Lancashire, or NIMHE

### **Aims and Objectives**

- To establish the mental health and mental health services needs of Asylum Seekers and Refugees, Irish people and Irish Travellers and Elderly Chinese in Liverpool
- Development and capacity building of individuals and communities involved in the project
- Adding to the BME workforce, supporting researchers to gain a qualification and enter possible employment in the Mental Health field

- To determine the mental health of Asylum Seekers and Refugees, Irish people and Irish Travellers and Elderly Chinese.
- To discuss any culturally specific explanations of their mental health
- Explore the interventions that are needed
- Explore what mental health services are accessed by BME communities
- Explore the types of community resources that could be developed to facilitate culturally appropriate intervention

**Delivering Race Equality in Mental Health Care (DRE)** is a 5 year working action plan for achieving equality and tackling discrimination in mental health services in England for all people of Black and minority ethnic (BME) status, including those of Asylum Seekers and Refugees, Irish people and Irish Travellers and Elderly Chinese in Liverpool

It draws on three key recent publications in particular:

- Inside outside: Improving Mental Health Services for Black and Minority Ethnic Communities in England
- Delivering Race Equality: A framework for Action; and
- The independent inquiry into the death of David Bennett (although DRE itself is not a direct response to the inquiry's report).

David Bennett was a 38-year-old African-Caribbean patient who died on 30 October 1998 in a medium secure psychiatric unit after being restrained by staff. As well as DRE, this document contains the Government's formal response to all the recommendations made in the report of the inquiry into David Bennett's death. The responses are overwhelmingly positive and, taken together with the action plan in DRE, comprise a coherent programme of work for achieving equality of access, experience and outcomes for BME mental health service users.

The programme is based on three 'building blocks', first proposed in the consultation version of DRE:

- More appropriate and responsive services – achieved through action to develop organisations and the workforce, to improve clinical services and to improve services for specific groups, such as Asylum Seekers/Refugees, Irish/Irish Travellers and elderly Chinese.
- Community engagement – delivered through healthier communities and by action to engage communities in planning services, supported by 500 new Community Development Workers; and
- Better information – from improved monitoring of ethnicity, better dissemination of information and good practice, and improved knowledge about effective services. This will include a new regular census of mental health patients

The vision for DRE is that by 2010 there will be a service characterised by:

- Less fear of mental health services among BME communities and service users;
- Increased satisfaction with services;
- A reduction in the rate of admission of people from BME communities to psychiatric inpatients units;
- A reduction in the disproportionate rates of compulsory detention of BME service users in inpatients units;
- Fewer violent incidents that are secondary to inadequate treatment of mental illness;
- A reduction in the use of seclusion in BME groups;
- The prevention of deaths in mental health services following physical intervention;
- More BME service users reaching self-reported states of recovery
- A reduction in the ethnic disparities found in prison populations;
- a more balanced range of effective therapies, such as peer support services and psychotherapeutic and counselling treatments, as well as pharmacological interventions that are culturally appropriate and effective;
- a more active role for BME communities and BME services users in the training planning and provision of services; and
- a workforce and organisation capable of delivering appropriate and responsive mental health services to BME communities

## Liverpool context and background

Liverpool, a port on the north bank of the estuary of the Mersey, was first used as a harbour in the 13<sup>th</sup> century for sending supplies to Ireland. Throughout the 16<sup>th</sup> century, Liverpool only had a population of around 500 and it wasn't until the late 1600's that Liverpool was made a parish on its own by act of parliament. Liverpool's Black community dates from this period and grew rapidly, reaching a population of around 10,000 within five years.

By the beginning of the 1800's more than 30% of the world's trade was passing through the docks at Liverpool and during the 1840's the Great Famine (An Ghorta Mór) brought many Irish to Liverpool. By the middle of the 1800's a quarter of the city's population was Irish born. Liverpool is the 'World in One City' and is home to many different people. It's believed that it has the oldest Chinese community in Europe and we have had a Black community since 1750. The population of Liverpool is rising for the first time in decades and now stands at 447,500.

### Liverpool's Ethnic groups (taken from 2001 census)

<b>White: British</b>	<b>403,625</b>	<b>91.8%</b>
<b>White: Irish</b>	<b>5,349</b>	<b>1.2</b>
<b>White: Other White</b>	<b>5,552</b>	<b>1.3</b>
<b>Mixed: White and Black Caribbean</b>	<b>2,308</b>	<b>0.5</b>
<b>Mixed: White and Black African</b>	<b>2,207</b>	<b>0.5</b>
<b>Mixed: White and Asian</b>	<b>1,352</b>	<b>0.2</b>
<b>Mixed: Other Mixed</b>	<b>2,040</b>	<b>0.5</b>
<b>Asian or Asian British: Indian</b>	<b>1,909</b>	<b>0.4</b>
<b>Asian or Asian British: Pakistani</b>	<b>1,050</b>	<b>0.2</b>
<b>Asian or Asian British: Bangladeshi</b>	<b>557</b>	<b>0.1</b>
<b>Asian or Asian British: Other Asian</b>	<b>1,303</b>	<b>0.3</b>
<b>Black or Black British: Caribbean</b>	<b>1,083</b>	<b>0.2</b>
<b>Black or Black British: African</b>	<b>3,071</b>	<b>0.7</b>
<b>Black or Black British: Other Black</b>	<b>1,223</b>	<b>0.3</b>
<b>Chinese or Other Ethnic Group: Chinese</b>	<b>5,143</b>	<b>1.2</b>
<b>Chinese or other Ethnic Group: Other Ethnic Group</b>	<b>1,701</b>	<b>0.4</b>
<b>Total</b>	<b>439,473</b>	

Source: National statistics website: [www.statistics.gov.uk](http://www.statistics.gov.uk)

The 2001 census indicates that 5.7% (35,848) of the population are from BME groups. The Asylum seeker and Irish Traveller groups are not adequately represented within the national census data.

## Community Research Groups

### The House of Lords definition of an ethnic group

*'Essential features are a long shared history and a common cultural tradition.'*

### There might also be some of the following present

- Common geographical location from a small number of ancestors
- A common language
- A common literature
- A common religion
- Being a minority within a larger community

### Asylum Link Merseyside

Researchers were recruited at the drop in centre and the team was made up of four females and one male, two of whom were destitute at the time of the project. Some had experience of using mental health services and all the group were familiar with the background of Asylum, either having come through the system or having worked with Asylum Seekers and Refugees. One-to-one structured interviews were used rather than focus groups as it was felt that this would help people to talk more freely about personal issues.

**Irish Community Care Merseyside** selected our researchers from our outreach projects. We were lucky to have a female Irish Traveller from the Traveller's project and two males from the Homeless outreach project. Our lead researcher came from our Community Outreach Project and we would have never been able to complete the research without her hard work and commitment to the project. Last but not least is our researcher from our Wirral Outreach Project who gave up a lot of time to complete the project and was also the ICCM administrator.

We at Irish Community Care Merseyside owe a great THANK YOU to all our hard working community researchers. We also owe a big thank you to all of our clients from across ICCM projects who gave up their time to take part in the research project. Without your help we would not have had a project.

### Merseyside Chinese Community Development Association

The process and selection of Chinese researchers for the Community Engagement Programme Mental Health research work was crucial to the success of the research project. The Chinese Community researchers are highly skilled, respected and well known within the Chinese community in Liverpool. They all have a track record of services within the Liverpool Chinese community.

Within the team dynamic was

- Project Co-ordinator working within the Liverpool Chinese Community since 1980.
- Qualified and experienced nurse worked within NHS and private health care settings
- Full Time House wife / Volunteer
- Bilingual Employment and Training Officer
- After School Study Group Teacher / Music Teacher
- Bilingual Advocate Fire Service Worker
- Community Midwife, working within the community for over 35 years.

Languages / Dialects covered by research team members:

Cantonese, Mandarin, Shanghaiese, Chou Zhou, Tai Shan, See Yep, Hakka, Hai Nan, Ni Bo, English

## Community Organisation Background

### Asylum Link Merseyside

ALM is a charity dedicated to assisting Asylum Seekers and Refugees and to raising public awareness around the issues involved. The Organisation works from St. Anne's Centre located in Liverpool L7, not far from the city centre. The main catchment areas are the wards of Abercromby, Granby, Kensington and Smithdown, all significantly affected by long-term economic, social and environmental disadvantage. People arrive at the centre from a wide variety of other places throughout the North West and even further afield from cities like Birmingham and Bristol.

Our reason for becoming involved in the research is relatively straight forward. Our personal experience in trying to access Mental Health Services was extremely poor, from attempting to obtain emergency care, through to the care people received in their homes. We also strongly suspected that far more Asylum Seekers suffer from Mental Illness than is currently recognised.

Visits to the centre from schools, faith groups and other organisations are actively encouraged as this brings people into contact with Asylum Seekers, dispelling many of the myths about Refugees. The majority of services are accessed on a drop-in basis and include:

- A hospitable welcome and friendship
- Welfare Benefits, Health and Housing Advocacy and OISC 3 immigration advice
- English classes and computer classes run by Liverpool Community College, and our own volunteer ESOL classes
- Housing advocacy and furniture for Refugees during move on and a Refugee Mentoring programme
- Alleviation of hardship and destitution amongst Asylum Seekers and Refugees through the provision of food, emergency cash grants, clothing and housing
- Encouragement to Asylum Seekers and Refugees to become volunteers
- Social events to encourage integration and friendship
- Imaginative initiatives to boost morale-a health and well-being programme including cooking demonstrations, bicycle repair and cycle club, the garden and allotments.
- Information and Research opportunities. The Tudor Trust, Liverpool University and community projects as well as individuals on degree/masters courses or for student placements have used St Anne's as a research base. Many statutory bodies use Asylum Link as a source of information and contacts.

Asylum Seekers in Liverpool can be broadly divided into 5 categories:

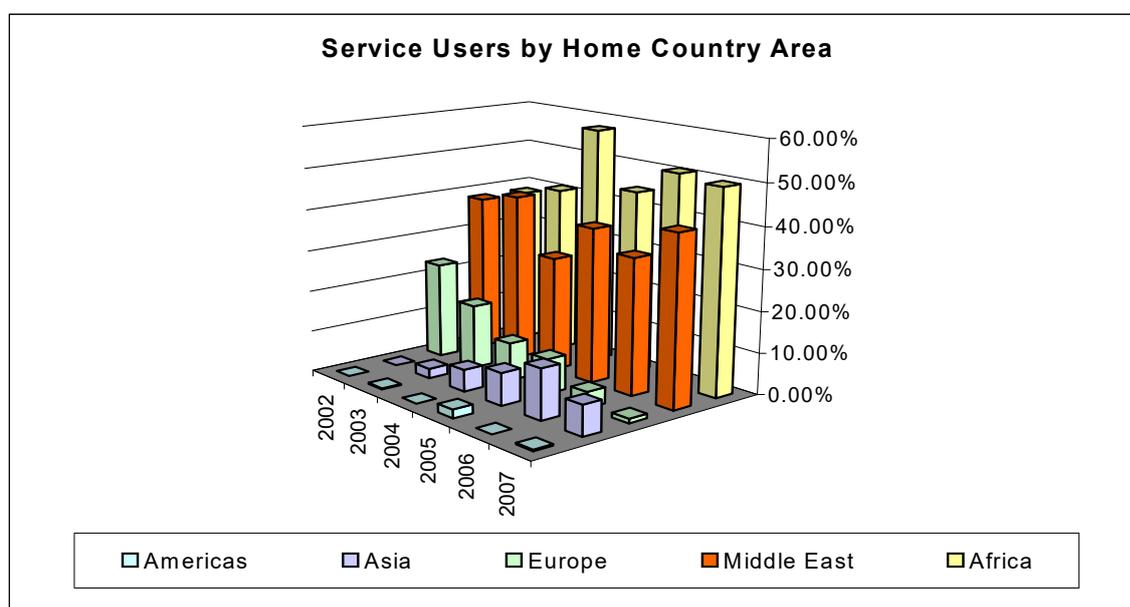
1. Initial Accommodation (section 98)\* – with the development of Liverpool as an initial accommodation centre and dispersal point as many as 5000 Asylum Seekers pass through the city each year, spending between one

and three weeks in designated sites at Greenbank or the Cathedral sites. They are then moved on to a different area: Middlesborough, Manchester, Bristol or wherever there is space. Some will be dispersed to Liverpool and stay here during the lifetime of their claim

2. Mainstream Accommodation in Liverpool (section 95)\* – during the claim period, anything from one month to years, but typically around six months, people stay in Liverpool whilst their claim is processed. This cohort is around 1800-2000 people, with a theoretical maximum of 2800. They are accommodated by a number of providers and placed around the city, typically in areas of cheap housing.
3. Hard cases (section 4)\* – these are people who have had their claims refused but cannot be removed. This can be for a variety of reasons: a war is still taking place, there is no safe return route, their country refuses to accept the person as a citizen. There are around 400 people in this category in Liverpool.
4. Legacy Cases – These are people who have been refused or not had a decision and are still in receipt of mainstream support. Nationally there are 400,000, of which around 24,000 are in the North West. As Liverpool has historically taken around one third of claimants in this area, there may be up to 9,000 people in this category in Merseyside.
5. Destitute Cases – In this instance the people referred to are absolutely destitute: no recourse to public funding – no benefits or housing, and no permission to work. As many as 300 people per year may become destitute in Liverpool

\*“Sections” refer to the appropriate section of legislation in the Asylum and Immigration (treatment of claimants) Act 2004

Even though Asylum claims have fallen nationally, the development of Liverpool as a major reporting centre has altered the way people arrive here and the numbers involved. In terms of the ethnic breakdown of people passing through the city, ALM does not record this, instead we record people’s nationality. This is done for around one third of visitors to the centre: those who open a case file. Last year the caseload rose sharply to around 750, within which there were 66 different nationalities.



The previous graph shows how the mix of asylum seekers at ALM is now predominantly from Africa and the Middle East (Middle East includes Afghanistan, Iran, Iraq and Kurdish regions). Less than 10% of our service users come from Asia (in which we have included Pakistan and China). As can be seen from the graph, the European area claimants have fallen to almost zero. This is largely due to the EU expansion as well as conflict resolution in the Balkans.

People are placed first and foremost in areas of the city where cheap housing is available. 5 years ago this was in the Granby, Toxteth, Lodge Lane and Smithdown Road areas of the City, with the one notable exception being the Tower Blocks in Everton which were eventually closed down.

As time has gone on, there has been a general move into Wavertree and Kensington, which the Police stopped for 6 months in 2005 due to problems within the communities. Now people are being housed in the North of the city, in Bootle, Anfield and Walton, areas not traditionally used by visible minority communities.

It seems as if the levels of Asylum Seekers coming to the city will be increased, following the investment in the Home Office reporting centre (where Asylum Seekers are screened and have to sign daily, weekly or monthly) in the City Centre, and that, by and large, the population of Asylum Seekers will move around the city based on the availability of cheap housing. The countries producing refugees are largely African and Middle Eastern and this pattern also seems set to continue, with Asian countries contributing. As long as there are Human Rights violations in the world, there will be refugees. The only variable seems to be the scale.

Lord Alton and Louise Ellman MP are both patrons of the organisation. We assist Asylum Seekers in as many ways as possible but at our heart remain the principles of Equality and Fairness and the need to provide a warm welcome. In Merseyside, according to our service users, “there is nothing quite like Asylum Link it is a place of safety”.

## **Irish Community Care Merseyside**

Irish Community Care Merseyside was established as the Welfare Section of the old Irish Centre in Mount Pleasant, Liverpool in the 1960's. The aim was to provide support to members of the community many of whom were newly arrived in Liverpool, planning to make a new life here with very few resources, no family support and very little knowledge of the city.

ICCM exists to identify and respond to the needs of both the Irish and Irish Travellers communities, offering and developing professional and culturally sensitive services. Our work focuses on linking our communities into services, opportunities and entitlements and ensuring that mainstream services respond appropriately to the needs of our communities.

We offer a range of front-line information advice and support services, which are co-ordinated from our office base at 60 Duke St, Liverpool. We also have an outreach office at the Lauries Centre, Cloughton Road Birkenhead. Our current services are:

- Daily drop-in information and advice around a range of issues i.e. homelessness, identification, health, GP registration, applications for accommodation, cultural isolation, maintaining family links etc
- Welfare Benefits Advice and Advocacy, linking people into range of welfare benefit entitlements from initial welfare benefits checks and form filling to representation at appeals and tribunals
- Irish Traveller Service working and campaigning to improve both the living conditions and access to service entitlements and opportunities of the Irish Travelling community
- Outreach Support offering home, hospital and prison visits to Irish people who are vulnerable through age, poor health, isolation, poor housing, low income or substance misuse.
- Suaimhneas Project offering an assertive outreach service to Irish people who are homeless and experiencing problems around mental health and substance misuse, supporting younger Irish people, the majority of whom are newly arrived in this country to link into services, employment and training opportunities and entitlements.
- Wirral Service developing a range of front-line support services for the Wirral Irish community
- Support groups for older people working to reduce isolation, and empower older people to make decisions on how they can best meet their social, cultural and welfare needs
- Irish Housing Project offering supported accommodation for four older people experiencing poor health

Migrants have been travelling from Ireland to England for centuries. This movement was often generated by poor economic conditions in Ireland and hope of better prospects across the water. Migrants left their native land with mixed feelings – anticipation, sorrow and cynicism. As Irish people we share a rich history with diverse cultures, traditions and religions. We are Black, Asian,

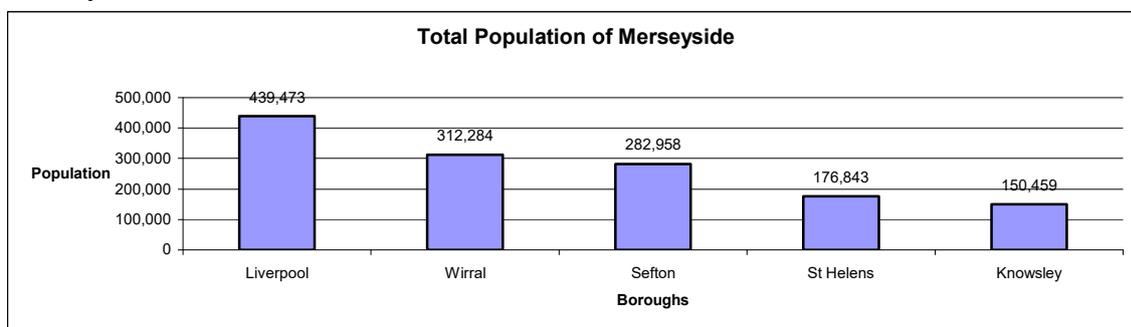
Chinese, Travellers, Jewish, Hindu, Muslim, Protestant, Quakers, Catholics, Agnostics. It is important to remember that Irishness is not just about place of birth, colour of skin or accent, because for centuries Irish people have left the shores of Ireland and traveled the world to live in other countries. Some of us stayed and those of us who had children now have a second generation of Irish young people who have a dual heritage. We had many different reasons for leaving Ireland, historically, the famine, work, family, health, safety, 'The Troubles' and not least of all adventure. As we come together in Merseyside we each have our own story of why and how we arrived here.

The 2001 Census indicates that White Irish people make up 1.2% of the population of England and Wales as a whole. When people of Irish parentage are included in this, the figure rises dramatically making the Irish community in Britain the largest migrant minority in Western Europe. Liverpool in particular has strong cultural links with Ireland. On their arrival to Britain, despite being white and English speaking, many Irish people experience culture shock, alienation and racism. The colonial relationship between Ireland and England has shaped the beliefs and the behaviour of Irish people and contributes to feelings of inferiority which often occur when they are confronted with negative stereotypes.

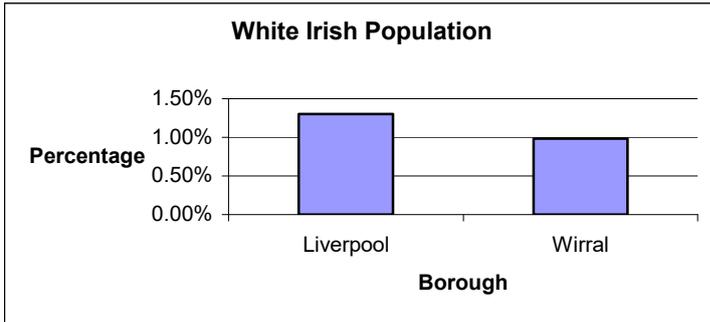
The dominant understanding of racism in the UK is in terms of a black/white dichotomy. Irish people have been classified either with the indigenous population or with other white minorities. As a result of this, Irish issues often remain invisible. It is only recently that an Irish ethnicity category has been included in UK census data. Previous records include 'Irish born' people only, neglecting the 'second' and 'third' generation population.

Irish people have the highest rates of admission to psychiatric hospitals in the UK. They are almost twice as likely to be hospitalised for mental distress than their native-born counterparts. Part of the explanation for such over-representation may lie with living as an 'invisible minority'. Services that recognise the distinctiveness of Irish culture are in short supply, as the research we undertook highlights.

The 2001 Census breaks down the population for each of the five boroughs in Merseyside:



However, difficulties arise when trying to estimate or record the number of Irish people living in Merseyside as there is very little data and very few statistics available. Local Authority websites provide percentages for the number of White Irish people residing in both Liverpool and the Wirral, yet information relating to the Irish community living in Sefton, St Helens and Knowsley is noticeably lacking.



The only information available in the Census regarding ethnic minorities in these other boroughs is data on the largest ethnic group for each borough, which is always recorded as 'white'. White Irish people are consistently grouped under the 'White Other' category and this makes it extremely difficult for us to locate the Irish community living in these boroughs. In turn, this means that it is increasingly problematic trying to identify how much access the Irish have to welfare services, housing etc.

Irish born people are statistically more likely to be socially disadvantaged, experience high levels of physical and mental health problems and long term disability. Research, (Generations of an invisible Minority-Pearson, Madden & Greenslade 1991) also shows that Irish men are the only immigrant group whose life expectancy worsens on emigration to England. Considering this, the fact that the Irish community are so un-represented in government statistics only adds further to their marginalisation in mainstream society, therefore creating a vicious circle.

## **Merseyside Chinese Community Development Association**

MCCDA is non-party political and it exists to: -

- Promote the education of people in the principles and practice of good citizenship and service to the community, and to
- Promote and provide social services of a charitable nature for the benefit primarily, but not exclusively, of Chinese person resident in Merseyside with the object of improving the conditions of their lives, and
- Advance the education of unemployed persons who are in need of assistance by providing them with vocation training.

The live projects are as follows: -

- Luncheon Club
- Silk Road News community news paper
- Chinese Carers Network
  - Sheltered Support (Supporting People)
  - Domiciliary / Respite Care
  - Befriending Scheme

## **METHODOLOGY**

Local Liverpool GP Dr O'Neil, having worked individually with the three communities, instigated the research partnership and became part of the steering group. The inclusion of the PHQ9 screening tool was to attempt to gauge the extent of clinical depression within the communities.

### **Recruitment**

Volunteer researchers were recruited from within the communities undertaking the research. Although around a third of the researchers dropped out, there were sufficient to undertake the research and subsequent analysis. They also advised the steering group and provided much of the driving force for the project

### **Training and support**

Through the workshop training by UCLAN across seven separate days in the summer of 2007, many questions were posed to stimulate our initial thoughts around our research: Who will do it? Who are the targets of the research? How much data? How much time? How will we maintain anonymity?

Following this, ethical approval was obtained from UCLAN.

The researchers were also given the opportunity to enrol for an accredited University Certificate in Mental Health and Community Research. In addition to the workshop, the community researchers were supported by an allocated support worker from the Centre for Ethnicity and Health. The support worker visited the project on a fortnightly basis to ensure tasks allocated were carried out in order to complete the project in the allotted time frame. She sometimes visited on a weekly basis depending on deadlines and level of support needed.

