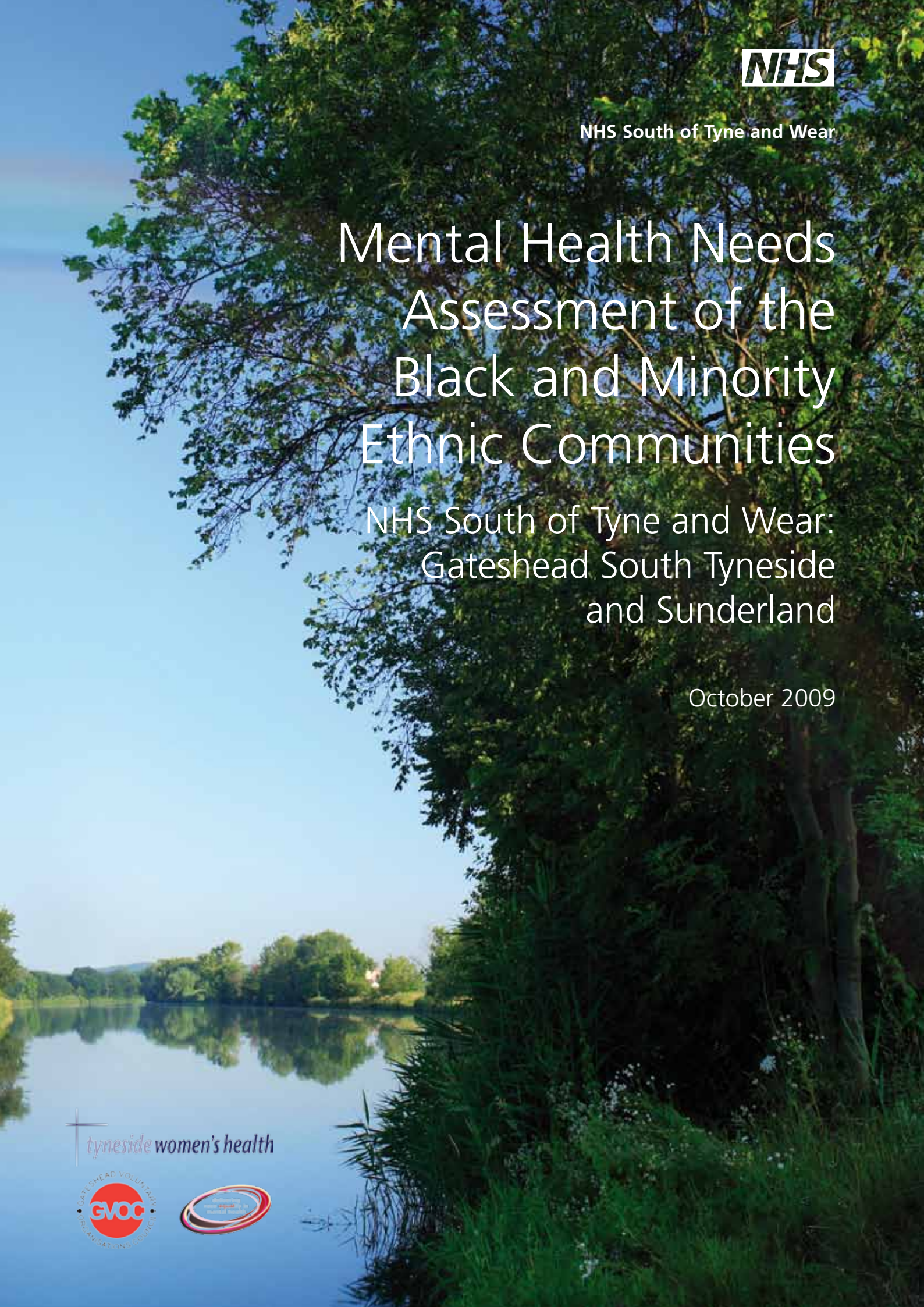

NHS South of Tyne and Wear

Mental Health Needs Assessment of the Black and Minority Ethnic Communities

NHS South of Tyne and Wear: Gateshead South Tyneside and Sunderland

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tyneside women's health

Contributors to this report

Catherine Mackereth, Public Health Lead – Mental Health and Well-being, NHS South of Tyne and Wear