The tasks allocated to the community researchers varied from individual to individual depending on their abilities. Key tasks for the community researchers were as follows:

- Attend workshops
- Develop questions for the structured questionnaire
- Develop a research tool
- Identify the sample group
- Provide access to the communities
- Raise awareness of project
- Organise and attend support meetings
- Pilot the draft questionnaire
- Complete questionnaires with sample group
- Assist in setting up the steering group
- Liase with steering group members
- Attend steering group meetings on a monthly basis
- Data collection
- Input of data
- Analysis of data
- Arrange focus groups
- Report writing
- Minute writing

- Working on the launch of the research project and report
- Disseminating findings

All the research team members participated in all the tasks, although individual researchers took the lead on specific tasks.

A specific training session was delivered by Manjeet Singh from CSIP on Focus Groups .

### **Setting up of the Steering Group**

A first meeting was set up with our support worker to initiate the recruitment of possible steering group members. It was imperative to involve CSIP North West to fit in with local and national priorities. Prospective members were contacted and recruited. Steering group meetings were arranged and conducted accordingly.

The role of the steering group was to provide support and guidance to the overall project and also to advise and assist on the development of the questionnaires and on forming recommendations. Steering group meetings were set up monthly to be held in the meeting room at ALM.

### **Data collection tools**

Our aim was to gather as much information as we could from our various communities in the time available. With Nadia Ahmed, our support worker, we spent many weeks discussing the method of data collection, its applicability and suitability to our situation and the problems and limitations associated with it. Through study and in our UCLAN workshop training we learned about data collection methods

First of all we designed a structured questionnaire and formulated questions to gather information about our communities experiences of accessing Mental Health services in Liverpool. We needed to explore their understanding of mental well-being and the experiences they had of mental ill-health.

Working across 3 different communities provided quite a challenge and the questionnaire was designed with filter sections to accommodate the needs of the individual communities.

With hindsight, an omission from the Asylum filter section was the absence of a question on the effects of detention which has a huge negative impact on mental health.

ALM and MCCDA also decided to use the PHQ9 depression screening tool as a method of gauging the scale of mental health problems within their communities. ICCM decided not to use the screening tool, having evaluated it as inappropriate for use within their communities.

We anticipated that quantitative and qualitative information on health service access and experience would be derived from the structured questionnaires. We compiled letters to inform people about the research and produced forms to

obtain written, recorded consent from the people who agreed to take part. Respondents were asked to sign and tick a box to confirm they understood the nature and purpose of the interviews and questionnaires, and that we would keep all matters confidential.

We realised that focus groups would not work for Asylum Seekers/Refugees as they were reluctant to speak in a group while discussing personal problems. On the other hand, ICCM and the MCCDA decided to use some focus groups. This gave us the opportunity to collect data from individuals (who were unable to travel, those) confident in a group setting, and those who preferred one-to-one interviews. A mixture of methodologies were used to reflect what was most appropriate for each organisation, this was determined after piloting the questionnaires.

### **Accessing Communities**

Data was obtained using several methods: focused discussion and structured questionnaires. The questionnaires were administered in two ways: in one-to-one interviews by researchers who spoke the same language as the interviewee, typically lasting between one and one and a half hours, or in common interest focus groups, either through interpreters or same-language facilitators. The three Communities sought views and collected data from different sources. ALM collected data from service users who currently attend the centre. ICCM conducted interviews on and off site including visits to Walton Prison, Tara Park Irish Travellers Site and Homeless Hostels. MCCDA undertook sessions within care homes.

### **Confidentiality**

Researchers explained to participants in one-to-one interviews that confidentiality would be observed. Facilitators of the focus group discussions explained the importance of confidentiality and trust to participants, and all participants agreed to respect the conditions of taking part in the group. The only exception to this procedure for confidentiality was if researchers came across information which led them to believe that there was a child protection or vulnerable adult issue, risk of harm to self or others, or risk of an act of terrorism. They would report such information to their project co-ordinator who would take further action through the appropriate authorities.

Data from the questionnaires was analysed and presented in such a way as to ensure that it was not possible to attribute any particular response to any specific individual. Participants were guaranteed confidentiality. The completed questionnaires were locked away and stored securely so that only members of the research team had access to them. Completed questionnaires and notes and digital recordings from focus group interviews were handed in to the co-ordinator, as soon as possible after the interviews were completed. Care was taken not to leave data in cars or any other unsecured spaces. Information was stored and analysed in Microsoft Excel. Only staff and volunteers working on the project had access to any of the information produced in this way.

No names or addresses of interviewees (where) recorded. Only information that is anonymised will be shared with other agencies and it will be shared only for the purposes of improving the provision of Mental Health Services for BME

communities in Liverpool. The research team received ethics training and all members had clear guidelines on maintaining confidentiality provided by UCLAN.

### **Health and Safety**

When planning the research we considered the personal safety of ourselves as researchers and the safety of respondents. Counselling and one-to-one support was available throughout the project. Respondents and researchers could end interviews at any time if they wished. A minimum of two researchers facilitated the focused discussion groups. Although we did not anticipate that we would encounter any hostile reaction, all our venues afforded adequate security for respondents and volunteers.

Respondents and researchers were informed that if they felt uncomfortable the interviews could be terminated immediately. This was not necessary at any time during the research. In one-to-one interviews respondents sometimes cried when recounting experiences. Researchers received training in interview techniques and body language. During interviews no personal advice was offered to respondents. The exception to this was where a participant had a high PHQ9 score and was advised to visit their GP. The PHQ9 score sheet and criteria are included at the end of the report.

## Findings Section - Structured Interview Data

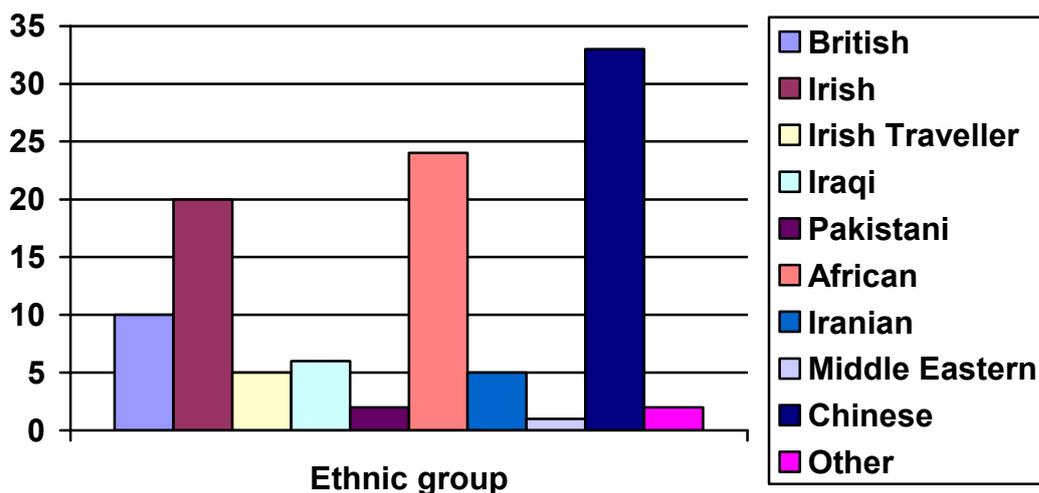
### Section 1 – Core Data

There were 51 (47%) male and 57 (53%) female. The majority (42%) were in the over 51 years age group. The next highest being 26-50 years (38%) and under 25 years (20%).

Ages	Asylum Seekers	Irish and Irish Traveller	Chinese
18 - 20	10		
21 - 25	6	6	
36 - 30	10	5	
31 - 35	9	4	
36 - 40	1	2	
41 - 45	2	4	
46 - 50		3	
51 and over		13	33
<b>Total</b>	<b>38</b>	<b>33</b>	<b>33</b>

Their ethnic groups, as described by themselves, fall into the following categories:

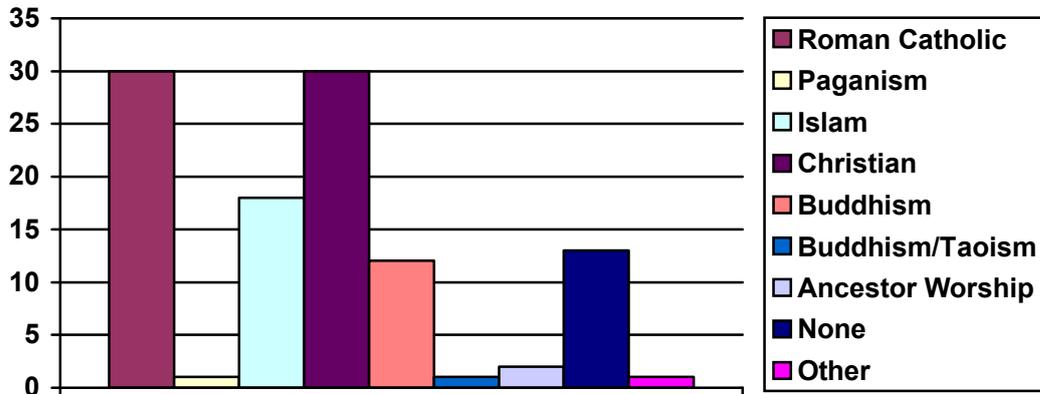
**Figure 1 : Ethnic groups**



Outside of the Chinese and Irish groups the largest number of participants were African (22%) who were from the Asylum Seeker Group.

Their religions fell into the following categories :

**Figure 2 : Religions**



The majority stated their religion as Christian (30%), Roman Catholic (30%) and Islam (17%), whilst 13% stated they had no religion.

**Time living in UK**

Time in years	Asylum Seekers	Irish and Irish Traveller	Chinese
Under 1 year	2	2	
1 - 5	26	6	
6 - 10	10	1	4
11 or over		24	29
<b>Total</b>	<b>38</b>	<b>33</b>	<b>33</b>

There have been long standing Irish and Chinese communities in Liverpool and the figures reflect this, showing 72% and 87% respectively having been here for over 11 years.

48% of the Irish and 84% Chinese classed themselves as a British Citizen. However only 35% and 3% respectively were born in the UK.

**Sexuality**

All but 5 of the total 108 participants stated they were heterosexual. These 5 chose not to answer the question.

**Languages**

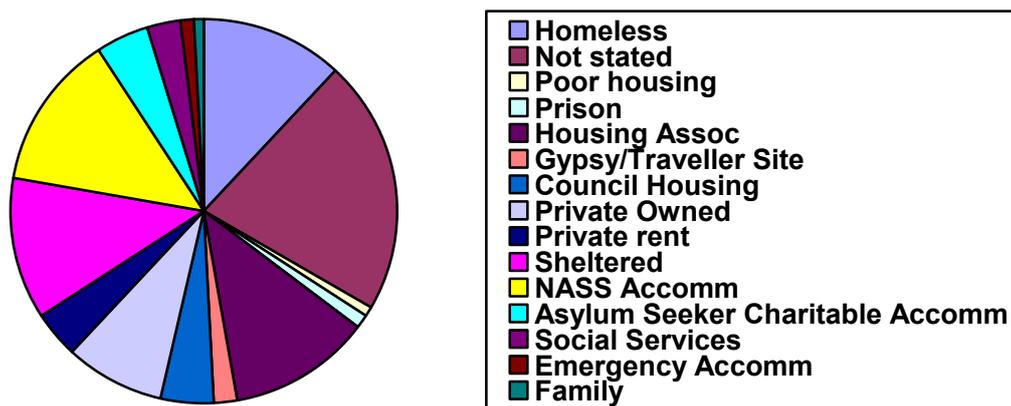
There were a total of 29 different first languages spoken. The Asylum Seekers had the most diverse at 20 languages and the Chinese have 8.

14% stated that they could write in *any* language.

Table showing the diversity of first languages spoken

Asylum Seekers		Irish and Irish Traveller		Chinese			
Musalati	1	Farsi	6	English	34	Cantonese	19
Foulah	1	Swahili	1	Irish	3	English	1
Ndebele	1	Dari	2			Hakka	4
Arabic	2	Musalati	1			Hoi Ping	2
Zagawara	2	Urdu	2			Mandarin	1
Begni	1	Kurdish	3			Ni Bo	2
Kikuyo	1	Luganda	7			Shanghainese	3
French	1	Wolloff	1			See Yip	1
Kinyarwanda	2	Shona	1				
Lusoga	1	Igbo	1				
<b>Total</b>			<b>38</b>		<b>37</b>		<b>33</b>

Figure 3 : Accommodation type

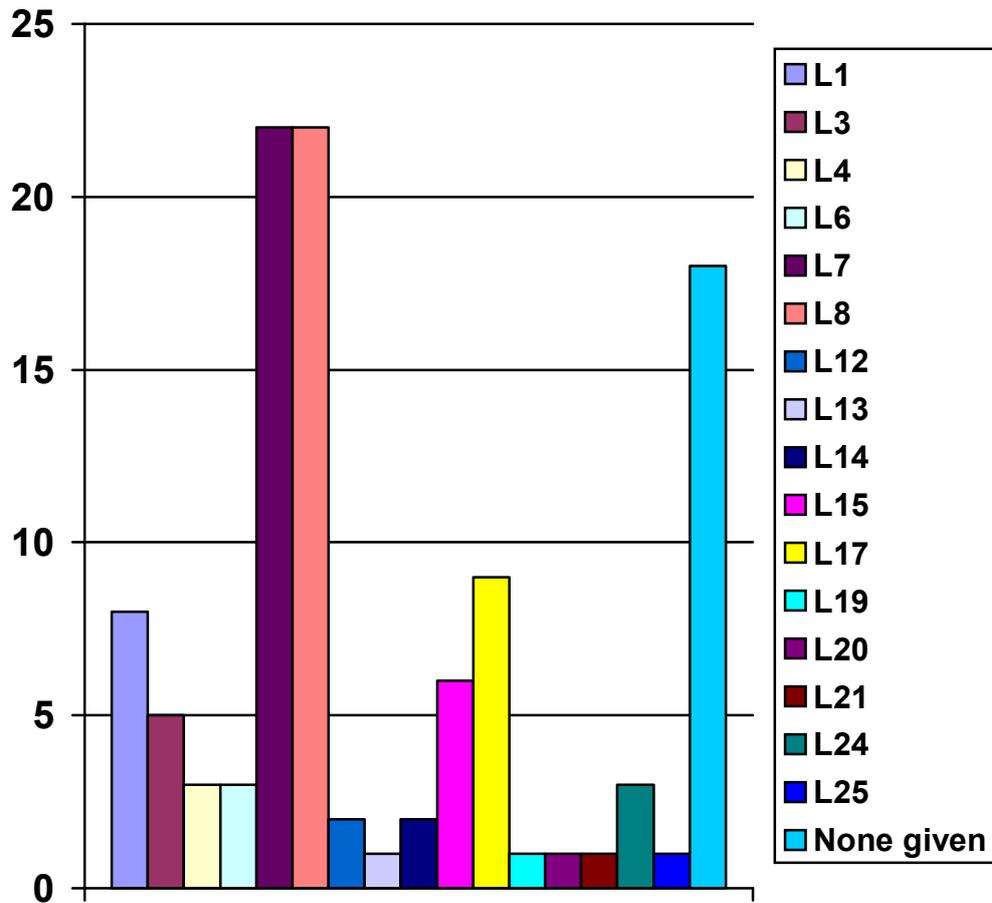


None of the Chinese community were homeless and this was the only group in which anyone owned their own home (27%). 29% of the Irish were homeless. 17% of all respondents were homeless. Within the Asylum Seeker group 24% relied on Charitable, Emergency or Social Services accommodation. 36% were in NASS accommodation and only 30% had settled housing with a Housing Association, Council or private landlord.

### Asylum Seekers' Status

Asylum Seeker	22
Refugee	11
Failed Asylum Seeker	2
Student	1
Indefinite Leave to Remain	2

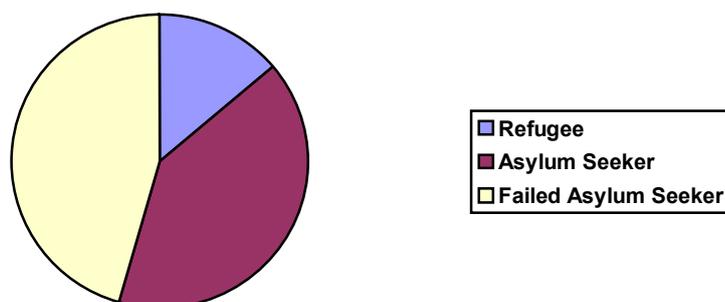
**Figure 4 : Post Code area**



The majority of participants lived in L7 Kensington and L8 Granby-Toxteth, both having 22%. The 17% not giving a postal code were homeless. 39% of the Chinese Community live in L8.

Almost all Irish Travellers lived on an established site in L3 Vauxhall, with the Irish participants widely dispersed across the city.

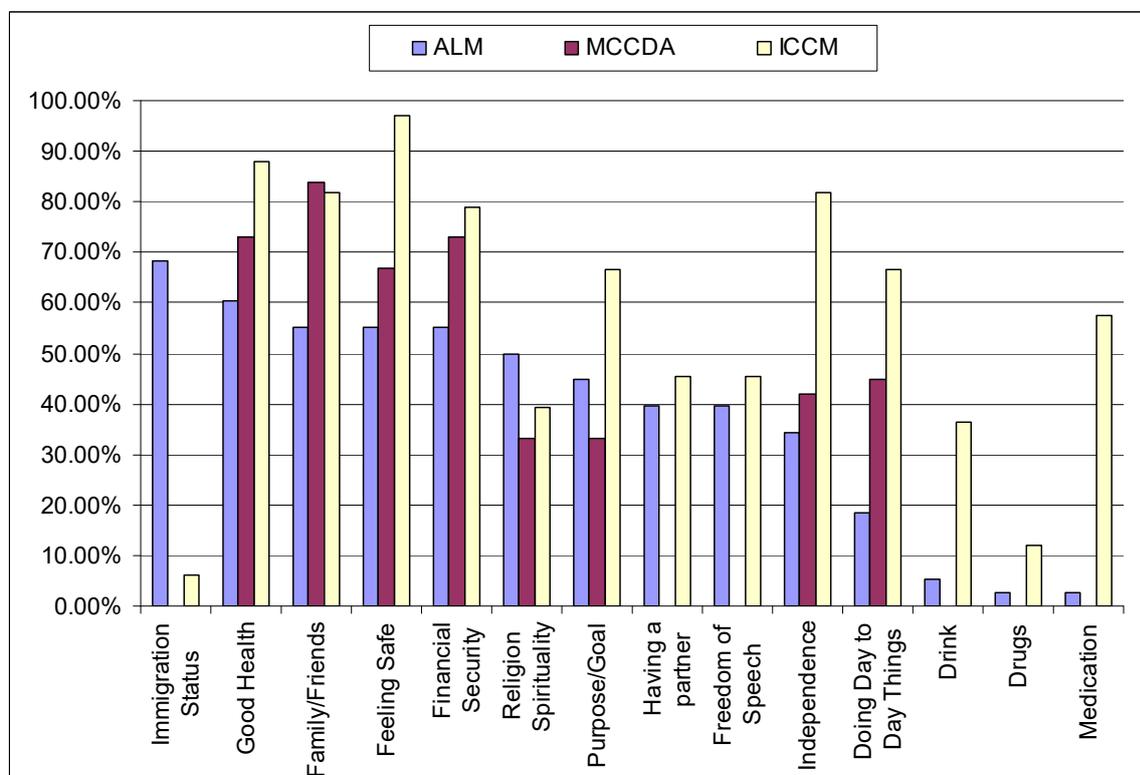
**Figure 5: Status of Asylum Seekers in L7**



This shows that 20% of Refugees, 66% of failed Asylum Seekers and 59% of Asylum Seekers are accommodated in the L7 area. Of all Asylum Seekers who gave a postal code, 45% live in L7.

## Section 2 – Personal Experiences

### 2.1 What makes you feel well/good/happy



#### MCCDA

Top category was family and friends, financial security, good health. Other notable answers were day to day things, independence, religion and having a purpose.

Also mentioned was Mah Jong, Karaoke, TV, Casino, gambling, brew alcohol, shopping for bargains, eating, visiting Canada, getting on with neighbours, visits from Church friends. It was observed during the interviews that many of the behaviours in the secondary categories appear to employ distraction as a way of coping or suppressing underlying issues.

#### ALM

Immigration Status (almost 70%) was the most significant factor affecting peoples well being.

Good Health, Family/Friends, Feeling Safe, Financial Security, Religion Spirituality were in the 60% to 50% range. Purpose/Goal, Having a partner, Freedom of Speech, Independence came further down the list.

Doing day to day things hardly figured – with no permission to work and an uncertain existence, day to day things are so far away from people’s normal experience as to be meaningless

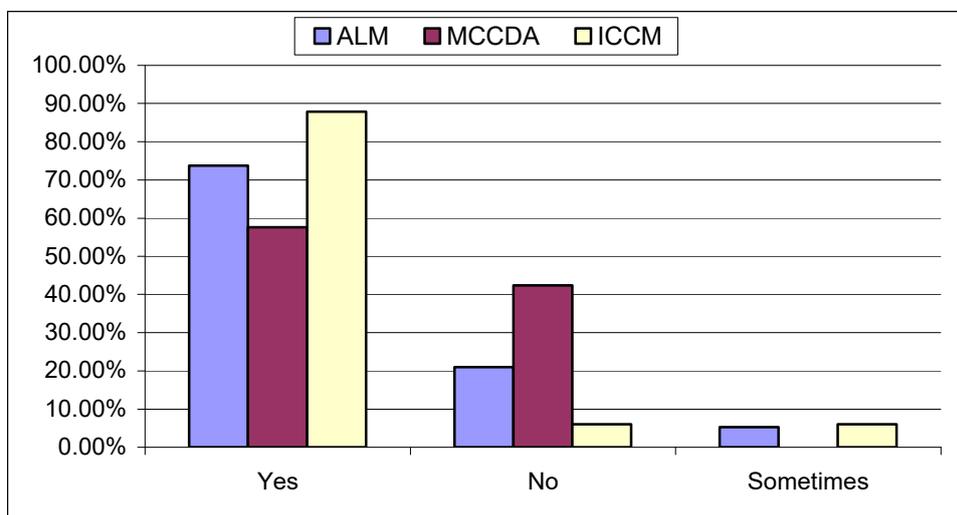
Health, physical and emotional security are key – these are the things firm foundations are built on but are completely lacking in the life of an Asylum Seeker.

### ICCM

‘Feeling safe’ ‘Good Health’ and ‘Family and Friends’ were the top categories in contributing to feeling good/happy. This reflects the number of homeless and chronically ill interviewees in this community. Homelessness and chronic illness go hand in hand.

The research highlighted the scarcity of homeless outreach workers and the inadequate provision and support provided by hostels for the homeless and statutory organisations. Voluntary/charitable organisations – always struggling for funding – are the bedrock of support for homeless people.

## 2.2 Has there been a time in your life when you didn’t have these things



### MCCDA

58% answered yes and 42% said no. Those affected by these losses described feeling unhappy, depressed, isolated and lonely. Two respondents wanted to die and one wanted to kill himself.

37% sought help from family and friends, 32% found solace in God/prayer, and two people coped alone. Two other respondents said no one helped, two other people received help from a support worker, and one mentioned help from a GP, another received help in hospital.

### ALM

Loss leads to feelings of loneliness, lack of independence, isolation and there is a requirement to build self esteem, remove isolation and fill the holes left by the loss of home, familiar background, employment, way of life and culture.

People got help from friends, strangers, charity, God, solicitors - a very wide range. Only one person mentioned hospital.

Volunteering opportunities, social interaction and things to do can help. Signposting to other organisations and opportunities where people can be

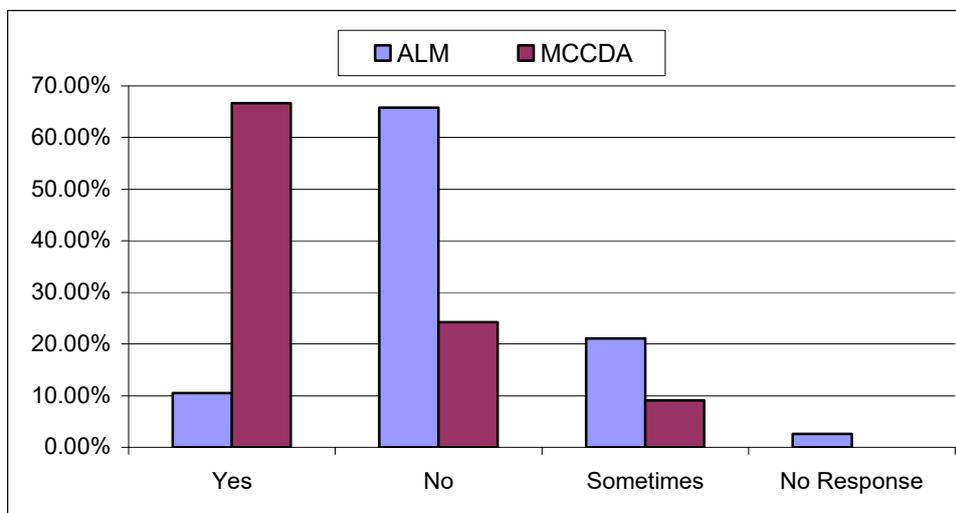
assisted and supported would improve the situation. Permission to work would benefit people's sense of self worth enormously.

### ICCM

Interesting to note that the Irish/Irish Traveller experience of loss scores even higher (nearly 90%) than the asylum seeker experience (75%)

## Questions 2.3 to 2.11 were asked of the Chinese and Asylum Seeking Communities only

### 2.3 Do you need an interpreter in order to make yourself understood



### MCCDA

70% answered yes, 21% said no and 9% answered sometimes. 3 people used interpreters only for legal issues. The vast majority of Chinese elders need interpreters, without them, many would not even be able to access a GP, who is usually the first point of contact in the health system. Many expressed difficulty with accessing interpreters.

There are also dialect issues. This study shows that there is a need for interpreters who speak less common dialects such as Hakka, Shanghainese and Ni Bo.

A few people mentioned that they had used interpreters but put greater trust in their families. One person expressed concern about confidentiality issues.

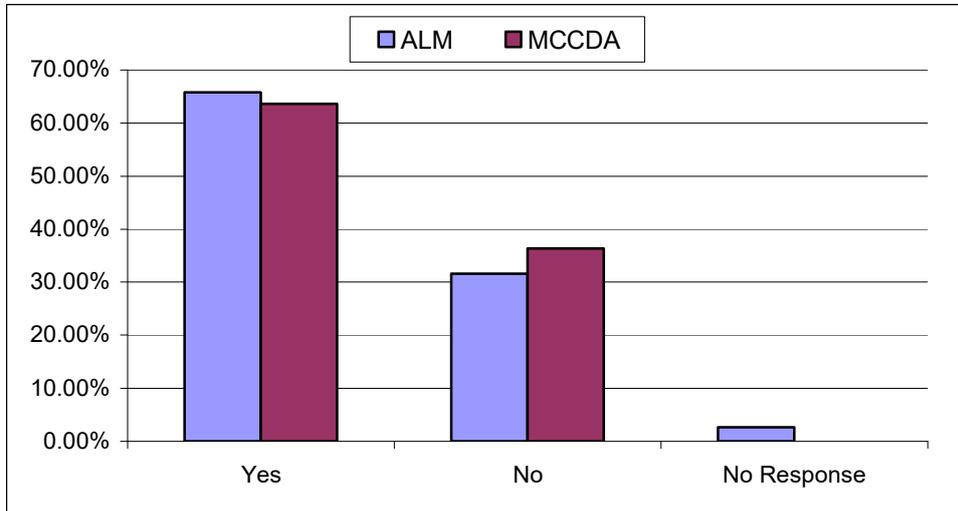
### ALM

Although many people said they did not need an interpreter, this result was influenced by our selection criteria for interview i.e. ability to speak English was a factor.

For people of less than a "good" level of English, interpretation is an issue, especially in technical situations – solicitors, home office and courts. For those who could not speak English, it was crucial. They experienced difficulties with the research questionnaire.

Anecdotally, some people said they did not trust the interpreter – would rather speak for themselves

## 2.4 When accessing services were you made aware of an interpreting service for your needs



### MCCDA

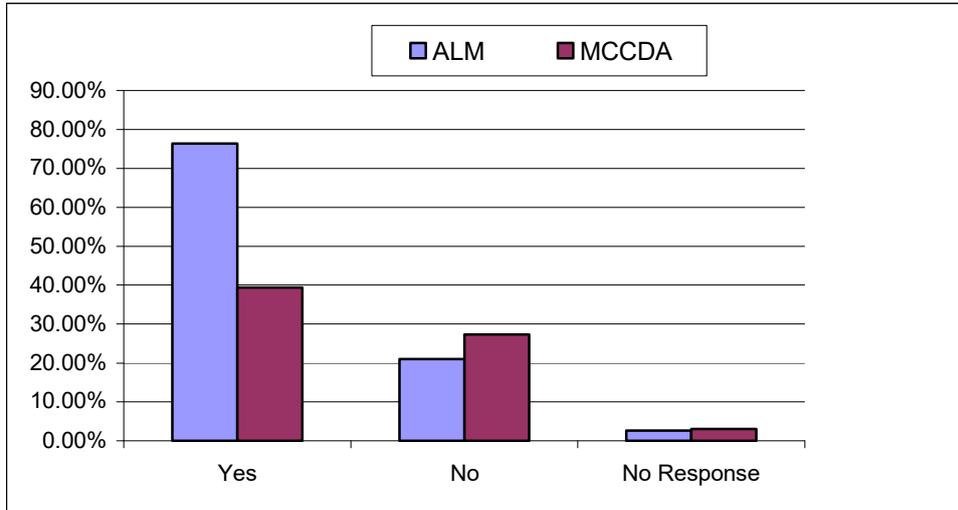
64% answered yes to this question, and 36% said no

### ALM

The majority of people know interpreters are available but we must *ensure* that *everyone* knows.

In discussions with the researchers on this question information transfer was an issue. Translated leaflets could be made available in a lot of places but especially in the Home Office – everyone has to pass through its doors. It is the one place that every Asylum Seeker is guaranteed to visit. There should be a welcome pack that includes mental health awareness and access to services information. However it should be recognised that not everyone can assimilate information easily and there are points where people are positively bombarded with it. There is also the issue of literacy ability. There needs to be both oral and written re-enforcement of information at other points on a person's journey.

## 2.5 Do you think that the situation that made you leave your country has affected your health



### MCCDA

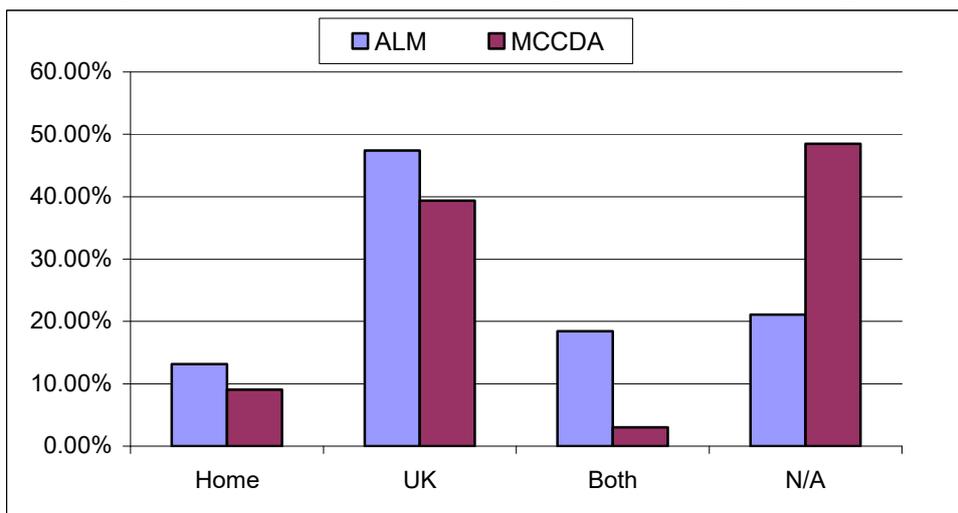
36% answered yes, 61% said no and 3% did not know.

### ALM

70-75% of people feel their home country affected their mental state. Contrast this with a success rate of 25-30% of AS claims and it can be seen that the system will place a lot of mental strain on people when they are 'inevitably' refused.

Most people are refused on grounds of credibility, which means the Government thinks they are lying. This is compounded by the Home Office's culture of disbelief which inevitably has an effect on people's morale and self esteem.

## 2.6 Did you develop this problem in your country of origin or in the UK.



### MCCDA

36% said that their problem developed in the UK, 9% said in their country of origin, 6% said in the UK and country of origin, and 15% did not answer.

One respondent developed physical problems in their home country, two developed physical problems in their home country and the UK.

One possible explanation for the higher incidence in the UK is that mental health problems may have remained dormant until later on in life. When many Chinese first arrived in the UK, they were primarily concerned with physical survival and making a living. Memories of home and families left behind may have been suppressed. Another explanation is that stress relating to migration, social and family networks being severed, language barriers and discrimination increase the risk of mental health problems. With the advent of retirement and more free time, perhaps emotional and psychological needs surface.

**ALM**

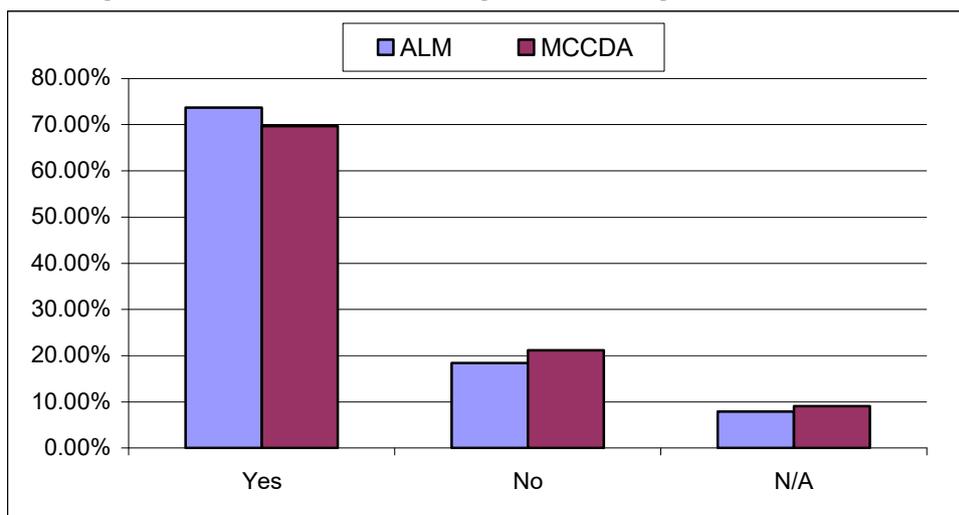
- 50% developed problems in the UK (only 1 was not for mental health reasons)
- 20% developed problems in both countries
- 15% developed problems in home country
- 15% had no problems

There are two possible reasons for the higher incidence in the UK

1. After someone’s initial escape, they have time to reflect and their past catches up with them
2. The hostile Asylum System and poor welcome in the UK (politicians and press)

A huge issue is the way information is communicated. For example every letter from the Home Office ends with “you are a person liable to be detained” – why does this need constant reinforcing? The correspondence could be worded more sensitively. If someone has one letter stating this warning surely it does not need to be repeated in all subsequent correspondence. It makes people fear the Home Office and become anxious every time they get letters or go in for interviews or signing. It almost seems as if it is the intention to instil a culture of fear.

**2.7 Do you think it has affected you mentally**



### **MCCDA**

39% answered yes, 48% answered no, 9% not applicable and 3% did not answer.

### **ALM**

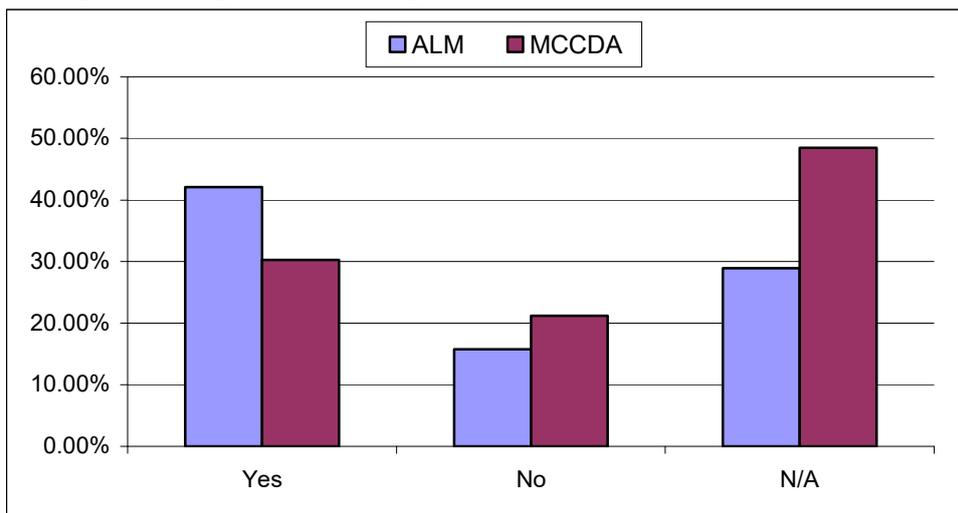
Yes – 74%. This high percentage indicates the urgency of the situation

Questions 2.5, 2.6 and 2.7 taken together with the PHQ9 scores indicate that 50% of Asylum Seekers have problems with depression that require medical intervention. This confirms the findings of a snapshot audit by medical students earlier in the year.

Information, materials and access to Mental Health Services should be universally available since the incidence is so high; 1 in 2 people are affected.

One question we did not put to people was how detention affected their mental well-being. Anecdotally we know that it has a traumatic effect both on families and single men and women who have come through the process.

### **2.8 If yes, did you seek help**



### **MCCDA**

77% said yes and they sought help, and 23% said they did not seek any help

### **ALM**

19 yes, 8 no, 11 n/a

When contrasted with the answers in 2.7, it can be seen that although 28 people felt their situation had affected them mentally, in the subsequent question only 16 had sought help. This means that around 25% of people were affected but did not seek help.

Correlating with the PHQ9 scores, 10 people who had a PHQ9 of 15 or above, indicating a need for possible clinical intervention, felt mentally affected but did not seek treatment.

This indicates that approximately 20%-25% of people feeling mentally unwell may not be seeking treatment for their illness.

The reasons some people did not go on to access mental health services were:

- One person did not want to be labelled
- One person wanted to sort it themselves
- One person said 'didn't do it because you don't when you're African'
- One person said you take your time and cope
- One person didn't know about services
- Two people said they didn't get help but from later questions it became apparent that they actually did

## 2.9 If yes, what kind of help did you seek?

MCCDA

Top of the list was GP, Pastor, Church, spirituality/ faith. Help from family and friends was significant.

ALM

Counselling	3
Counselling and Psychiatrist	2
GP and psychologist	1
GP	4
Hospital	3
Social Services	1
Total 37% of group	14

## 2.10 If no, why?

MCCDA

Answered varied from;

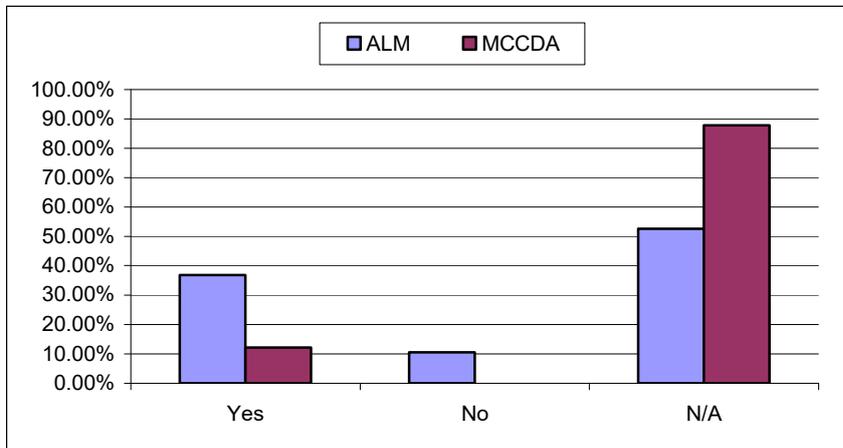
- Too busy trying to make a living
- Rely on self
- Don't need help
- Had no support
- No one available to help
- I didn't think I had a mental health problem
- Young-could cope
- Accept whatever life brings

ALM

Prayer/Religion as self supporting	2
Culture of coping/self support	2
Refused treatment by GP	1
Stigma – people think you lie to get status	1
Unaware of any services	1
Unable to say why	3
Total 26% of group	10

The last 2 questions show that almost as many people do not get help as those who do.

**2.11 (If yes) were you referred to mental health services or did you find them on your own**



**MCCDA**

Three people were referred - one by a GP.

One found services on their own.

Two accessed services in a crisis situation,

Four have not accessed mental health services.

Four people who perhaps required mental health services, were denied them simply because they either were not recognised as being ill, or did not use the services.

**ALM**

The main referral route is the GP. 8 out of a total of 11 people were referred in this way.

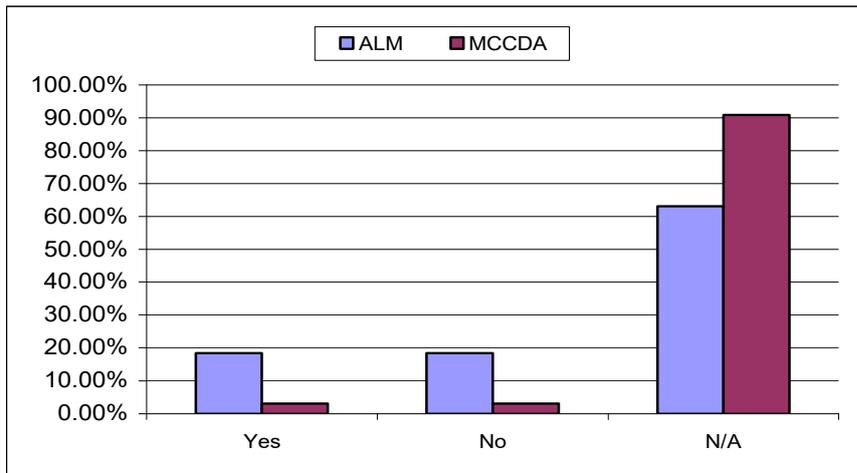
From this and questions 3.1 & 3.2, GPs are seen as the gateway to mental health services although people were also referred by Social workers or by Merseycare.

Only 1 person self referred

The delay between referral and accessing psychiatric services is almost always an issue

Other difficulties include interpreters and the complexity of the arrangements.

### If you were referred was the process easy?



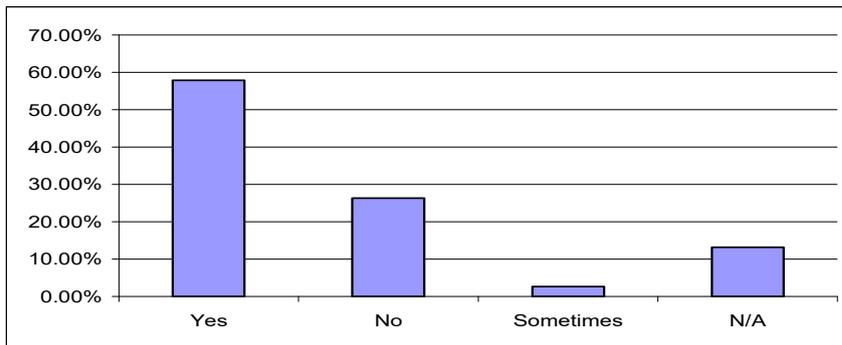
#### MCCDA

One answered yes, one said no, one not known and one was not aware. The respondent who gave the answer as 'not aware' was in a crisis situation and could not remember any details

#### ALM

Only four said it was easy and this seemed to be because people arranged things for them.

## 2.12 (Asylum Seeking Community) Do you think your immigration status has affected the way you've been treated?



ALM

Yes – 60%

There is a lack of specific answers. Giving a broad brush picture of life in Britain for an Asylum Seeker the Health Service, apart from a few specifics, seems well respected and listened to (see 4.2) There is however a problem with the wider communities perception and treatment of Refugees.

People do not naturally connect their general treatment by the Home Office and public as affecting their mental health. Comments in this section, however, suggest differently as do the results in 2.6 ( 50% becoming ill in the UK plus the added pressures of detention and the regimes inside the reporting centres.)

- *Asylum Seeker for 5 years and very stressful*
- *At first it was very difficult for me to be registered with a GP where I used to live when I arrived until NASS took me to another place of residence i.e. receptionists unhelpful*
- *Because I am an AS I was treated badly. I believe that my colour and status was taken into consideration rather than my sickness*
- *Discrimination, stereotyping, unhelpful*
- *Feel discriminated against*
- *Felt segregated and lost self esteem*
- *For certain things in this country like applying for certain things, your status means a lot to be considered for success. Priority goes to people with settled status in terms of job, education and other opportunities*
- *Friends started mocking him and making fun of his problem*
- *Generally outsiders are good except the home office people are not friendly*
- *I don't feel safe as I am always waiting for the home office to send someone to deport me and I don't feel good*
- *I was shouted at many times locally, mainly at my accommodation and in the street*
- *If he was not an Asylum Seeker he could do anything he wants e.g. work, go to university, have a partner and support her. He lives in fear and cannot disclose his health problems enough.*
- *She says when she gets status she will know what to do and have choice. She also said it is a very big problem*
- *She wants to know where her immigration status stands - if negative or positive*
- *She was detained and imprisoned. Also being homeless and economically poor affected her mentally*
- *Some people are very bad and racist to Asylum Seekers and Refugees*

- Some whites use unfriendly words e.g. go back to your country some even want to beat you and use abusive language
- Sometimes people look at you strangely because you are not British
- The Asylum process has been criminalised and Asylum Seekers are seen as health tourists within the health sector and so getting basic health needs is a problem
- When waiting for status I think all the time about the home office and it makes me stressful
- You cannot get what you want and what you feel like doing. Also you are not allowed to work

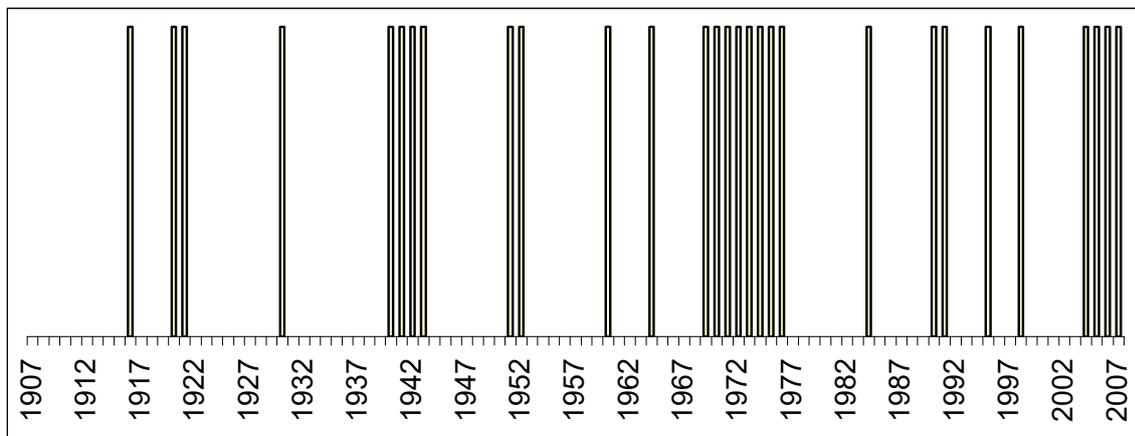
**Questions 2.13, 2.14, 2.15 and 2.16 were asked of the Irish/Irish Traveller Community only.**

### 2.13 When did you/your parents/grandparents first come to the UK

The graph indicates when, during the last 100 years, grandparents, parents and the participants came to the UK.