Gateshead

Tyneside Women's Health
Alex Richards, Community Development Worker
Kate Mukungu, Chief Executive Officer

GVOC
Rowshon Uddin, Coordinator
Irene Ruto, Community Development Worker
Sarinder Bhandal, Community Development Worker

South Tyneside PCT – Public health

Anissa Hussain, Community Development Worker
Espe Biallu Ngituka, Community Development Worker

Sunderland TPCT – Public health

Jackie Nixon, Coordinator
Maureen Bell, Community Development Worker
Mark Roberts, Community Development Worker
Yusuf Meah, Community Development Worker

Sue Ward - Editor

Part I; Introduction

This document is a Mental Health Needs Assessment for the Black and Minority Ethnic communities within the NHS South of Tyne and Wear (SoTW) area, which covers the boroughs of Gateshead, South Tyneside, and Sunderland. The need for the current report was identified by the Sunderland team of DRE Community Development Workers (CDWs) employed in the area under the *Delivering Race Equality* (DRE) action plan. It complements the overall report, *Mental Health Needs Assessment* (Mackereth 2009 available on NHS South of Tyne and Wear's website, http://www.sotw.nhs.uk/content.aspx?id=556).

The term 'Black and minority ethnic' (BME)

> "is used to refer to all people of minority ethnic status in England. It does not only refer to skin colour but to people of all groups who may experience discrimination and disadvantage, such as those of Irish origin, those of Mediterranean origin and East European migrants" (DH, 2005a, p. 11)

This report highlights the mental health needs of the adult BME population within SoTW, and identifies the services available. Part I explains the context of the MHNA, and brings out the key points from the various statements and recommendations driving policy-making in mental health, especially on the issues of equality and diversity. Part II is an epidemiological assessment of the mental health needs of the BME population of SoTW. The report considers the national statistics, local statistics where available, and other local research material.

Part III covers expressed mental health needs. Section A summarises the results of public consultations. As well as those carried out particularly for this report, these include some which took place in previous years in earlier NHS-commissioned research. Section B outlines research findings on the views of professionals and invites further debate on the matter among professionals on the wellbeing needs of BME communities, and Section C then gives an overview of existing services. Part IV lists the conclusions and recommendations for SoTW.

Aims of this report

The aims of this Mental Heath Needs Assessment are to;

- provide information on current and future mental health and wellbeing needs of the BME people of the SoTW area; that is, the population of Gateshead, South Tyneside and Sunderland;
- Inform the public mental health and mental health commissioning strategies for each borough, and for SoTW as a whole.

The need for a specific assessment for the BME population arises from the recognition that the BME population in the UK is diverse and has complex health needs. Many live in areas of deprivation and suffer the consequent health problems. It has been further recognised that the mental health needs of minority ethnic groups have not been identified and adequately met. Local workers report that mental health services are not always accessible, responsive or appropriate.

Provision of such an assessment was one of the recommendations of the major Government publication, *Delivering race equality in mental health care; a Framework for Action* published by the Department of Health (DH) in 2003 and discussed in more detail below.

Policy Context; mental health issues and the Black and Minority Ethnic population

The NHS plan (2000) set down five areas for NHS development: partnership, performance, professions and the wider NHS workforce, patient care and prevention. It stated that services should be responsive to the needs of patients, including minority ethnic groups, should challenge discrimination and should improve accessibility to all.

In 2004, the Department of Health published *National standards, local action: health and social care standards and planning framework 2005/6 – 2007/8.* Two core standards are of particular relevance. Health care organisations must

- 'challenge discrimination, promote equality and respect human rights' (p. 30)
- 'enable all members of the population to access services equally' (p. 33)

Ethnic minority populations have a different experience of mental health from that of the population as a whole. This is due directly to the discrimination that they may suffer, which may affect their self-esteem, ability to cope, and can lead to people feeling isolated, intimidated and fearful. Poor outcomes for mental health problems can be due to lack of access to appropriate services, whether because they are unavailable or because they are not recognised as being in need of such services.