#### ICCM

The first significant Irish immigration to Merseyside occurred after the Irish Rebellion of 1798. This was the start of an unceasing immigration. There was another mass influx in the mid 1840s following the potato famine in Ireland. Irish people have continued to be part of the area ever since.



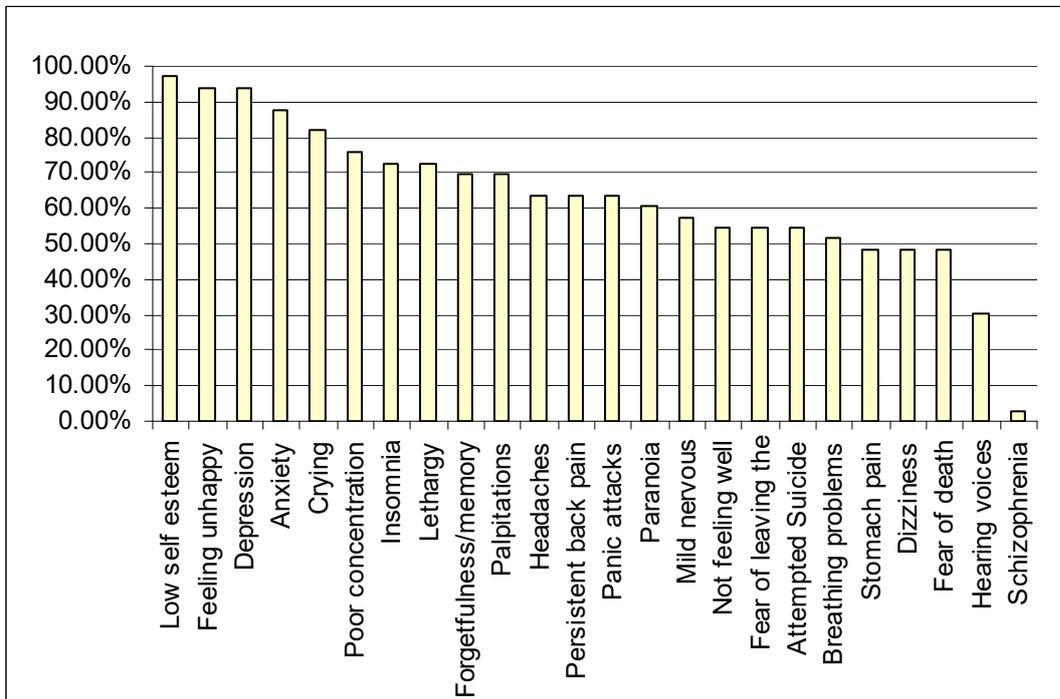
Irish-born people, who have emigrated from their own country to find employment and make a new life, have contributed to the development of industry, commerce and services in Britain. Patterns of migration for Irish-born people differ from other groups in that men and women migrated alone rather than in families. This compounded the feelings of loneliness and alienation inherent in the life of an immigrant.

- *'The NHS or new regime was started and I was sent (from Ireland) to train to be a nurse in 1951 to Walton Hospital, Liverpool 9.'* (Elderly Irish Woman)
- *The NHS was built by the Irish immigrants.....'* (Elderly Irish Woman)

## 2.14 How has being Irish or an Irish Traveller in the UK affected your Life/Health

- *'I am taking methadone – in my hostel people put me down. At the job centre, am only offered low grade jobs or exploited with cash in hand offers.'* (Young Irishman)
- *'Work – always very difficult – factory-sewing. I was at school until 16. Discrimination in England's not as bad as in Ireland. I've had 12 months of abuse from my brother-in-law. Children badly affected by it.'* (Irish Traveller Woman)
- *'Years ago it was hard to get a doctor. Now we've had the same doctor and dentist in Vauxhall for years and they are quite good. If you need a counsellor they will get you one.'* (Irish Traveller Woman)
- *'I did not adapt to the system here because I was Irish and Dyslexic. Dyslexia is still a huge problem. Always living on my wits. Became a chronic alcoholic .....worry about family and my future.'* (Middle-aged Irish man)
- *'I don't know, maybe is because my family are Irish Catholic, but there were basically too many of us. I was the oldest of 9 and we were in great poverty. There were too many of us to support, we were the poorest family in a run down area.'* (Middle-aged Irishman)
- *'Racism – signs "No Travellers – No dogs" – in shops until about 5 years ago - after Ellesmere Port when a 15 year old Irish Traveller was killed.'* (Irish Traveller Woman)

## 2.15 Have you at any time in your life experienced?



### ICCM

These quotations are from two young homeless men, both unwell, both existing in a wilderness and totally removed from any support although they walk our streets daily.

- *'I don't know. My dad and 3 brothers are paranoid schizophrenics. I have never gone to the GP'.*
- *'Yes, all of the above. I have experience them a lot since coming off drugs a year ago. When my dad died 10 years ago, tried going to a GP, but he did not help'*

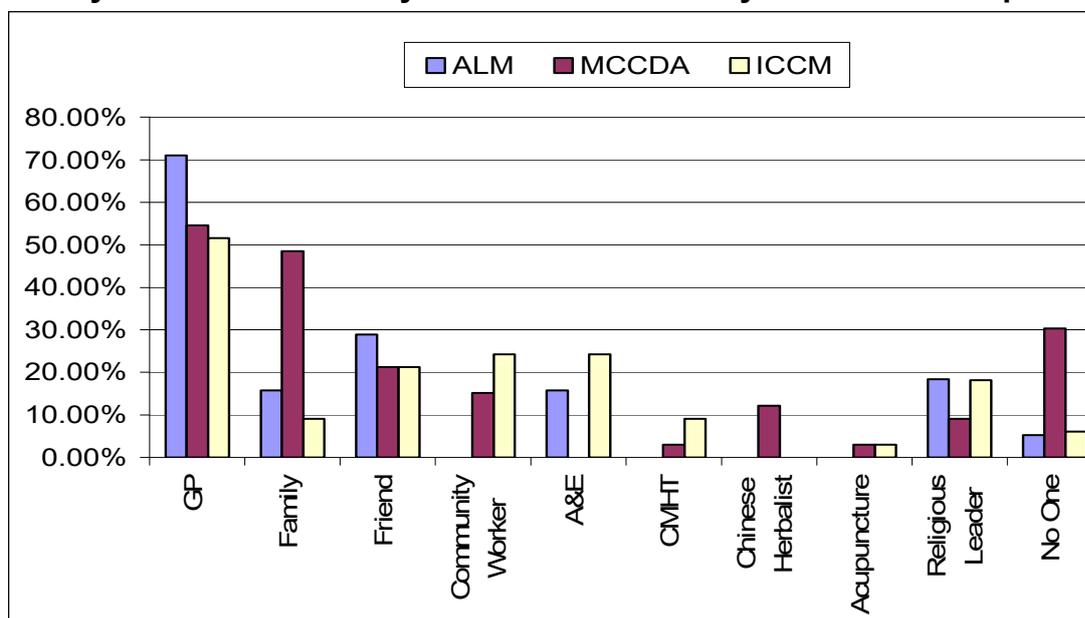
## 2.16 When did these feelings start?

### ICCM

The majority of respondents have suffered these feelings for a considerable time, ranging from 10 to 30 years, even originating in school days. One participant had had these feelings during the past year and another had started 4 years ago.

## Section 3 – Access to Services

### 3.1 If you become mentally unwell where would you first seek help



#### MCCDA

The majority would seek help from their GP in the first instance, closely followed by family. Those that said they would seek other help, mentioned Mah Jong, keeping busy, neighbours, prayer, Chinese social services unit, Pagoda, photography, and Housing association.

- *'A chat to the community worker makes me feel better'*
- *.'Chinese Social services noticed I cried a lot when mother hanged herself'.*
- *'I was v. depressed and tried to hang myself'*
- *'Go to town to occupy myself. Dance, play Mah Jong, karaoke. Volunteer to help old people.'*
- *'Housing association warden. Pagoda centre, support worker and MCCDA'*
- *'I always get sectioned. My neighbours intervene or I am arrested by the police'.*
- *'I ask an neighbour to call emergency services when I am mentally unwell'.*
- *'I keep it all inside. I watch TV that's how I cope with my feelings'.*
- *'I pray to God. I see my two daughters'.*
- *'I will get help from the Pagoda.'*

- *Just want to hide it and don't want to tell everyone. They cannot do anything if you have a mental illness.*
- *Photography takes my mind off being alone, and sad memories.*
- *Support worker.*
- *Wife*
- *Worship*

### **ALM**

GPs were by far the most recognised source of help. The difficulty people expressed was with obtaining one

Other sources were –  
999.

Hospital/Hospital Pharmacy.

Partner

Prayers

Royal hospital

Social Services

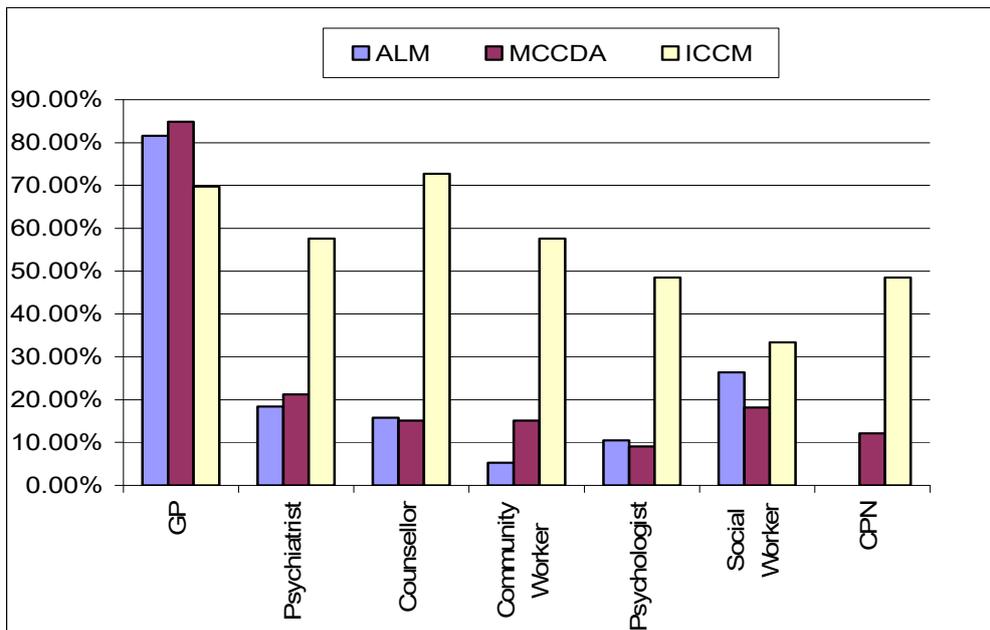
- *'Told Anita (caseworker) at ALM. She is very close to me and very helpful. I trust her - she is my mum'*

### **ICCM**

50% would seek help from their GP. Next came a Community Worker and A & E

- *'Lady GP referred me to a psychiatrist. I only went a couple of times. I was too shy to go in. We sat in a circle. There were loads of men there. The psychiatrist went around the people. I did not want to discuss my issues in front of people. I did not expect a group.'* (Irish Traveller Woman)
- *'I went to a GP, but it was a male GP, but I could not tell him so I said I wanted to give up smoking.'* (Irish Traveller Woman)
- *'I have attempted suicide eight times, feeling started ten years ago. GP referred me to the Windsor Clinic. The most that A & E did was to tell me that mixing cider with medication could kill me – another way to do it !'* (Irish Traveller Man)
- *'It would have to be my GP or the dreadful A&E as I cannot self-refer even though I have been a Mersey Care patient for 10 years.'* (Irish Woman)

### 3.2 If you required professional help, would you see any of the following



#### Other responses not included above

*Cannot go to any because he is out of the system, Case Worker*

*Caseworker at ALM, advisor at CAB, Consultant*

*Hospital - not really aware of other help*

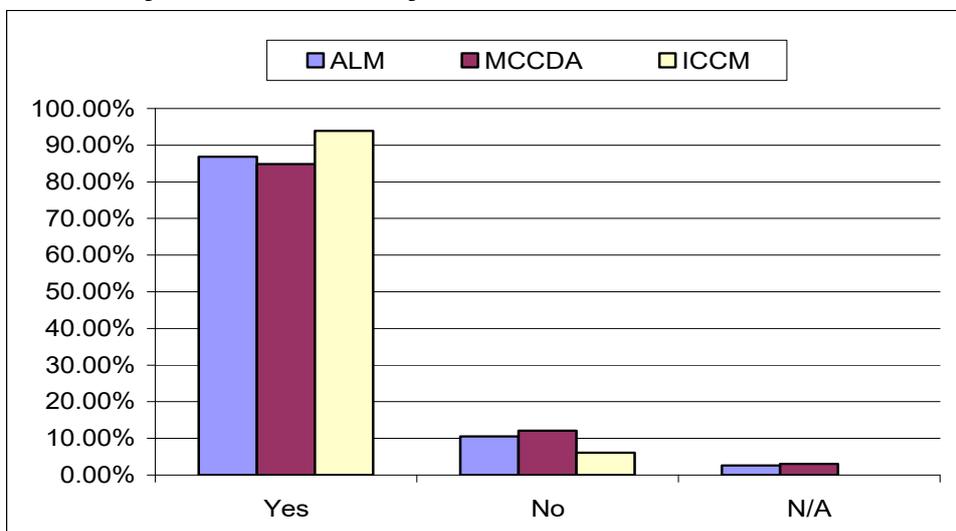
*Physiotherapy, Royal hospital*

*"I would not go to psychiatrist, they would say I am mad"*

#### ICCM

Counsellors were the profession of choice, closely followed by GPs. Social Workers were almost always the least popular choice being associated with breaking up families and taking children into care.

### 3.3 Have you ever used any of the above services



## MCCDA

76% answered yes and 24% answered no

## ALM

87% of respondents had used the services in 3.2. 60% had accessed them within the last month. Even people who said they didn't need help eventually went for it.

**ICCM** – 93% of respondents had used the named services

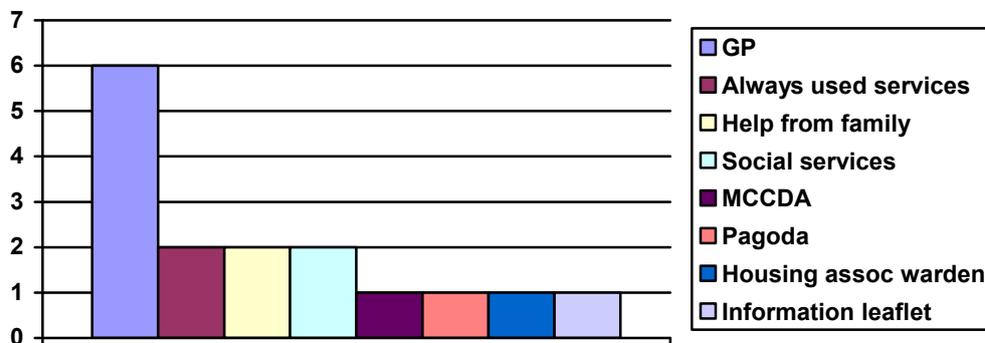
*'Yes, I was referred to a counsellor by Basement. I'm seeing her currently and she is non-judgemental and very good.'* (Young woman)

*'My GP had no empathy. No help, I wanted bereavement counselling but he said no.'* (Middle-aged woman)

*'I saw a Psychiatrist and counsellor when I was 12 and was brought into A & E. I saw them in Care Homes as well. I was passed around and they did not care. Trying to make me talk and I did not want to. I would not rush to go see a counsellor, or talk to anyone.'* (Young man)

## How were the services accessed?

### MCCDA



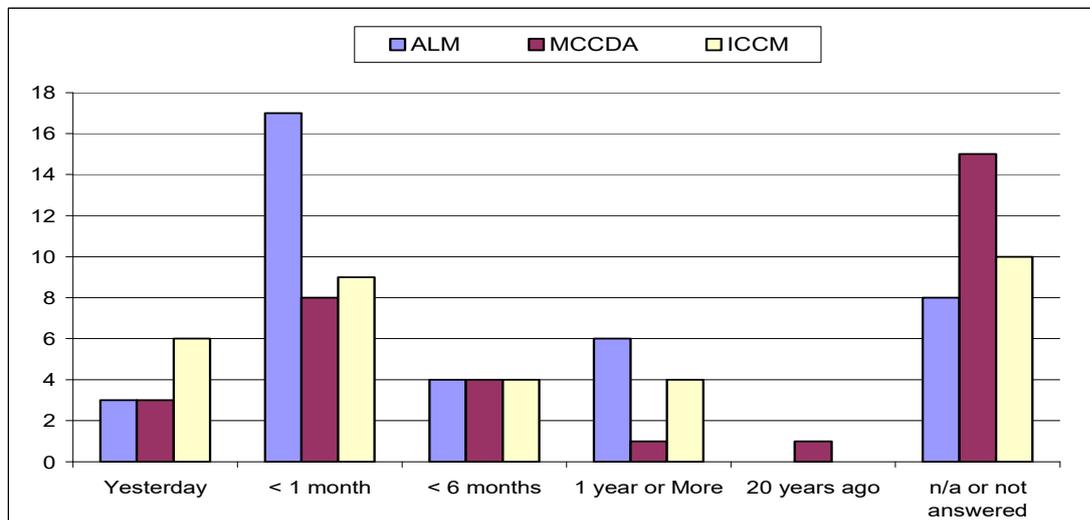
### ALM

Accommodation Provider referral	3
ALM	2
Family referral	1
Foster Parents and Social Worker	1
Friend	6
GP	6
Support Agency	3
Home Office referral	1
Landlord referral	1
Self referral	1
Social inclusion team	2
Social Worker	5
Solicitor referral	1

## ICCM

GP	12
ICCM – caseworker	2
Hospital	2
A&E	1
College Counsellor	1
Community Worker	1
Family	1
Friend	1
Hostel	1
Solicitor	1
No response or n/a	12

## When were they last accessed



### 3.4 If you did not seek professional help, what other sort of help did you seek

#### MCCDA

Majority sought help from family and friends, next came pastor, self help, Mah Jong, did not seek help/ did not know where to go.

#### ALM

This question was not well understood by the participants. Of ten responses, three said friends, two said A&E, one said 'go back to Home Country', one would not use any help, one put faith in God, one bought medication from the supermarket and one used drugs.

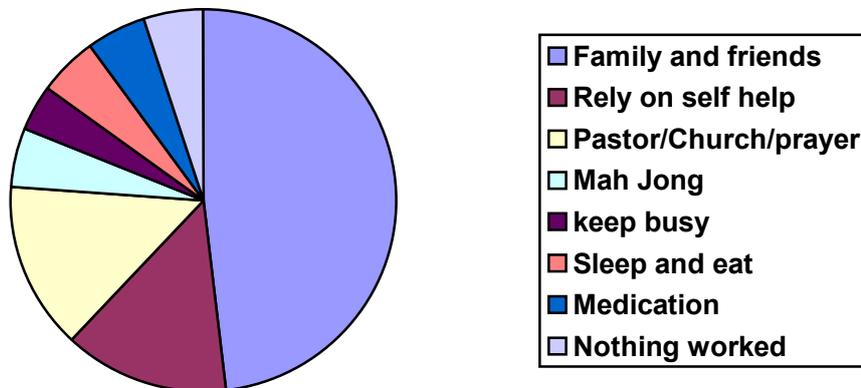
#### ICCM

Very few participants had not accessed professional help. The comments below are from those who did not.

*'I don't trust psychiatrists - they think they know everything'.*  
*'There's no help - just get on with it!'*

## What worked and why

### MCCDA



By far, family and friends are important in the lives of many Chinese people. They may in fact be a vital component in maintaining the mental well-being of loved ones

In a shame-based society, there is a strong cultural leaning towards self-reliance.

The role of the pastor/church and prayer are also of significance as the spiritual aspect of peoples lives can play an important role in mental wellbeing.

Playing Mah Jong, keeping busy, sleeping and eating are activities that perhaps help to divert attention away from problems or issues.

### ALM

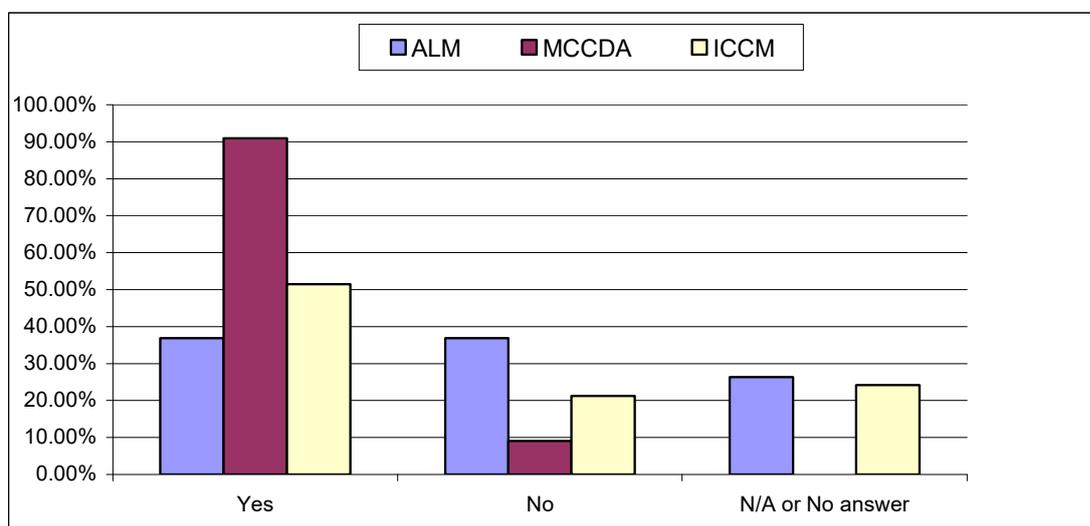
*friend gives me good advice and help me find the right way*

*I believe in my country's doctor*

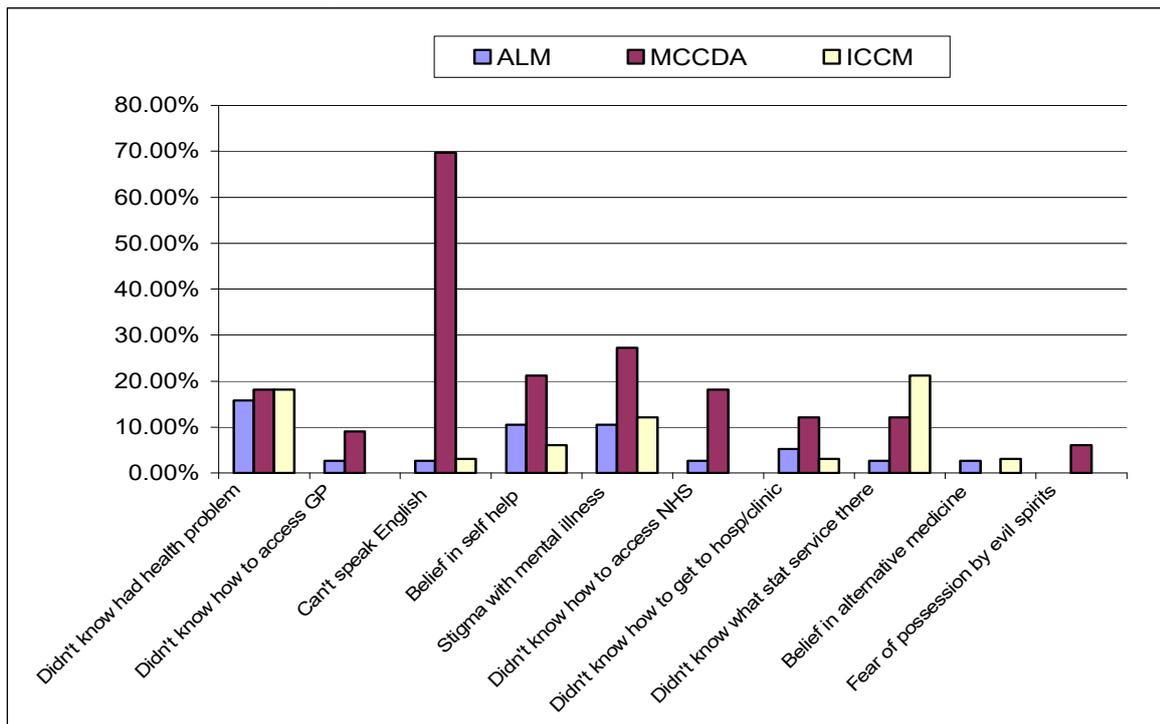
*Contacting friends can direct you to the relevant connections for help*

*Dentist perfect as well as GP*

### 3.5 Were there things that made it difficult for you to seek help



## What were those things



### MCCDA

91% said things were difficult. The reasons for this is:

- Cannot speak English
- Did not know how to access GP, NHS and statutory services
- Stigma
- Believe in self-reliance
- Did not know what mental health problem is
- Did not see stress as mental health problem.
- Lack of appropriate services for Chinese people
- Fear of others,
- Poor quality of GP surgery interpreters

It is essential to highlight that the vast majority of Chinese elders cannot speak English. This affects access to services and the ability to explain clearly problems/symptoms. This could lead to an incorrect diagnosis, inappropriate treatment or an inappropriate referral. Language barriers could also result in the service user not having an understanding of their treatment or possible side effects.