However, research findings are mixed in terms of the extent of these problems. Raleigh et al (2007) found that Black respondents did not report negative experiences of mental health services, but Asians were more likely that any other group to respond negatively. Consultation with local ethnic service users is vital to addressing inequalities in the provision of mental health services (Bowl 2007).

The medically dominated mental health orthodoxy has been challenged by many (Marrington-Mir et al 2007). The language and understanding of mental distress differs across ethnic groups (Mallinson and Popay 2007). Some patients from BME communities present with multiple somatic complaints (Ivbijaro et al, 2005). In the Yoruba and, to a lesser extent, in the Bangladeshi culture, magic has a role in causation and cure for mental distress (Lavender et al 2006). Khalifa and Hardie (2005) found that amongst Muslims in Britain, there is a widespread belief in jinn (spirit) possession. These ideas are alien to most professionals working in the mental health sphere. It is therefore crucial that mental health issues are addressed with cultural sensitivity and an understanding of different cultural models (Khalifa and Hardie 2005, Lavender et al 2006).

In 2004, the Social Exclusion Unit published *Mental health and social exclusion,* which identified problems that have particular relevance to ethnic minority population:

- stigma and discrimination – particularly important for those who experience the added burden of racial discrimination
- social exclusion – a situation faced by many ethnic minority populations
- compulsory detention – members of a minority ethnic group are more likely to be detained compulsorily
- diagnosis – certain ethnic groups are more likely to be diagnosed with mental illnesses e.g. black men diagnosed with schizophrenia
- depression, anxiety and phobia – certain groups are more prone to such problems, for example Asian mothers (McAvoy and Donaldson 1990)

Other reports, including the Mental Health Act Commission's 9th Biennial Report (Clayton, 2001), and those from the NIMHE (2003), SCMH (2002), and DH (2003) have shown that, with regard to mental health issues, BME groups are more likely to experience:

- Problems in accessing services
- Lower satisfaction with services
- Cultural and language barriers in assessments
- Lower GP involvement in care
- Inadequate community-based crisis care
- Lower involvement of service users, family and carers
- Inadequate support for Black community initiatives
- An adverse pathway into mental health services
    - higher compulsory admission rates to hospital
    - higher involvement in legal system and forensic settings
    - higher rates of transfer to medium and high secure facilities
- Higher voluntary admission rates to hospital
- Lower effectiveness of hospital treatment
- Longer stays in hospital
- Higher rates of readmission to hospital

- A lower likelihood of having social care or psychological needs addressed within care planning and treatment processes
- More severe and coercive treatments
- Lower access to talking treatments

The major national publication relating to the mental health of ethnic minorities is *Delivering Race Equality in Mental Health Care; An action plan for reform inside and outside services and the government's response to the independent inquiry into the death of David Bennett* (DRE: DH 2005a). It provides an action plan for achieving equality and tackling discrimination in mental health services for all minority ethnic groups.
It draws on three key publications:

- *Inside outside: Improving mental health services for Black and Minority Ethnic communities in England* (National Institute for Mental Health in England 2003)
- *Delivering Race Equality: A framework for action* (DH 2004b)
- the report of the independent inquiry into the death of David Bennett (Norfolk, Suffolk and Cambridgeshire Strategic Health Authority 2003)

The plan is based on three 'building blocks':

- **'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 older people, asylum seekers and refugees, and children;
- **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.

Subsequently, a number of Focused Implementation Sites (FIS) were set up to 'fast-track' the national DRE Action Plan, testing out what worked, sharing and facilitating good practice and supporting partnership working. The Northumberland, Tyne and Wear FIS started in January 2006, hosted by the Gateshead Voluntary Organisations Council (GVOC) and working to a three year contract with the Strategic Health Authority. Unusually, it was run by the voluntary sector though working closely with the NHS (GVOC, 2009).