The inability to speak English takes away the individual's ability to advocate for him/herself

### ALM

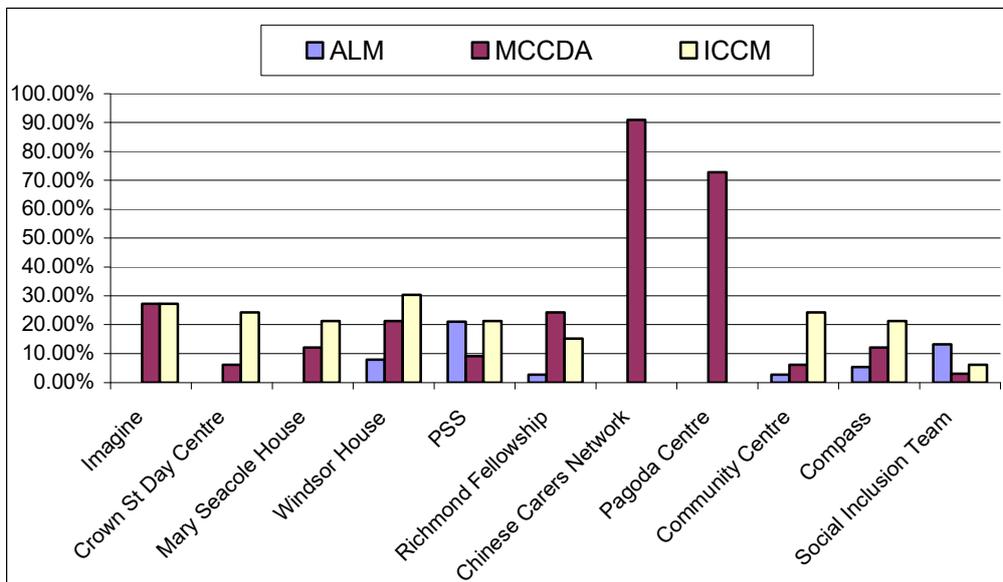
30% said 'yes' things were difficult

## ICCM

49% said Yes, 20% said No

- *'Yes, as a prisoner, there are 2 doctors servicing 1500 prisoners and 1 medic at night. It takes 9 months to see a dentist and there is no confidentiality around health matters'* (Male Prisoner)
- *'I had such a bad experience of Mental Health Services in the past that I was afraid of looking for professional help. I also felt that I was being treated differently because I was middle class and not seen as deserving help as much as people who were from deprived estates'* (Irish Woman)
- *'Being judged on my past, a drug history 17 years ago follows you.'* (Irish Man)
- *'I don't want to go into sheltered accommodation. I like my rubbish here. I bought everything and worked for it. I would have to pay more for sheltered accommodation. I don't hear good things about it. I don't know how to go about services. I know I would need a laundry service – money all the time.'* (Elderly Irish Woman)
- *'Had no name for my illness. (Encephalitis – Acquired Brain Injury) Put in a box for depression. GP still keeps offering anti-depressants.'* (Irish Woman)

### 3.6 Are you aware of these services



## MCCDA

24 out of the 33 respondents were aware of the Pagoda Chinese Community Centre, and the Chinese Carers Network (MCCDA)

These services were developed specifically for Chinese people, and remain a hub of activity whereby people can gain access to help for issues such as immigration, welfare benefits and health. Stigma about mental health persists in

the Chinese community. Perhaps offering mental health services from a venue such as the Pagoda could assist in educating the community, and demystifying mental illness.

Only 21% have heard of Imagine and Compass counselling, and 18% heard of PSS.

Also mentioned were - the MCCDA luncheon club, the Sheila Kay Centre and Social Services

*'I have a home help and a support worker. A lady from Ni Bo village helps me to apply cream on my eczema.'*

*'I have joined support groups to find out more information for my brother who has schizophrenia.'*

### **ALM**

Practically no one had ever heard of the services

Only PSS and the Social Inclusion Team were known and only by a small number i.e. 8 for PSS

Other responses included:

- Doesn't know any of above
- Don't remember the name -not included in list
- Hospital
- *Imagine* in Bolton?
- My GP made an appt at Arundel and then I was Sectioned at Broad Oak hospital
- Social Services

### **ICCM**

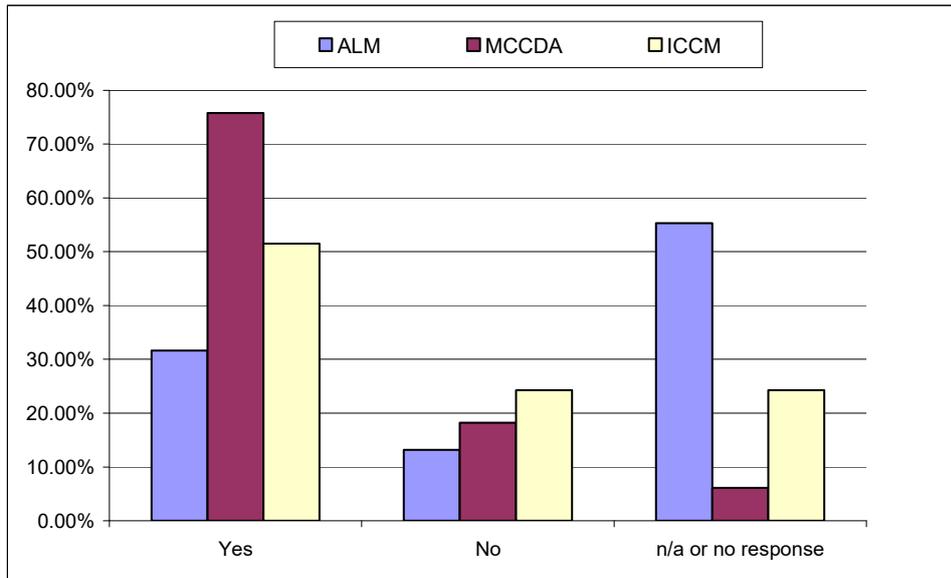
Imagine	9
Crown St. Day Centre	8
Mary Seacole House	7
Windsor House	10
PSS	7
Richmond Fellowship	5
Community Centre	8
Compass (Counselling)	7
Social Inclusion Team	2
Other – Basement, Whitechapel, Novas	17

*I know nothing of them. I paid my own support worker since August. She comes everyday for 2 hrs.*

*'Broadoak better than Windsor House - more staff '*

*'I use the Whitechapel - referred by a friend.'*

## Ever used these services?



## How did you access them

### MCCDA

- By word of mouth
- By phone
- Through the church
- I was approached and I registered
- Through Chinese community news
- Used services since arriving in the UK
- Picked up by mini bus
- Access is difficult if client cannot speak English (comment made by a referrer to the services)

### ALM

This part of the question was not well understood by the respondents

### ICCM

*'The Irish Centre in London signposted me to ICCM. ICCM signposted me to New Start. I still use New Start support worker (am living in New Start house) and ICCM.'*

*'While living on the streets I met someone from the Basement at the GPs and they told me about it.'*

*'I've used Whitechapel for 20 yrs. Heard from people who went there.'*

*'Heard of them through other homeless people'*

## What was your experience?

### MCCDA

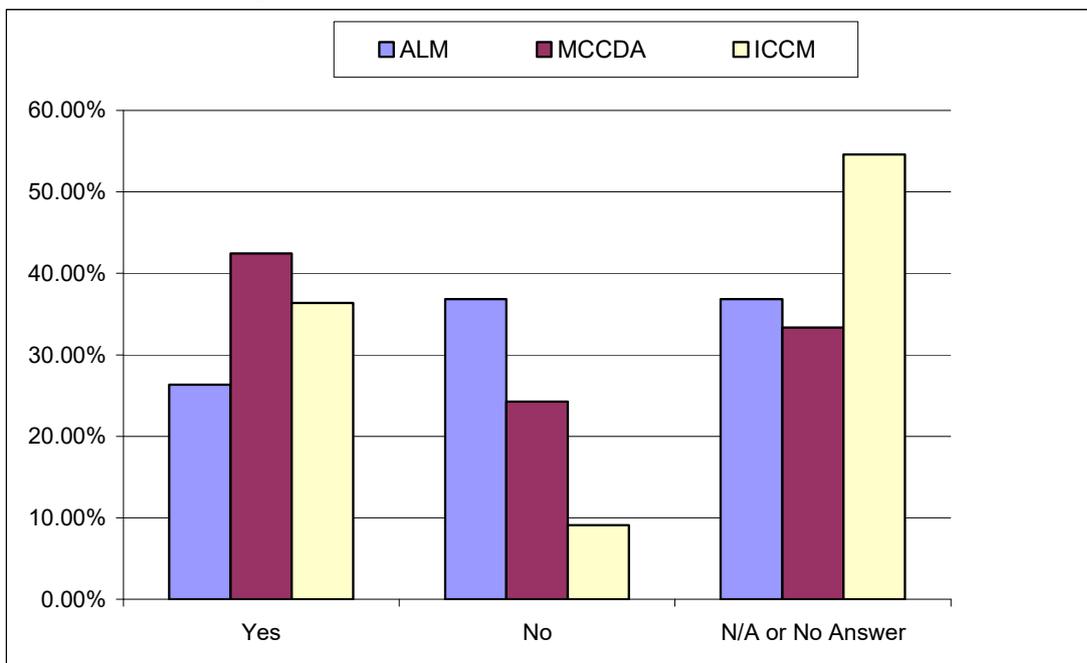
The majority of responses were very positive:

Helpful	Life would be difficult without Pagoda
Supportive	Timely
Approachable/friendly	Very good
Organise activities	Disagreement, don't use services

### ICCM

*'I discovered PSS through a friend. I found the counselling excellent.'*

## 3.7 Were there things that made it difficult for you to seek help when you were mentally unwell



### MCCDA

82% answered yes and 18% no. Reasons given were:

- *Language barriers and lack of knowledge about services*
- *Language barriers within Chinese community and outside the community*
- *Don't know where to get help*
- *Stigma and stereotype. Generic service for all. Not tailored for the individual. Not sensitive towards religious and cultural beliefs. Not friendly atmosphere*
- *I don't know as I am no longer in control and I don't remember much*
- *Don't want to cause problems for others and feel obligated to them for helping me*

- *Shame, don't know if people are trustworthy*
- *I don't want to go out. I think there is someone in our house and things seems to be going missing*
- *I want to be alone*

9 of the respondents that answered yes to question 3.7, did not give consistent answers for the question that followed regarding using mental health services. This information was recorded as NK (not known)

### **ALM**

9 Yes 12 No

- *Because I was an Asylum Seeker, I was scared to open up*
- *Being asked about your status*
- *Doctors didn't understand me when I told him I was anxious, thought it was normal, nearly committed suicide when Home Office refused me*
- *I was too upset to talk about anything*
- *It took too long for the social worker to take him for admission*
- *Lacked knowledge of the Mental Health services. The stigma of being an Asylum Seeker*
- *Thought that he had asked for so much that he couldn't ask any more*
- *My NASS support was terminated so I was automatically barred from access to these services*
- *She didn't have someone to assist her*
- *Stigma associated with it - the impression of other people*

The stigma of being an asylum seeker along with being labelled mentally ill prevents many people from asking for help

### **ICCM**

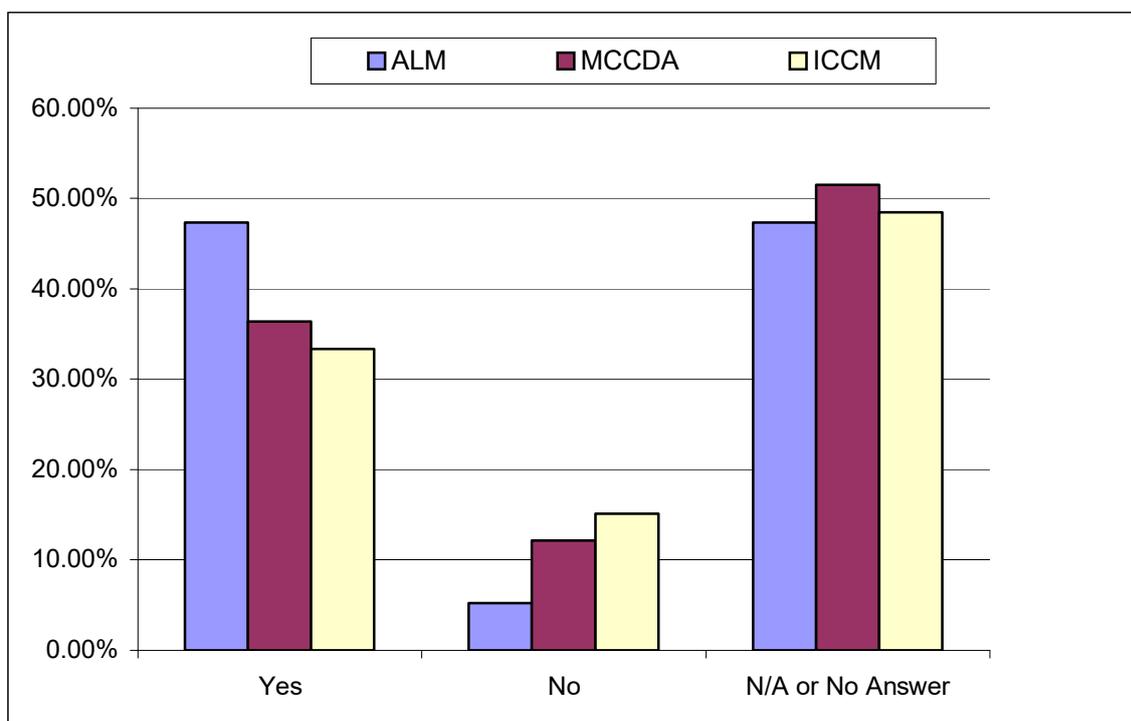
12 Yes 3 No

- *I was crying out for counselling but my GP did not suggest it*
- *A more specialist hospital (Walton)*
- *All the stuff I've already mentioned - lack of information I suppose it boils down to. Also - my Mum had a very poor attitude to mental health problems. She was very unsympathetic and told me to pull myself together.*
- *Being a stranger in a strange town*
- *Didn't know where to go*
- *Didn't know who to go to and too stubborn to go. Nothing made it easier*
- *The whole system*
- *Yes - culture of keeping going*
- *Yes - finding my way through the system. It was slow and confusing*
- *Yes - hard to do anything when you're feeling depressed*
- *Yes - I found that if you're not already known to the system and familiar with it, it is very difficult starting from scratch. I would never have accessed a decent psychiatrist if it weren't for Mary Seacole House. Prior to that I'd only seen a succession of locums who were sexist and completely*

*uninterested. It felt like I was seen as not physically dangerous and therefore not relevant to services.*

- *Yes - no energy, No money. No information.*
- *Yes - people thought I was putting it on (pretending) Doctor gave me gip.*

### 3.8 Was there anything that made it easier to get help



#### **MCCDA**

75% answered yes to this question and 25% said no. Things that made it easier are listed as:

- Interpreters
- Family
- Chinese community centre/organisation with Chinese speaking staff
- I am a regular service user
- Information leaflets

#### **ALM**

14 Yes, 1 No

- *A&E showed that they are caring by attending to him and asking him how he was feeling*
- *Because it was arranged*
- *Being helped by friends*
- *Doesn't know*
- *GP referring to Psychologist*
- *Having money (credit) on her phone*
- *I think that arrangements by the doctors made it easier*

- *I was connected with refugee action and social inclusion team and then to GP*
- *I was still under age (minor?)*
- *My English was not so bad*
- *My Social Worker organised everything for me*
- *She went to a women's drop in centre. She goes there to spend time and later mentioned it to a friend who directed her to their services*
- *Social Services looked after him very well and provided transport whenever needed*
- *The help I was getting at ALM*
- *The prayers and when she listens to people. They share their problems. She also has night prayers and what she asks for, she gets*

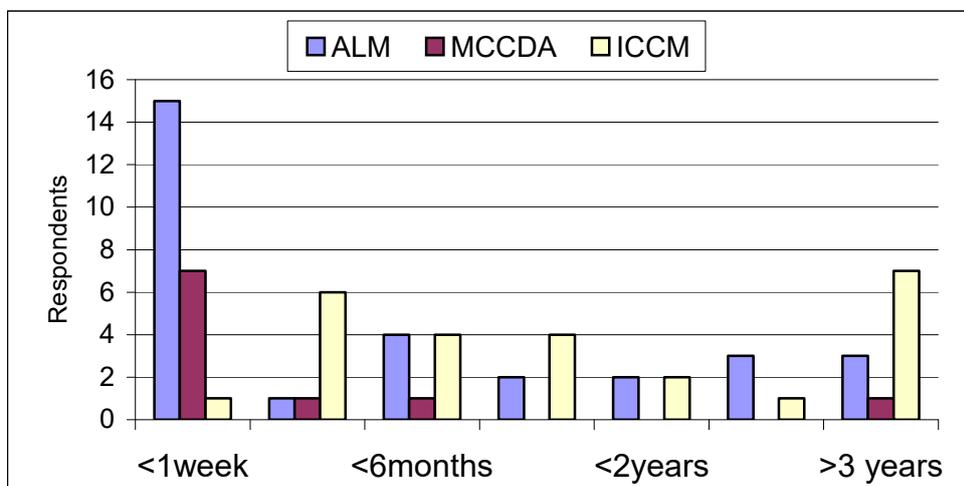
### **ICCM**

11 Yes 5 No

- *Mary Seacole House was the main thing that made it easier to get help*
- *GP is a lovely lady*
- *ICCM - signposted to other services.*
- *If I know what I want I'll hunt it out. I'm quite determined..... friends will point you in some direction.*
- *My GPs support was good but he did not move me forward. I had to ask for a referral.*
- *Good GP and Counsellor*
- *Having been a nurse*
- *ICCM*
- *Network of agencies - signposting from ICCM*
- *ICCM and Brownlow Practice*
- *Careworkers at Whitechapel*
- *My despair and determination*

## Section 4 – Experience of Services

### 4.1 How long had you been ill before you accessed professional help



#### MCCDA

9 out of 11 were seen within a week. 2 cases were probably physical problems. One person was seen within one month, another was seen within six months and another said that they waited for over 10 years.

#### ALM

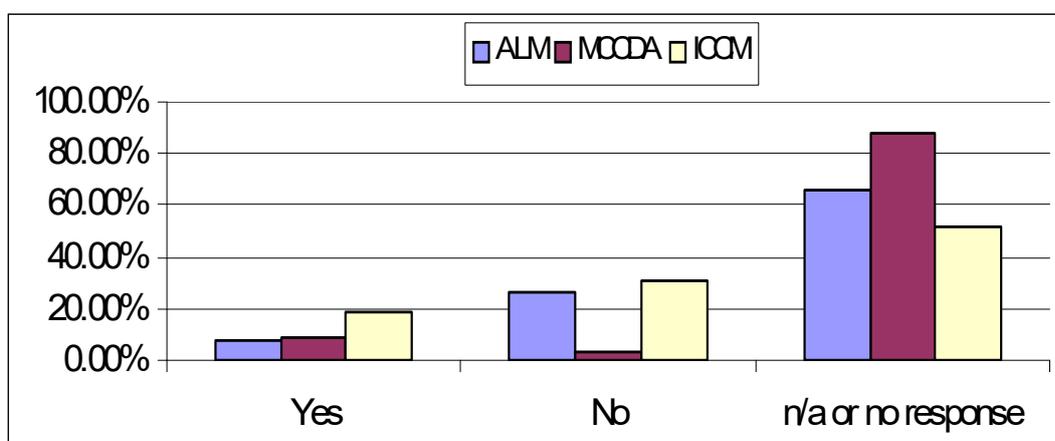
Majority of people within a week – but one or two took years

#### ICCM

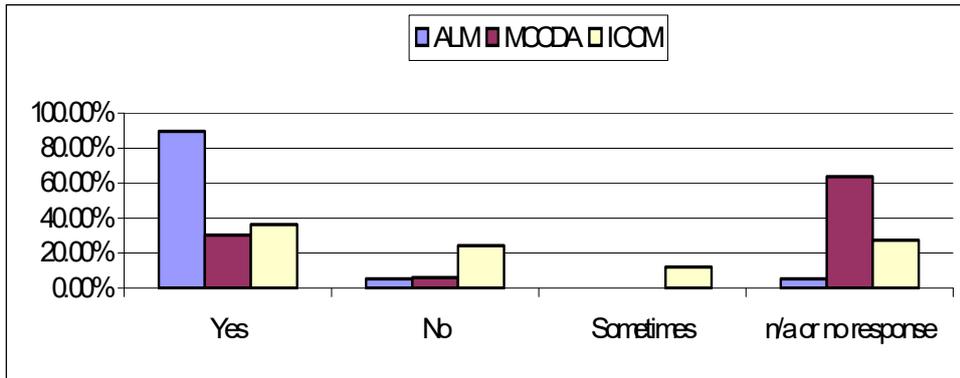
The majority of participants sought help within a year of feeling unwell.

### 4.2 Describe your experience of the service that you used

Were you treated with respect? Was your dignity respected?



## Were you listened to?



### MCCDA

This question produced rather polarized responses:

Five people said that the doctors/staff were patient/kind/very good/comforting/willing to help.

Other responses are as follows:

- *Good as I know the system*
- *Usually good, but drugged up to the eyeballs*
- *Not as good as before*
- *Staff quite horrible and physically violent*
- *Some doctors are good and some are bad*
- *No one woke me up for meals*

Of the 12 who answered, 73% were treated with respect and listened to.

There was no preference for single sex wards

### ALM

Majority good – 55% Quick, caring, kind,

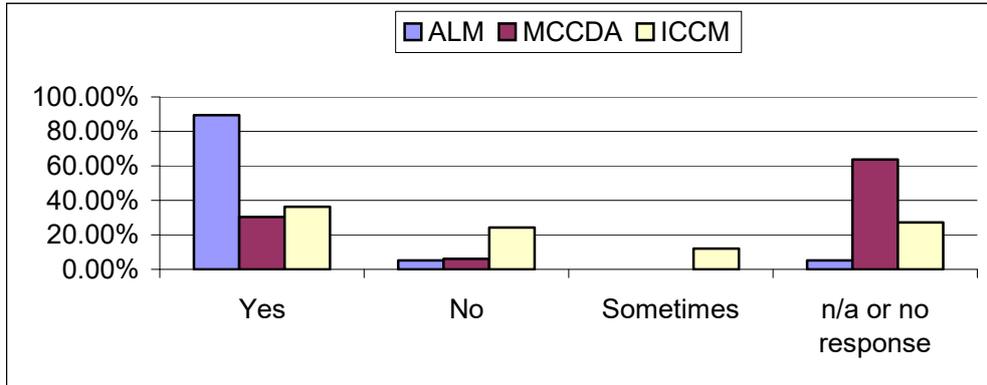
Majority of people listened to and treated with respect

Single Sex ward – 8 No, 3 Yes – most people seemed not to mind but it should be an option

### ICCM

Yes 12, No 8, 4 sometimes, 12 n/a or no response

### 4.3 Was your illness explained to you



#### MCCDA

8 people answered yes to this question, and 2 answered no

#### ALM

25 Yes, 4 No

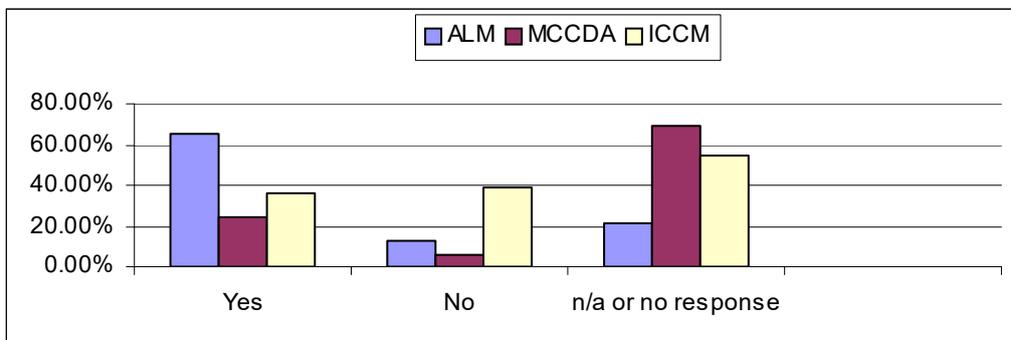
#### ICCM

12 Yes, 12 No, 2 Sometimes

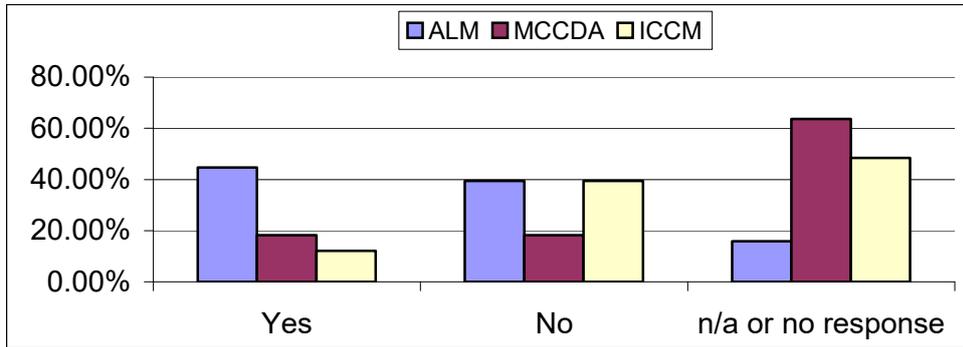
*'No, my illness was not explained to me, I hallucinated in hospital for a week. They did not explain about my illness.'*

*'I was suicidal for weeks in front of my children, was then taken to hospital'.*

### Did you understand



#### 4.4 Did you see the same clinician each time



#### MCCDA

5 people said yes and 5 answered no. Responses ranging from:

- *I have a preference as the same doctor knows my problems better*
- *Saw same counsellor for ten sessions*
- *At first, I saw the same doctor but not anymore*
- *Different as there are many doctors on the ward*
- *Different doctors, hardly saw the same doctor*
- *The same clinician would be much better. I have to repeat myself every time they speak to me*

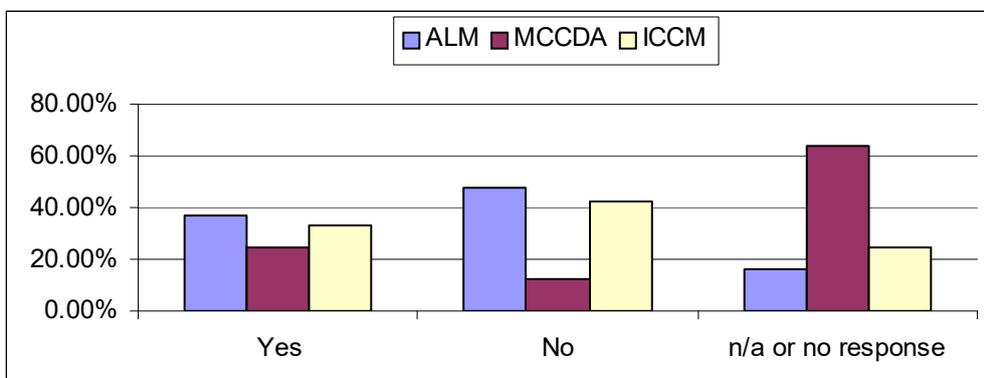
#### ALM

About 50/50 for seeing same GP and most people seemed to accept seeing a different person as just the way the system was.

#### ICCM

Yes 4, No 13, No response 16

#### 4.5 Were you made aware of a choice of treatments appropriate to your needs



#### MCCDA

Five people answered yes and six said no. Most respondents said that to an extent treatment was appropriate.

*The doctors would change the prescription if side effects were diagnosed.*

*I did not have a choice in the matter as it was decided for me.*

*If I show sign of improvement, the doctors would increase my medication and give me injection.*

Other respondents said that they had no choice of treatments. They accepted any medication that was offered to them.

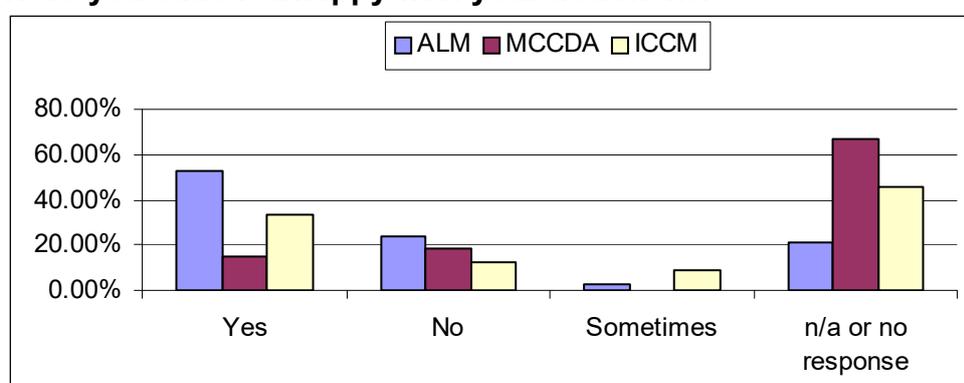
ALM

11 Yes, 18 No

ICCM

11 Yes, 14 No, 8 No response

### Were you satisfied/happy with your treatment?



MCCDA

5 Yes, 6 No

ALM

20 Yes, 9 No, 1 Sometimes

ICCM

11 Yes, 4 No, 3 Sometimes

**NB** It is important to analyse questions 4.2 – 4.7 as a group in order to highlight the connection between the way people are treated and their perception of a service..

Where someone's illness was explained and understood, the same clinicians were seen and a choice of treatment offered, people, in general, had a much better perception of the health services provided

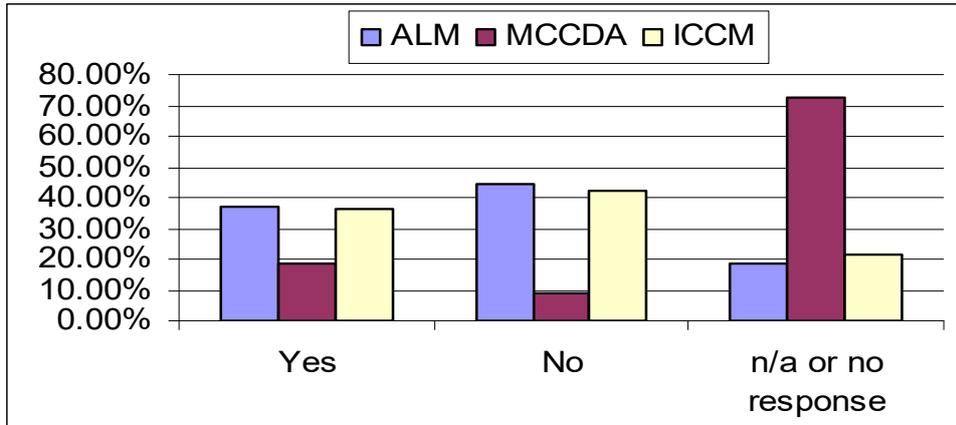
However, where there was no explanation of the illness, different clinicians were seen and no choice of treatment was offered, this resulted in a poor experience for the service user.

What is emerging from these questions is that if treatment is properly explained and people are given the time to understand and become aware of what is going

on, their response is much better. Everyone offered a choice of treatments was happier.

*'The doctor tried his best to explain to me what side effects I may get and reassured me that I should not get worried because they would subside with time. So I took the treatment with confidence and was ready for everything. He referred me to a counsellor whom I shared my situation with and tried to guide me to see how I would be able to cope with my problem.'*

#### 4.6 Were the possible side effects of medication explained to you



#### MCCDA

5 people said yes and 2 said no

#### ALM

13 Yes, 16 No Only 4 said they had side effects but from reactions during the interviews, a significant number of people recognised they had side effects after having them listed.

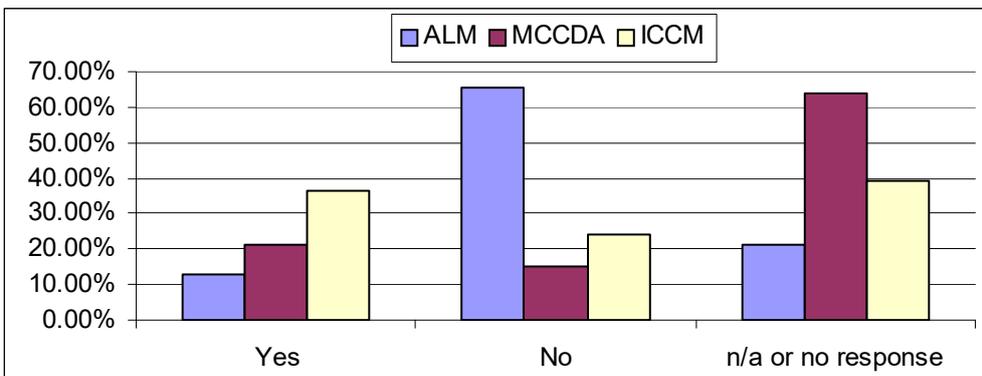
Many people did not connect the sleeplessness or headaches they were having with the medication they were taking. Sometimes they took a side effect to be something which indicated that the medicine was working. Sometimes it was only after the medication was finished that the side effects occurred.

In general, even if the person was told about side effects, the explanation seemed inadequate. Perhaps medical jargon was used which is not well understood showing the need for simple language and interpreters.

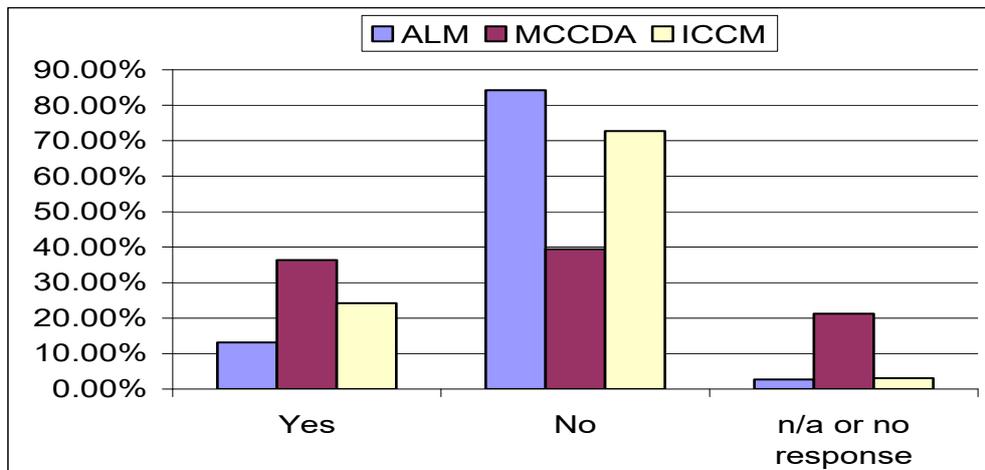
#### ICCM

12 Yes, 14 No, 7 no response

#### Did you suffer side effects



#### 4.7 Do you know what a care plan is



##### **MCCDA**

Only 24 out of 33 interviewees responded to this question. It is unclear if the question was not understood, or if 9 people did not think that the question was personally relevant.

10 people answered that they knew what a Care plan is, and 14 said no

##### **ALM**

5 Yes, 32 No, 1 n/a

As Mental Health Services purport to base their care around Effective Care Co-Ordination and Care Planning it seems very odd that people who have accessed services would not know what a care plan is. A Care Plan outlines the services a person is deemed to need and how these are to be delivered and by whom. It should be drawn up collaboratively with the service user, signed and reviewed regularly. The use of other phrases such as Treatment plan or Support plan may have confused the issue – the term is not universal.

It is recognised that not everyone who feels unwell and goes to the doctors will have a care plan. However of those who accessed psychiatrists, counselling or psychologists, none had an understanding of what a care plan was nor did they have one.

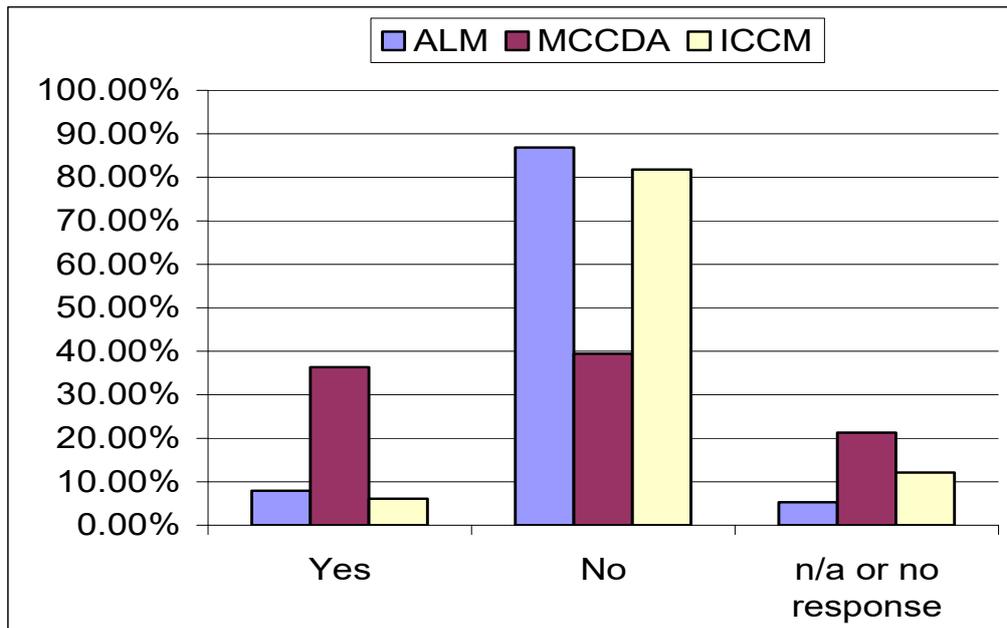
Since the care plan has contact numbers and treatment plans for people they should know about them. It is vital that this plan is negotiated between provider and patient – this links back to 4.3, 4.4, 4.5, and helps reinforce the same conclusions around explanation and understanding.

##### **ICCM**

7Yes, 24 No, 1 n/a

Again a large majority had no idea of what a Care Plan is. Many of these interviewees had at some time used the Mental Health Service so this would seem to indicate that Care Planning is not being used properly and not being explained.

## Do you have a care plan



### MCCDA

5 people answered yes, and 14 people said no. The answers to question 4.7 were rather inconsistent. Perhaps this was not clearly understood

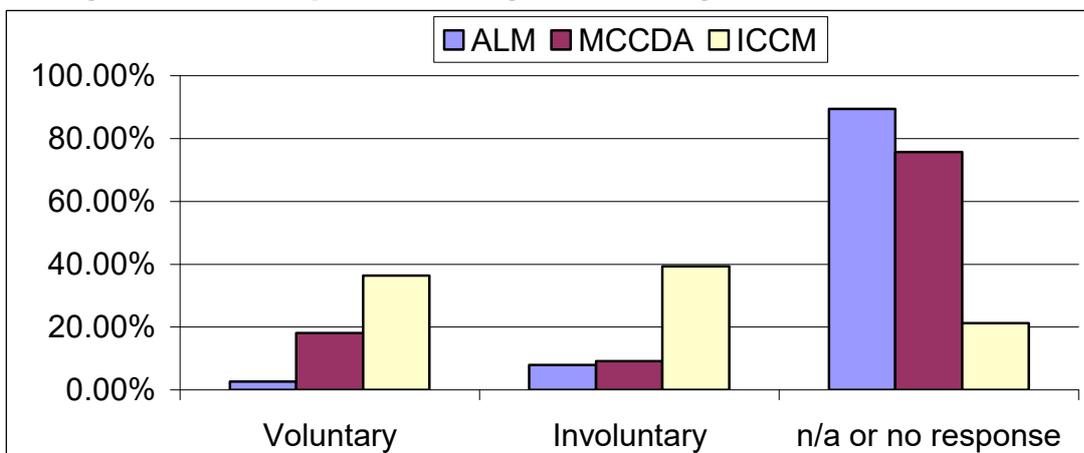
### ALM

Only 3 people said yes

### ICCM

2 Yes, 27 No, 4 n/a

## 4.8 If you were an inpatient were you voluntary or sectioned



### MCCDA

2 people were sectioned, 5 voluntary and one person was sectioned and sometimes voluntary

## **ALM**

4 people sectioned – 1 voluntary – no Police involvement

### **This seems an extremely high percentage – 12%.**

The UK wide figure is 27,353 in England in 2006, Total pop 50,763,000 (less 19% who are under 16) gives you 41,118,030 – which in turn gives a figure of 0.07% - roughly 0.1%

The relatively high number of people sectioned can perhaps be attributed to the lack of alternatives for Asylum Seekers - i.e. no family, no friends or neighbours.

## **ICCM**

6 Voluntary, 3 Involuntary,

### **If sectioned, brought in by police**

## **MCCDA**

1 person responded by saying, *'They usually come in a big group to arrest me. I joked, you all come in like a band of soldiers'*

## **ICCM**

**14 voluntary and 3 sectioned**

## **4.9 Did you have access to an advocate while in hospital**

### **MCCDA**

One said yes - Ten said no.

One respondent said - *'I complained and asked for a lawyer. They helped me to get one to represent me at tribunal'*

### **ALM**

None had

This could have been because of language barriers. The word *advocate* is an issue - for French speakers it means solicitor or lawyer. Following on from 4.8, if you've no family or friends you definitely need an advocate whether this is a support worker or support service.

It also flags up a carer's role for the 'Asylum Link' family – we are in effect people's support workers. We also advocate on people's behalf.

**ICCM**            2 (possibly 3 – 1 person did not know)

Summary - from a total of 38 people who were hospitalised - voluntarily or otherwise - only 3 (possibly 4) had advocates

#### **4.10 What was your experience when leaving hospital**

##### **MCCDA**

5 people were offered community support, crisis support and a 24 hr emergency. 5 people had no follow up services.

**ALM** 4 people had follow up – Social workers. All the people sectioned had some form of ongoing contact when they arrived home.

**ICCM** One GP referral - one Outpatient appointment

Summary - Of the 38 people admitted only 11 had any form of follow up

**4.11 Do you know about Advance Statements** *(An Advance Statement is a document, written or dictated by a service user when they are well, stating how they wish to be treated if they become ill again. It can include arrangements regarding their homes, pets and financial affairs. It can specify medication or treatment that they do not wish to receive and people that they do or do not wish to visit them when unwell. It must be signed by two witnesses and should be kept with the service users records.)*

6 (1 MCCDA and 5 ICCM) out of the 104 respondents knew about advance statements

##### **Do you think it was/would be useful to you**

59 out of 104 said they felt it would be useful

## Section 5 – Participant Recommendations

These are the recommendations taken from the structured questionnaires. They have had key words placed at the front of the recommendation and were then sorted to try and show major areas of concern or importance. To provide an overview the data from the 3 communities has been brought together, however, to preserve the group identity from which the recommendations have come, different text has been used to indicate which community said what. The following comments come directly from the research participants.

Plain text – ALM     *Italic text – MCCDA*     **Bold text - ICCM**

### 5.1 What would have made the whole experience of using Mental Health Services better?

#### Access

*Easier access and simpler referral system, more choice of treatment*

Better access for Asylum Seekers

Appointment reminders and collection for appointment if needed

#### Advanced Statement

**Advanced Statement (would have made the experience better) had I been aware of it  
Being told about Advance Statement**

**Advocates - Having a social worker**

#### Communication

*Communication - better listening skills in staff,*

*Staff who can speak the language*

*More patience*

*Respect for the elderly*

*Doctors taking time to know patients*

*More counselling, less medication*

**Communication - explain to you what's wrong with you and why**

**Dignity - proper hospital robes.**

**Personal Touch. Better communication.**

**Education and Training - More clued-in GPs**

#### Community/Community Workers

Provide Health Workers in the community. Recruit from within communities.  
Provide information direct to homes

**Publicise - Community Centres**

**Local free papers, Internet, Schools/PTA, Gyms, local radio**

**Publicise - Community Centres and lunch clubs. Pensioners telephone line**

**Publicise - Community Centres Surgeries - in large print**

**Publicise - Community centres, A&E, local radio**

## **Publicise - Community Centres, CAB, Health visitors**

*Home visits from Community Workers*

### **Cultural sensitivity**

*Culturally sensitive health services*

*Lack of cultural awareness.*

*Lack of interpreters, well trained interpreters needed*

*Lack of knowledge. Language Barriers. No advocate or support worker.*

*Language barriers, don't know rights or how the system works*

*Staff lack understanding of Chinese culture.*

*Language barriers. There are no bilingual advocates, advisors and health workers.*

*I can't access MH services. I have mobility problems due to a stroke and I cannot make myself understood*

*Better Services - GPs who understand the language*

*Chinese speaking Doctors and Staff - friendly staff.*

*Doctors with the same language.- Make things so you are more able to explain your illness*

Professionals don't take Travellers seriously - stereotyped for being a Traveller –

Well trained staff who can pray with people

Discrimination – because I am an Asylum Seeker, because I am Black

Don't know about what is available. Asylum Seeker status limits access

Stereotyping of Asylum Seekers. - Stigma

Unfriendly Health Policies

### **Information**

*Simple written information - no jargon*

*Spoken - by community workers, local radio*

*Spoken - not all travellers can read*

*Better information on getting access to what I needed*

*Leaflets about GP services at Job Centre*

*Through Community Workers*

*Clear simple information - community counsellors, libraries, CAB.*

*Delivered verbally*

*Information in hostels*

*Home visits*

*Health Centres*

*Social Security Offices*

*Key workers*

*Face to face*

*Leaflets*

*DDU(Drug dependency Unit)*

*Surgeries*

*Local radio - I can't read*

*Spoken personalised local information*

*Travellers don't realise there is help out there.  
Lack of community counsellors  
Lack of information in the community.*

*Need more available*

*Friendly Staff.*

*No difference in treatment because of Asylum Status*

*ALM Staff & volunteers & other NGOs should be made aware of mental health services in order to pass on information*

*Through Advocates - Asylum Seekers should have social workers to guide them where the services are*

*More translation*

*More widely available. Better trained staff*

*Local community centres*

*Centres attended by Asylum Seekers*

*Community Organisations*

*GP Surgeries, Charities and Chemists -*

*Media*

*Public institutions*

*City centres and organisations*

*Public places such as schools, hospital, surgeries etc*

*More knowledge and information about mental health and available services*

*Audio visual materials for home use - well explained and translated materials*

*Bilingual leaflets, bilingual signs in hospital*

*Bilingual materials, Bilingual staff*

*TV, radio*

*Information through Pharmacists & Community Centres*

*Community nurses/workers interacting with the community*

*Direct contact.*

*Education - more within the Chinese community, for friends and family*

*Health Education talks - translated materials*

*Home visits - information in Ni Bo dialect*

*Leaflets to homes*

*Awareness raising with home visits, advertise services widely*

*More Chinese community workers*

*Publicise - TV, radio - in Ni Bo dialect*

*Proper explanation of the services available and how they work*

*Mental Health awareness talks*

*TV, radio, translated leaflets in Shanghainese and simplified Chinese*

*Spoken Communication*

*Talks from specialists*

*Talks - mental health awareness days*

*Translated materials*

## **Services**

*More services locally*

*Make services more easily accessible to Asylum Seekers*

*Quick access to GP - mental health services available at the surgery*

Quicker access  
Quicker appointments  
Quicker appointments - more counsellors  
Treated without prejudice or reference to Asylum Status

*Lack of inter agency working*

*Reduced waiting times*

*Right Treatment*

*An easier, clearer pathway through*

*Specialist dry clinics for heroin addicts instead of just writing methadone prescriptions*

*Support alongside medication*

*Support and guidance at the important times*

*Security - Ward and staff policy on prevention of violence/racism*

*Single sex wards*

*GPs of the same gender as the patient*

*People in the surgery to talk to as GPs have no time*

*Mental Health Services seem to be a dumping ground for drug and alcohol problems*

*No meaningful activity on wards*

*Caring for people now is just a business not a profession.*

*Security - prevent attack by violent patients*

*Security - wards - privacy and security, less overcrowding*

*Hospital environment - freedom to leave to visit and at weekends, paid travel expenses*

*Uncommitted and untrained staff - poor attitudes*

## **Staff**

Friendly and sympathetic

Friendly - more information

Friendly services available from clinics through to hospitals

Friendly well equipped hospitals

Give people status on arrival

Good advice and treatment

Good environment, treated by nurses as well as doctors

Health Services to inform Home Office of problems

**A more culturally sensitive & caring attitude - they've got you by the short and curlies**

**Empathy - Understanding - Follow-up**

**Listening**

**Listening health professionals**

**More compassion - more listening - more understanding**

**Sensitivity to needs and personal circumstances.**

**Having medication properly explained.**

**Staff bad attitudes, uncaring, unkind.**

**Dr's make assumptions, bad mannered receptionists**

**Lack of empathy and understanding**

**Lack of training and understanding**

**Not listened to**

## 5.4 What are the 3 most important features of a Mental Health Service?

### 1st Priority

**24 hour service - ease of access**

**Help with Alcohol problems**

**All patients are listened to**

**Care Plans**

**Choice - Good drugs, some physical treatments such as massage.**

**Communication - explain what's wrong**

**Compassionate Staff**

**Confidentiality**

**Everyone treated in same manner**

**Openness**

**People to be polite and understanding**

**Jargon free**

**Good Clinicians**

**Holistic Services not just dependent on medication as treatment**

**Honesty re diagnosis**

**Treating each person as an individual**

**More accessibility to a variety of supported opportunities in mainstream life and less segregation**

**More prison doctors**

**Respect - you have to give respect to gain it back**

**To explain, to listen - I was refused treatment at the Royal because I was anxious, confused and they didn't try to understand**

*MH services that are culturally appropriate, private and understand my language barriers*

*A caring service that will take time to listen to me*

*Better cooperation between GPs and other health professionals*

*Bilingual staff who understand my language and culture*

*Cantonese speaking staff because I can't speak English or any other Chinese dialects*

*Chinese GP*

*Chinese staff who can speak Hakka*

*Dedicated mental health services that cater to Chinese speaking patients, and culturally appropriate*

*Facility should not be far from Chinatown*

*For old people, a social worker or health visitor can assist them whilst in hospital*

*Good communications, environment and working conditions*

*Joint working between the professionals who deliver the care*

*More bilingual staff*

*Plenty of therapeutic activities such as singing, drama and social activities*

Asylum Link should be allowed to access all services

Kind and understanding staff

Equal access for everyone regardless of ethnicity and immigration status

Fairness to all users including Asylum Seekers

Treatment based on need

Provision of information on how mental health problems present so that people can come early to the doctors  
Same treatment no matter what colour or status

## **2nd Priority**

### **Advance Statements**

**An understanding service treating people sympathetically**

**Caring-Listening-Action**

**Counsellors & Information**

**Homely environment somewhere you'd want to go - no clinical rooms**

**Honesty    Listening    Genuineness**

**Let people talk**

**Liaison with family-Safe aftercare**

**Listen - instead of writing a prescription**

**More access**

**More understanding**

**No-one forced to share accommodation with the opposite sex, with people who may assault or bully them**

**People being valued**

**Quality staff - non judgmental**

**Quick referrals**

**Self referral**

**Someone to talk to**

**Spend time with the patient**

**Things explained in simple language**

**To be heard without bias**

**Treating people as individuals**

**Understand different cultures - Don't treat us as aliens**

**Understanding people's needs**

**Understanding local services**

**Vocation in staff**

*Awareness of Chinese culture and dietary needs*

*Awareness of Chinese customs, culture and diet*

*Best facilities*

*Better cooperation between nursing staff and patients*

*Better follow -up services*

*Better living environment on wards with more space, furniture and sofas*

*Bilingual staff would be ideal then I can speak to them directly*

*Chinese interpreters who are sympathetic, approachable and friendly*

*Chinese leaflets on medication*

*Confidentiality of records*

*Diet needs to cater for Chinese tastes*

*Employ kind natured staff who will not lose their temper*

*Facility that has good security and privacy*

*Good follow-up care and advice to patients*

*Good support*

*Health professionals who can understand Chinese culture*

*Highly qualified and experienced staff who are caring and approachable*

*Language support*

*Named worker designated to help me*

*Offering a whole range of treatments and support which are socially, culturally and spiritually appropriate*  
*Outings to various places*  
*Provide facilities for older people*  
*Providing advocates and interpreters*  
*Services tailor made to my needs*  
*Services that are culturally and language appropriate*  
*Staff that understand Chinese culture*  
*Provision of Chinese food*  
*Staff who speak Hakka and Fukien*  
*To have choice about my care*

All clinical/hospital staff should be kind and understanding to create a friendly service for patients  
Better care services where people should feel loved and accepted  
Good Environment, Provision of Good Medication  
Helpful Staff and awareness of different cultural background  
Right medication  
People should progress and be healed, not just kept on medication  
Single mums should be helped to cope with their situation right from maternity  
Support from Public organisations  
There should also be not only nurses but professional doctors to deal with the patients  
Treating Asylum Seekers like anybody else  
Well Trained Doctors and Nurses

### **3rd Priority**

#### **More Information**

**Be approachable**

**Counsellors at GP practices**

**Day centres - goals - things to do**

**Dignity is paramount**

**Drop-ins Community nursing**

**Community support for all service users - whether through CPNs or some other role**

**Caring**

**Get rid of half the paperwork and targets and let nursing staff CARE**

**Good environment**

**Holistic Cultural sensitivity**

**Information**

**Listening**

**Mental Health Support groups in the community**

**Immediate access - Self referral - not having to wait for weeks/months when in need**

**More funding**

**One building for all services instead of closing everything down**

**Open access - self referral**

**People to be happier leaving than arriving**

**Personal Care Plan**

**Properly ethically managed resources and facilities**

**Same person to talk to**

**Smiling**

**Staff with empathy - Smiles on faces**

**Visibility**

Employ God fearing people to pray and cast out the demons disturbing people

Equality of treatment regardless of Mental Health

Good reception Staff

Good trained doctor, someone who understands patients in such conditions

People under age need advice through their social workers and NHS as they cannot manage themselves and the environment they are in

Right advice from the doctor because health is not just about medicine but also about good advice from the doctor

They should ensure that sanitary facilities are clean and adequate in size

*A flexible service that can meet my needs, gives me time, and is willing to listen to me*

*A venue suitable to Chinese people where they feel comfortable, acceptance and belonging*

*Approachable staff*

*Better education about medication and side effects, more options about medication*

*Care should be accessible and timely*

*Chinese doctors and nurses who can speak Chinese to me*

*Chinese staff who can speak my dialect*

*Consultation between professionals, patients and their families in suitable care*

*Easy transport to the facility*

*Facilities made available for religious and faith practices*  
*Facilities should be in the city centre, Chinatown or where there is a large Chinese community to ensure involvement from Chinese people*  
*Facilities should be located in the town centre so it is easy to access*  
*Facility in a central location with good public transport*  
*Good follow-up*  
*Help with getting benefits for people who are ill - disability living allowance*  
*High level of support, education, services and information about the NHS for those who don't understand the system*  
*Improve the appointment system to make it easy to access*  
*Information to be more accessible*  
*Lots of leisure and recreational activities*  
*Mental health centre for Chinese people easily accessible by public transport*  
*Mental health centre near Chinatown*  
*Mental health services located within the Chinese community*  
*More female staff and more privacy*  
*MH facility in town centre with easy access to public transport*  
*Single sex wards in a secure setting. Sometimes male patients wander into female wards and I don't feel safe when that happens*  
*Staff who are caring, who develop and gain patients' trust*

## Individual Community Findings and Recommendations

### **Recommendations from Asylum Seekers and Refugees Interviews**

#### A. Information

Information should be universally available, in translated form, preferably as part of a welcome pack. It should describe the services available to people and how to access them. The information will require detailed updating for local services in each area.

This information should be made available at critical points in the journey through the asylum process including: The Home Office, Accommodation Providers and Asylum Seeker friendly centres and agencies. (the key organisation here is the Home Office as 100% of all Asylum Seekers will be required to attend there)

Many of the respondents to the survey expressed the wish for information to be available on TV, Radio and other media. Whilst accepting that this may not be easily attainable, we would recommend that this and other ways of making information available be explored.

#### B. Routes into Mental Health Services

There must be a well defined and easily accessible route to mental health services, providing universal and timely access. Most Asylum Seekers recognise the GP as the first point of contact therefore Asylum Seekers and Refugees should be put into contact with GP Services as soon as practicable. We also feel that the potential need for a specialist integrated Health Centre in Liverpool, dedicated to Asylum Seekers should be addressed. Given the increased numbers of Refugees coming through the city, this could be the key gateway to mental health services, currently missing, and should provide screening and preventative measures, as well as ongoing treatment.

We would also argue strongly for an on-site health care professional in places such as initial accommodation centres or in drop-in centres accessed by large numbers of Asylum Seekers. This person would not only have a role in assessing, identifying and treating people, but would also create a therapeutic environment using techniques such as cognitive behaviour therapy and anger management. They would also advise staff, volunteers and others accessing the centre, developing a 'culture' of mental health care as well as identifying the services and routes to mental health services.

#### C. Levels of care and the delivery of care

People should have their illness properly explained to them. They should ideally see the same professionals each time they access care. They should be made aware of the choices of treatment available to them. They should be made aware of possible side effects of treatment. They should be integral in drawing up their care plan and have as practicable as possible an understanding of what it is, what it means and how to use it. (the care plan not only sets out what will happen and who to call in an emergency, but is also viewed as a form of access to

services, i.e. what is available to the patient. It is therefore a crucial part of someone's treatment)

Implementation of this recommendation means that Health Professionals need to take care and time to properly explain to people what they are experiencing, how it is likely to affect them and to incorporate the Asylum Seeker, as much as possible, into the process of getting well. In order to do this, GPs, other healthcare professionals and their frontline staff, (i.e. receptionists), should be given adequate training and information on the Asylum process in the UK and background information on the reasons people flee to this country.

The following findings need to be borne in mind when evaluating the recommendations.

- i. Over 50% of Asylum Seekers and Refugees had a score of over 15 on the PHQ9 depression screening tool, indicating that over half the group had a level of depression which could require medical intervention. This ran from medium to severe depression.
- ii. 70% of participants felt their circumstances had affected them mentally. 50% felt their problems developed after their arrival in the UK.
- iii. 12% of the sample had been sectioned and detained as compared to less than 0.1% of the UK population
- iv. The Status of being an 'Asylum Seeker' and the way the Home Office processes their claim affects people's health.

These statements indicate the severity of the problems faced by Asylum Seekers and the need for information and services to be made universally available.

### **Information to Health Professionals**

GPs and other healthcare professionals should be given adequate training and information on the Asylum process in the UK and background information on the reasons why people flee to this country.

## Recommendations from Irish and Irish Traveller Interviews

- Adequate **community counsellors** whom people can access quickly and who are culturally sensitive. We recorded, particularly within the Irish Traveller community, many instances of inappropriate treatment that caused additional stress to the service user and had no success whatsoever. Travellers do not easily discuss personal problems – even in their own community. There is, therefore, no point in sending a suicidal depressed and traumatised Traveller to Rodney Street for group counselling. They will not make it past the front door.
- A system that allows **self-referral** when help is urgently needed.
- A **24 hour mental health crisis service** The only place that people have to go, out of hours, is an A&E service that routinely turns distressed people away and discharges suicide attempts without any psychiatric referral or follow-up.
- Proper **Care Planning**. Only one person interviewed knew what a care plan was. All who were hospitalised had been discharged without either care-plan or any community support arrangements. No in-patient was aware of the existence of a care plan. Our health service professes to base patient care around care-planning – they don't.
- A good, effective **Homeless Outreach** service. A large proportion of homeless people interviewed had never been approached by outreach personnel. The most help they receive is from three charities – The Whitechapel Centre, The Basement and the Sisters in Seel Street. Homeless hostels run by the council are ill-staffed, ill-run and offer no proper support for those using them. Most of the clients are drug-addicted and those that are not quickly become so through association.
- **Interagency Working** There is a deplorable lack of communication and joined-up working between agencies. As one interviewee said *'what good is it going in to detox for two weeks and then coming out to the same hopeless, homeless situation?'* Another asked *'How come that I get more support to stop drinking in prison than I do in the community?'*
- The lack of any proper treatment for those with a **Dual Diagnosis** (Alcohol/Drugs and Mental Illness) is a tragic manifestation of this refusal of services to work together. Service users with such a diagnosis are abandoned to a wilderness of neglect with no service engaging properly with them.
- Drug and alcohol addicts attempting to detox in the community are given methadone scripts and weekly blood tests with little or no support or counselling. How can this possibly be expected to work?
- Without fail interviewees asked for services and practitioners who **Listen instead of telling; who are non-judgemental; welcoming and empathic; who explain both illness and treatment.**

## **Recommendations based on Chinese elderly interviews:**

### **Overview of Chinese Analysis**

Language barriers remain a big issue amongst Chinese elders. Professionally trained interpreters are essential for accessing mental health services. It must be recognised that less common dialects such as Hakka, Shanghainese, Ni Bo, to name a few are spoken in the Chinese community, and that there is a need for interpreters who speak these dialects.

The Pagoda Chinese Community Centre and Chinese Carers (of MCCDA) were established to provide a variety of services to help Chinese people. Many interviewees have used these services, expressed trust in the staff and are familiar with the venues. Extending the range of services provided by these centres to include mental health services will assist Chinese elders to gain access to vital care

Some responses to question were wide ranging and showed discrepancies. For example, an interviewee said that it was difficult to seek help when mentally unwell. However, he did not disclose any information when asked about experience of services or choice of treatment.

Five interviewees who said that it was difficult to seek help when mentally unwell did not disclose any other information apart from not having a care plan. It is uncertain if these people received care or they simply did not want to answer for reasons known only to them.

Some interviewees had high PHQ9 scores but were not in contact with mental health services nor had they received treatment. Stigma remains prevalent. Coupled with the propensity to self-reliance, these factors may prevent some people from actively seeking help

### **Recommendations**

‘Care packages should be designed to meet the unique needs of the Chinese community. Offering a whole range of treatments and support which are socially, culturally and spiritually appropriate’.

‘Facilitating self-help groups for Chinese people. Providing the ‘know how’ to set up these groups with support and professional help, and networking’.

It is recognised that positive changes are more likely to take place when there is an effective partnership between service providers and service users. The recommendations fall into two main headings. Firstly, action to be taken by service providers. Secondly, action to be taken by service users.

### **Improvements in service provision:**

- More professionally trained interpreters
- Interpreters who speak a range of Chinese dialects especially the less common dialects of Ni Bo and Shanghainese

- More health professionals who speak Chinese
- Culturally appropriate services
- Staff training on Chinese culture, customs and dietary needs
- Highly qualified and experienced staff who are caring and approachable
- Quality, committed work force
- Choices on provision of care/treatment
- Advocacy – Chinese elders are largely voiceless because of their inability to speak English
- Flexibility of services
- Better follow-up services/advice to patients
- High level of support, education services and information about the NHS system for those who do not understand the system and how to access services
- Better liaison between the professional who deliver the services
- Better cooperation between GPs and other health professionals
- Facilities should be in town centre, near Chinatown, or easily accessible by public transport
- Facilities made available for religious and faith practices

#### **Facilitation of service user involvement:**

Service users can take greater control of their mental well being by being better informed about mental health matters and access to available services.

This can be achieved by the formation of self-help/support groups, with input from mental health professionals

The provision of educational material in a variety of media is also important.

- Leaflets in Chinese
- DVDs, CDs in a variety of Chinese dialects
- TV and Radio programmes in a variety of Chinese dialects
- Magazines and news letters in Chinese
- Mental health awareness talks/open days
- Health professionals disseminating information face to face in the community.

#### **Specific areas to cover are:**

- What services are available
- How to access services
- How the NHS works
- Patients rights

## Overview and Reflection

### **ICCM Research Team**

It's been quite a year! We've covered every emotion from enthusiasm to despair. We've learned how to - and absolutely how not to - carry out a project and how to rely on ourselves as experts in our own area.

The most important learning has been about ourselves – three groups from the same city who knew nothing of each other. We have worked together and developed networks and friendships that will endure to the benefit of all our communities and to our own enrichment.

There have been lessons to learn. A project researching mental illness and using, as researchers, community members who have mental health issues themselves needs to be mindful that stress can be a powerful trigger to illness. Constant deadlines and intensive learning sessions at a previously un-experienced level can create huge stress and anxiety. Our own team lost three members because of this. The project also lost an invaluable Co-ordinator at a crucial time in its development. This key co-ordinating role was then undertaken by a hitherto researcher which was an intensive drain on the research team and impacted greatly on our ability to deliver within the timeframe.

A project requiring such intensive input needs to understand the additional pressures imposed upon already under resourced organisations, who day to day are balancing the tasks of delivering quality services to many vulnerable Service Users, trying to communicate clear messages at a strategic level and accessing funding to continue to deliver much needed services. The level and intensity of work involved in such a project across three community organisations needs to be resourced properly, to ensure that they can effectively participate without impacting so greatly on their core business. There also needs to be sufficient financial resources to ensure that participants receive appropriate remuneration for all their hard work and commitment.

The timeframe of any further projects needs to be revisited. From our perspective valuable time was wasted in the planning / set up stages leaving minimal time for the completion of the research over an extremely busy time for everyone i.e. the Christmas festivities. We understand completely that UCLAN support is also under resourced but we felt that towards the end of the project the research teams were offered very little support and organisations left to challenge each other to complete a clear comprehensive and professional research report.

ICCM was adamant that the completed report could not be submitted until the team was satisfied that it fully reflected the input of all participants, was consistent throughout and had strong collective recommendations, so apologies to all who may have felt that our team were becoming an extremely painful thorn in the side!!!!

We scroll through the pages of this report and think how dull and uninteresting it looks. What a shame that 'official' writing cannot incorporate some of the colour, vitality and variety of its participants. Why does the 'system' have to be so un –

inspiring? Why must the template strangle the individuality that it purports to champion?

Where is the opportunity to show you some of the extraordinary people we interviewed? The incredibly brave elderly people who have battled adversity and neglect with humour and courage and unflagging pride and independence. Homeless people, many experiencing addictions, all of their potential buried and failed by systems that purport to help them. The mentally despairing, so many of whom our emergency services seem to regard as a nuisance. Why do our social 'systems' and 'services' so often end up exploiting and neglecting the vulnerable they avow to protect?

Please don't let this project become part of the 'system' - another report gathering dust in a library occasionally sourced by an academic to help produce another and another and another.....

Please DO something to make things better. We will do all we can, making sure that as many health managers and commissioners as possible here in MerseyCare sign up to change. We promise to use it as a battering ram at every mental health meeting that we attend! All of you can do the same – please, please, do.

***ICCM Team***

<i>Mary O'Reilly</i>	<i>ICCM Researcher</i>
<i>Valerie Gray</i>	<i>ICCM Administrator</i>
<i>Ita O'Keeffe</i>	<i>Project Co-ordinator until October 2007</i>
<i>Pauline McGrath</i>	<i>ICCM Suaimhneas Project Co-ordinator</i>
<i>Breege Mc Daid</i>	<i>ICCM Director</i>

**Ewan Roberts – ALM Centre Manager**

The best thing about this project has been the people involved: discovering the passion which others have for their work and communities and finding a group of people who see the need to address fundamental inequalities in our society beyond hypothetical principles and morals, but at a practical day-to-day level, the level at which most of us live our lives.

What has also come through is the self esteem within our team, generated by the project. The process of claiming asylum in the UK is de-humanising. There are very few decisions left to the Asylum Seeker: not permitted to work, no choice of where to live, paltry benefits and to be made destitute at the end of the process, as two of our researchers were, leaves people feeling powerless and isolated.

It has been a privilege to watch people grow in confidence, plan and carry out the research, to the point where they are able to play a full part in something like this, and even talk in public about their experiences. They have my respect and admiration because they have stood up and been counted for something they believe in, working from the most difficult of circumstances.

For Asylum Link, this project has stretched our resources and, at a time when visitors to the centre have risen sharply, the project has impacted on areas of

casework, management and even simple areas such as clothes distribution and bagging up for recycling.

Countering this, we have learned more about our service users and have already altered some of our practices to reflect the high incidence of depression within the Asylum Seeking communities. It has been hard work and although we may have learned a lot, ultimately, it depends on what other people – commissioners, GP's, service providers and even the Home Office – take from the report, which will be the true measure of its worth.

*Ewan Roberts*

### **Grace Nazziwa – ALM Researcher**

The project is about how people in Liverpool: Asylum Seekers & Refugees, the Irish /Irish travellers and the Elderly Chinese communities who are among the Black and Minority Ethnic groups, access and experience mental health services.

The outcome and the findings will be disseminated to the various statutory organisations i.e. Mental Health Service Commissioners and Health Professionals for the purpose of improving access to and experience of mental health services and in delivering race equality among the Black and Minority Ethnic communities.

An opportunity was offered to those who participated in carrying out the research to under go training in community based research and mental health policies and practice and qualification was attained for those who took the course and this was supported by the university.

The qualification was quite challenging but I have gained various qualities, skills and knowledge which means so much for me since it is like a stepping stone to my future career developments and prospects.

At this juncture let me take the opportunity to thank all those who have helped me especially Ewan the manager, Dr. O'Neill and Ben and my big thanks go to University lectures, Nadia Ahmed my supervisor and Manjeet, the community lead for their support. I hope the outcome will be for the benefit of all the people who are faced by this disparity in our communities.

*Grace Florence Nazziwa*

### **Helen Owen – MCCDA Research Team Manager**

The Chinese research team have thoroughly enjoyed their experiences in the research project; as we were all from different backgrounds and different life experiences; from different part of China and spoke different dialects, which made our experiences even more unique and interesting.

The methods in which we selected our researchers were quite special as we advertised the research work in local community outlets and some researchers contacted us by recommendations and word of mouth. The researchers included

a community midwife, employment and training worker, community worker, single parent, teacher, student / house wife and a fire officer; who all knew the Chinese community and trusted by them.

It has been a privilege working with the Chinese research team and also completing the Uclan Community Research and Mental Health Certificate. The whole team worked well together and it has been hard work. Nevertheless, it has been a great team building exercise for us and it has also build up our confidence in any future research work.

The Chinese elders have been fantastic in coming forward to give us their accounts of mental health experiences, which was most invaluable; without them we would not be able to complete this important piece of research.

It was great to have the whole Chinese community supporting this work and we feel that we have all contributed in helping each other. We are looking forward to the launch of the research and seeing the recommendations and findings put into practice and service delivery in “Delivering Race Equality”.

*Helen Owen*

## Appendix 1 PHQ9

### **PHQ9 Analysis – ALM**

As part of the research we tested the PHQ9 depression screening tool to see whether this could be used by non-clinicians in the ALM environment, and also to try and gauge the depth of need within the Asylum Seeker cohort.

Of the 36 participants scored, 19 had scores of 15 or higher, indicating a need for clinical intervention. This amounts to 53% of our sample and shows the pressure that many Refugees are under; several people regularly contemplated suicide.

#### 1.5 – What is your immigration status

3 of the respondents were refused Asylum Seekers – all scored very high on the scale (21,23,27). In contrast people with Refugee Status tended to score lower, the highest being 17.

#### 1.11 – Standards of Housing

This had a minimal effect on the PHQ9 score. Some people with poor housing had low scores, others in good housing had high scores. Overall the standards of accommodation are good but there are problems associated with sharing, lack of privacy and cleanliness which affect people mentally.

### **PHQ 9 Analysis – MCCDA**

The rationale behind using the PHQ 9 screening tool was two-fold. Firstly, to measure the prevalence of depression within the Chinese elders cohort, and secondly, to ascertain whether there was a correlation between prevalence and uptake of services.

8 out of 33 respondents had scores above 15 which indicates the need for medical attention. These scores were 19, 17, 16, 19, 21, 24, 18 and 24

7 people had scores of 10 - 13. These were 12, 12, 13, 10, 13, 13 and 11

In total 15 out of 33 respondents had moderate to high PHQ 9 scores, and 13 reported having difficulty accessing services.

### **PHQ 9 – ICCM**

Irish Community Care Merseyside did not use the PHQ9 Mental Health Screening Tool as part of our research process. We felt that this tool was inappropriate for our participants as many were already in the Mental Health system, either undergoing a mental health assessment or having already had a mental health diagnosis. ICCM felt that to use this tool would not achieve any additional outcome for the research and would only add to the stress and anxiety of the participants.

One member of ICCM's research team had a particularly negative experience when she unknowingly took part, without informed consent, in the completion of the PHQ9. She was very insensitively given the results, which left her extremely distraught and upset. ICCM fed this back to ensure that any training or ongoing support offered to the research teams in the completion of the PHQ9 was appropriate and comprehensive.

## PHQ-9 – Nine Symptom Checklist

**Patient Name**

**Date**

1. Over the last 2 weeks, how often have you been bothered by any of the following problems? Read each item carefully, and circle your response.

a. Little interest or pleasure in doing things

**Not at all Several days More than half the days Nearly every day**

b. Feeling down, depressed, or hopeless

**Not at all Several days More than half the days Nearly every day**

c. Trouble falling asleep, staying asleep, or sleeping too much

**Not at all Several days More than half the days Nearly every day**

d. Feeling tired or having little energy

**Not at all Several days More than half the days Nearly every day**

e. Poor appetite or overeating

**Not at all Several days More than half the days Nearly every day**

f. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down

**Not at all Several days More than half the days Nearly every day**

g. Trouble concentrating on things such as reading the newspaper or watching television

**Not at all Several days More than half the days Nearly every day**

h. Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual

**Not at all Several days More than half the days Nearly every day**

i. Thinking that you would be better off dead or that you want to hurt yourself in some way

**Not at all Several days More than half the days Nearly every day**

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

**Not Difficult at All Somewhat Difficult Very Difficult Extremely Difficult**

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## PHQ-9 – Scoring Tally Sheet

Patient Name

Date

**1. Over the last 2 weeks, how often have you been bothered by any of the following problems? Read each item carefully, and circle your response.**

Not at all	Several days	More than half the days	Nearly every day
0	1	2	3

- a. Little interest or pleasure in doing things
- b. Feeling down, depressed, or hopeless
- c. Trouble falling asleep, staying asleep, or sleeping too much
- d. Feeling tired or having little energy
- e. Poor appetite or overeating
- f. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down
- g. Trouble concentrating on things such as reading the newspaper or watching television
- h. Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual
- i. Thinking that you would be better off dead or that you want to hurt yourself in some way

Totals

**2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?**

Not Difficult At All	Somewhat Difficult	Very Difficult	Extremely Difficult
0	1	2	3

## PHQ-9 – How to Score

- Scoring Method For Diagnosis**     **Major Depressive Syndrome is suggested if:**
- Of the 9 items, 5 or more are circled as at least "More than half the days"
  - Either item 1a or 1b is positive, that is, at least "More than half the days"

- Minor Depressive Syndrome is suggested if:**
- Of the 9 items, b, c, or d are circled as at least "More than half the days"
  - Either item 1a or 1b is positive, that is, at least "More than half the days"

### **Scoring Method For Planning And Monitoring Treatment**     **Question One**

- To score the first question, tally each response by the number value of each response:
  - Not at all = 0
  - Several days = 1
  - More than half the days = 2
  - Nearly every day = 3
- Add the numbers together to total the score.
- Interpret the score by using the guide listed below:

#### **Score**

≤4

> 5-14

≥15

#### **Action**

The score suggests the patient may not need depression treatment.

Physician uses clinical judgment about treatment, based on patient's duration of symptoms and functional impairment.

Warrants treatment for depression, using antidepressant, psychotherapy and/or a combination of treatment

### **Question Two**

In question two the patient responses can be one of four: not difficult at all, somewhat difficult, very difficult, extremely difficult. The last two responses suggest that the patient's functionality is impaired. After treatment begins, the functional status is again measured to see if the patient is improving.

## CSIP Community Mental Health Research Questionnaire

A project researching how people in Liverpool of the Asylum Seeker/Refugee, the Irish/ Irish Traveller and the Elderly Chinese Communities access and experience mental health services. It is funded by CSIP (Care Services Improvement Partnership) managed by ICCM (Irish Community Care Merseyside) and supported by UCLAN(the University of Central Lancashire). The final report will be shared with the Commissioners of Mental Health Services on Merseyside to assist in the improvement of services. Participation in the research is voluntary and confidential.

**Date of interview:** \_\_\_\_\_

**Name of Interviewer:** \_\_\_\_\_

### Part 1 - Core Questions

1.1 Age last birthday .....

1.2 Gender

Male	<input type="checkbox"/>
Female	<input type="checkbox"/>
Transgendered or Transexual	<input type="checkbox"/>

*(A transgendered/transsexual person identifies as the gender opposite to the sex assigned to them at birth).*

1.3 Ethnicity: White

British	<input type="checkbox"/>
Irish	<input type="checkbox"/>
Irish Traveller	<input type="checkbox"/>
Gypsy	<input type="checkbox"/>
Other (please explain)	<input type="checkbox"/>

Mixed	White and Black Caribbean <input type="checkbox"/>
	White and Black African <input type="checkbox"/>
	White and Asian <input type="checkbox"/>
	Other (please explain) <input type="checkbox"/>

Asian or Asian British	Indian <input type="checkbox"/>
------------------------	---------------------------------

- Pakistani
- Bangladeshi
- Other (please explain)

- Black or Black British
  - Caribbean
  - African
  - Other (please explain)

- Chinese or Other Group
  - Chinese
  - Iraq/Iran/Afghanistan
  - Other (please explain)

1.4 Were you born in the UK: Yes   
No

If no, how long have you lived here ? Less than 1 year   
1-5 years   
6-10 years   
11 years or more

1.5 Are you a: British Citizen   
\*Refugee   
Undocumented Migrant   
\*Asylum Seeker   
Refused Asylum Seeker   
Other (please explain)

*\*Refugee – person having received an official ‘decision’ that they can remain in the UK*

*\*Asylum Seeker – a person awaiting a ‘decision’*

1.6 What is your first language?

Spoken or signed: .....Written: .....

1.7 Which languages are you fluent in?

Spoken or signed : ..... Written:.....

1.8 What is your religion?

- None
- Christianity
- Buddhism
- Hinduism
- Islam
- Sikhism
- Ancestor Worship
- Taoism
- Other (please explain)

1.9 What is your sexuality?

- Lesbian or gay woman
- Homosexual or gay man
- Heterosexual or straight
- Bisexual
- Do not wish to answer
- Other (please explain)

1.10 Do you have a disability?

- Yes  (please explain .....)
- No

1.11 How would you describe your housing ? Prompts: Good? Poor? Very Poor? Postal code (eg L7) \_\_\_\_\_

Housing Status :

- Actually Homeless/Rough Sleeper
- Poor Housing Conditions
- Living in Charitable Accommodation
- Living in Urban Deprived Area
- Privately Owned
- Privately Rented
- Housing Association
- Sheltered Accommodation
- Nursing Home
- Tied to a catering business
- Living with family
- Other (please explain)

Tell me about your housing :

## Part 2 - Personal Experiences

2.1 What makes you feel well/good/happy?

- Family/Friends
- Feeling safe
- Good health
- Financial Security
- Doing day to day things
- Independence
- Having a partner
- Being granted status
- Drink
- Drugs
- Prescribed Medication
- Having freedom of speech
- Religion /Spirituality
- Having a purpose/goal
- Other (please explain)

**2.2 Has there ever been a time in your life when you didn't have these things?**

Yes

No

How did that make you feel?

How did you get help?

## **Filter Questions**

### ***Chinese and Asylum Seeking Communities***

2.3 *Do you need an interpreter in order to make yourself understood?*

Yes

No

Sometimes  *If sometimes, in what situations?*

2.4 *When accessing services were you made aware of an interpreting service for your needs?*

Yes

No

2.5 *Do you think that the situation that made you leave your country has affected your health?*

Yes

No

2.6 *Did you develop this problem in your country of origin or in the UK?*

2.7 *Do you think it has affected you mentally?*

Yes

No

2.8 *If yes, have you sought help?*

Yes

No

2.9 *(If 'yes') What kind of help did you seek?*

2.10 *If no, why?*

2.11 *(If yes) Were you referred to Mental Health Services or did you find them on your own?*

*If you were referred was the process easy?*

*If you self referred how did you find the process?*

### ***Asylum Seeking Community***

2.12 *Do you think your immigration status has affected the way you've been treated?*

Yes  *If 'yes' please explain :*

No

### ***Irish Community***

2.13 *When did you /your parents/grandparents first come to the UK?*

2.14 How has being Irish/Irish Traveller in the UK affected your life/health?

Prompts:

Life experience  
Job opportunities  
Social Status  
Family life  
Health  
Discrimination

2.15 Have you at any time in your life experienced ?

Prompts:

Not feeling well   
Headaches   
Persistent Back Pain   
Stomach Pain   
Dizziness   
Insomnia   
Lethargy

Have you ever experienced any other symptoms? :

Prompts :

Forgetfulness/ memory problems <input type="checkbox"/>	Poor concentration <input type="checkbox"/>
Panic Attacks <input type="checkbox"/>	Insomnia <input type="checkbox"/>
Fear of Death <input type="checkbox"/>	Hearing Voices <input type="checkbox"/>
Mild Nervous Breakdown <input type="checkbox"/>	Depression <input type="checkbox"/>
Low self-esteem <input type="checkbox"/>	Feeling Unhappy <input type="checkbox"/>
Crying <input type="checkbox"/>	Anxiety <input type="checkbox"/>
Breathing Problems <input type="checkbox"/>	Palpitations <input type="checkbox"/>
Fear of leaving the house <input type="checkbox"/>	Attempted Suicide <input type="checkbox"/>
Paranoia <input type="checkbox"/>	Schizophrenia <input type="checkbox"/>
Other(please explain) <input type="checkbox"/>	

Do you think that any of these could be associated with mental distress?

Yes

If 'yes' please explain :

No

When did these feelings start?

Have you sought help?

Yes

If 'yes' please tell me about it

No

If 'no' why not?

2.16 When did these feelings start?

## Part 3 - Access to Services

### 3.1 If you became mentally unwell where would you first seek help

- GP  Chinese Herbalist   
\*Family member  Acupuncturist   
\*Friend  Pastor/Religious Leader   
(What sort of help did family/friend give?) Other (please explain)   
Community Worker  No one   
A&E   
CRHT  (*Crisis Resolution/Home Treatment Service*)

### 3.2 If you required professional help, would you see any of the following

- GP  Social Worker   
Psychiatrist  Counsellor   
Community Worker/Advisor  Psychologist   
CPN (Community Psychiatric Nurse)   
Other (please explain)

- 3.3 Have you ever used any of the above services? Yes   
No

If 'yes' how did you access/learn about the service?  
If 'yes' when did you last seek help?

- 3.4 If you did not seek professional help what other sort of help did you seek? What worked for you and why?

- 3.5 Were there things that made it difficult for you to seek help? Yes   
No

If yes, what were these things?

- Didn't know it was a mental health problem   
Didn't know how to access GP   
Can't speak English   
Belief in self help   
Stigma associated with mental illness   
Didn't know how to access NHS   
Didn't know how to get to hospital/clinic   
Didn't know what statutory services available   
Belief in alternative medicine (please explain)   
Fear of possession by evil spirits   
Other (please explain)

3.6 Are you aware of

- Imagine
- Crown St Day Centre
- Mary Seacole House
- Windsor House
- PSS
- Richmond Fellowship
- Chinese Carers Network
- Pagoda Chinese Community Centre
- Compass (Counselling)
- Social Inclusion Team
- Other (please explain)

(If 'yes') Have you ever used them?

(If 'yes') How did you access them and what was your experience?

3.7 Were there things that made it difficult for you to seek help when you were mentally unwell? Yes  No

(If 'yes') Tell me about those things

(If 'no') How did the process work?

3.8 Was there anything that made it easier to get help? Yes  No

(If 'yes') Tell me about those things

## Part 4 - Experience of Services

**(For all of this section, if appropriate, ask if an interpreter was present)**

4.1 How long had you been ill before you accessed professional help?

4.2 Describe your experience of the service that you used.

Why was it a good/bad experience?

Were you treated with respect? / Was your dignity respected?

Yes  No

Explain:

Were you listened to?

Yes  No

Explain:

(If hospitalized) Did you have access to a single sex ward when in hospital?

Yes  No

(If no) - would you have preferred to have?

(If yes) - was provision satisfactory?

4.3 Was your illness explained to you? Yes  No   
(If 'yes') Did you understand?

4.4 Do you/did you see the same clinician/therapist/counsellor each time you attended? Yes  No  Please tell me more

4.5 Were you made aware of a choice of treatments appropriate to your needs? Prompts: Therapy, Counselling, Different medications  
Yes  No

Were you satisfied/happy with your treatment? Yes  No

Please explain :

4.6 Were the possible side-effects of medication explained to you?

Yes   
No

Prompts:

Weight gain   
Tremor   
Muscular Spasm   
Increased salivation   
Blurred vision   
Extra Sensitivity to Sunlight   
Feeling better   
Other

Did you suffer side effects? Yes  No

If 'yes' please tell me about them :

4.7 Do you know what a Care Plan is? Yes  No

(If 'no' explain to interviewee - *A Care Plan is a written document outlining the services a person is deemed to need and how these are going to be catered for and by whom. The Care Plan should be drawn up collaboratively with the service user, signed by the service user and should be reviewed regularly*)

Did you have a Personal Care Plan which you helped to draw up with your named nurse and which was reviewed regularly? Yes  No

4.8 If you were an In-Patient were you

Voluntary  Sectioned  (under the Mental Health Act)

If sectioned were you brought to hospital by the police? Yes  No

(If yes) Tell me about that experience

4.9 Did you have access to an advocate while in hospital ? Yes  No

Tell me about this

*( An advocate is an independent person who will represent/speak for a service user who is unable to represent themselves)*

4.10 What was your experience when leaving hospital ?

*Prompts*      Community support organised?   
Were you assured of crisis support   
Did you have a 24 hour contact for emergencies?

4.11 Do you know about Advance Statements?

Yes   
No  (If not explain)

*(An Advance Statement is a document, written or dictated by a service user when they are well, stating how they wish to be treated if they become ill again. It can include arrangements regarding their homes, pets and financial affairs. It can specify medication or treatment that they do not wish to receive and people that they do or do not wish to visit them when unwell. It must be signed by two witnesses and should be kept with the service users records.)*

Do you think it was/would be useful to you?      Yes       No

Explain :

## Part 5 - Recommendations

5.1 What would have made the whole experience of using Mental Health Services better?

5.2 What way would you like information about services to be made available ?

5.3 What do you see as the barriers to good mental health services?

5.4 If you could design an ideal Mental Health Service what would be its three most important features?

## **Mental Health Community Engagement Project Information Sheet - One to One Interviews**

### **(a) What the Project is about**

The project is researching how people access and experience mental health services in the Asylum Seeker and Refugee, Irish and Irish Traveller and Elderly Chinese Communities. The research has been commissioned by the Care Services Improvement Partnership(CSIP), a government body which is trying to improve services in the National Health Service and for local communities.

This research is being undertaken by Asylum Link Merseyside, Irish Community Care Merseyside and the Merseyside Chinese Community Development Association, supported by the University of Central Lancashire.

We intend that the resulting report will be used to inform Health Service Professionals, and those Commissioning Mental Health Services on Merseyside on how to improve services for the researched groups.

We are gathering information by conducting an interview with you and recording your answers on a corresponding questionnaire. For the sake of accuracy we would like to record the interview but if you do not wish this please tell the researcher.

### **(b) Taking part is voluntary**

This means you do not have to take part if you do not want to. However we feel this is an opportunity to improve the system and we would greatly appreciate your help

### **(c) What will happen to the information given**

The information you provide will be stored at the centre before being compiled into a report in January 2008. Once the report has been produced, all original data – the questionnaire being completed here – will be destroyed. This will be the same for any tape recordings.

The resulting report will be seen by CSIP the commissioning body, the project Management Committee and researchers, the University of Central Lancashire support workers and managers, Health Service Professionals and other bodies associated with the delivery of mental health services.

It will be given to the Commissioners of Mental Health Services in Liverpool and it is our hope and intention that this will lead to improvements in health service provision for our groups

**(d) Answering Questions**

You do not have to answer any question if you do not wish to and

**(e) Stopping the interview**

You may stop the interview at any time if you do not wish to continue.

**(f) Confidentiality**

All information will remain anonymous and confidential. No names will appear either on the questionnaires or in the final report

**(g) Age limits**

If you are younger than 18 years we are not allowed to interview you as part of this research. This is because of the extra safety checks required when working with minors. We are only allowed to work with adults.

**Thank you**

## **Mental Health Community Engagement Project Consent Form - One to One Interviews**

**Reference ..... (i.e. ALM 1 – corresponds to the questionnaire)**

This form allows us to interview you and use your responses within the report we will then produce. By signing this form you are showing you agree to this as defined in the criteria below.

I agree to be interviewed for the purposes of research into access to mental health services

I understand that this is a voluntary arrangement

I understand I do not have to answer any question I do not wish to

I understand that I can stop the interview at any time

I understand that any answers I give will remain strictly confidential, will remain anonymous and will not be used for any other purposes than the specified research.

I confirm that I am aged 18 years or over

Please tick the box to confirm your agreement

Date .....

**Thank you**

## **Mental Health Community Engagement Project Information Sheet - Focus Groups**

### **(a) What the Project is about**

The project is researching how people access and experience mental health services in the Asylum Seeker and Refugee, Irish and Irish Traveller and Elderly Chinese Communities. The research has been commissioned by the Care Services Improvement Partnership(CSIP), a government body which is trying to improve services in the National Health Service and for local communities.

This research is being undertaken by Asylum Link Merseyside, Irish Community Care Merseyside and the Merseyside Chinese Community Development Association, supported by the University of Central Lancashire.

We intend that the resulting report will be used to inform Health Service Professionals, and those Commissioning Mental Health Services on Merseyside on how to improve services for the researched groups.

We are gathering information by conducting a focus group with you and several other people and recording your answers following a questionnaire made for this purpose. For the sake of accuracy we would like to record the discussions but if you do not wish this please tell the researcher. If any one person objects the tape recorder will not be used.

### **(b) Taking part is voluntary**

This means you do not have to take part if you do not want to. However we feel this is an opportunity to improve the system and we would greatly appreciate your help

### **(c) What will happen to the information given**

The information you provide will be stored at the centre before being compiled into a report in January 2008. Once the report has been produced, all original data – the questionnaire being completed here – will be destroyed. This will be the same for any tape recordings.

The resulting report will be seen by CSIP the commissioning body, the project Management Committee and researchers, the University of Central Lancashire support workers and managers, Health Service Professionals and other bodies associated with the delivery of mental health services.

It will be given to the Commissioners of Mental Health Services in Liverpool and it is our hope and intention that this will lead to improvements in health service provision for our groups

**(d) Answering Questions**

You do not have to answer any question if you do not wish to and

**(e) Stopping the interview**

You may stop the interview at any time if you do not wish to continue.

**(f) Confidentiality**

We will at all times try to ensure that information given remains anonymous and confidential. No names will appear either on the questionnaires or in the final report. However, this is a discussion forum and *we cannot guarantee* that confidentiality will be maintained beyond the group, although we request that members respect each persons' right to confidentiality.

You should consider this carefully as it may affect your participation in discussions

**(g) Age limits**

If you are younger than 18 years we are not allowed to interview you as part of this research. This is because of the extra safety checks required when working with minors. We are only allowed to work with adults.

**Thank you**

**Mental Health Community Engagement Project  
Consent Form - Focus Groups**

**Reference ..... (i.e. ALM F1 – corresponds to the questionnaire)**

This form allows us to interview you and use your responses within the report we will then produce. By signing this form you are showing you agree to this as defined in the criteria below.

I agree to be interviewed for the purposes of research into access to mental health services

I understand that this is a voluntary arrangement

I understand I do not have to answer any question I do not wish to

I understand that I can stop the interview at any time

I understand that any answers I give will remain strictly confidential, will remain anonymous and will not be used for any other purposes than the specified research. However I acknowledge that confidentiality may not be maintained outside the Focus Group because of the number of participants, but that all participants have signed this form before attending and have agreed to respect each others privacy.

I confirm that I am aged 18 years or over

Please tick the box to confirm your agreement

Date .....

**Thank you**

- Offering practical support and friendship to refugees and asylum seekers -

# Asylum Link Merseyside



**MERSEYSIDE CHINESE COMMUNITY  
DEVELOPMENT ASSOCIATION (M.C.C.D.A.)**  
墨西郡華人社區發展協會

**NHS**  
*National Institute for  
Mental Health in England*