In order to support measurement of progress in the DRE programme, the "DRE Dashboard" has been developed within the Delivering Race Equality (DRE) in Mental Health programme (National Mental Health Development Unit, 2008). It is intended for use as a detailed menu of measurement to support and guide NHS organisations in better understanding how to use the work generated through the DRE programme and service delivery generally to improve access, outcomes and experiences for people from BME communities. It is also to be used as a tool for gathering detailed narrative information on the range of work undertaken within the DRE programme since its inception in 2005. The aim is to support service improvement and policy implementation to address the 12 characteristics for service change set out in the DRE Action Plan.

No Patient Left Behind (Lakhani, 2008), found four main inter-linked reasons for dissatisfaction:

- a substantial communication problem between patients and practices was caused by language and culture barriers;
- the disease burden was greater in BME patients who tend to have a poorer health status;
- the quality of GP services was too variable and
- the ϵ

*Commissioning IAPT for the whole community (*DH 2008*)* is guidance intended to assist health service commissioners to deliver Improving Access to Psychological Therapies (IAPT) services that are effective and appropriate for the whole community, using innovative ways of meeting the needs of local people. To summarise relevant points;

- The IAPT workforce should reflect and be representative of the local community, and the capacity and capability of therapists should be appropriate for the people they will be serving.

- *Practice-based commissioning* (PBC) should be undertaken;
- *Commissioning for outcomes*; Routine collection of outcomes data is fundamental. The data should be used to ensure that the right service is delivered to the right people, at the right time with the right results.
- *Acceptability of different treatment options;* Individuals should have a choice of treatments appropriate to their needs.
- Commissioners should ensure that services adhere to the relevant legislation and principles that eliminate unlawful or unjustifiable discrimination and promote equality of opportunity.

The *Black and Minority Ethnic (BME) Positive Practice Guide, (*IAPT/ DH January 2009) together with their *Equalities Impact Assessment and Equalities Toolkit* (IAPT, 2008) provide additional information and practical guidance for commissioners.

The importance of ethnic monitoring

A further element in policy is the emphasis on ethnic monitoring, and the need to improve this and make use of the results. In *Count me in* (DH 2005b), a regular census set up following the recommendations in DRE, the DH encouraged providers of these services to have accurate procedures for collecting information on the ethnicity of inpatients. It found that hospital admission and detention rates were higher for Black Caribbean, Black African and other Black Groups, with higher seclusion rates once detained.
A practical guide to ethnic monitoring in the NHS and social care (DH/Health and Social Care Information Centre/NHS Employers, 2005) points out that through using data in these ways, and openly sharing results with the public, patient and user groups, staff and other stakeholders, NHS trusts can demonstrate that data collection can make a positive difference to individuals' experiences of the NHS. It suggests that the routine use of data, particularly at Board or committee level, also usually leads to improvements in the scope and quality of those data.

Part II; Epidemiological Assessment

Demographic data

In recent years, the BME population of Great Britain has been changing. The most recent comprehensive figures are in the 2001 Census (ONS, available on www.ons.gov.uk). Much of the material in this and subsequent sections is taken from this publication, and uses their terminology. Further statistical detail about the region is available O'Donnell et al (2008).

In 2001, 4.6 million people of Great Britain, or 7.9% of the population, belonged to Black, Asian, Mixed and Chinese ethnic groups. More detailed analysis shows that around half of the 4.6 million were Asian, that is Indian, Pakistani, Bangladeshi or other Asian origin and a further quarter were Black, that is, Black Caribbean, Black African or Other Black. 15% were described as being Mixed and about a third of this group were from White and Black Caribbean backgrounds. There were almost 691,000 White Irish people in Great Britain, 1% of the GB population.

Within the overall picture, the North East is the least ethnically diverse region in England. The 2001 Census gives the following figures for the SoTW area (table 1-figure 1).

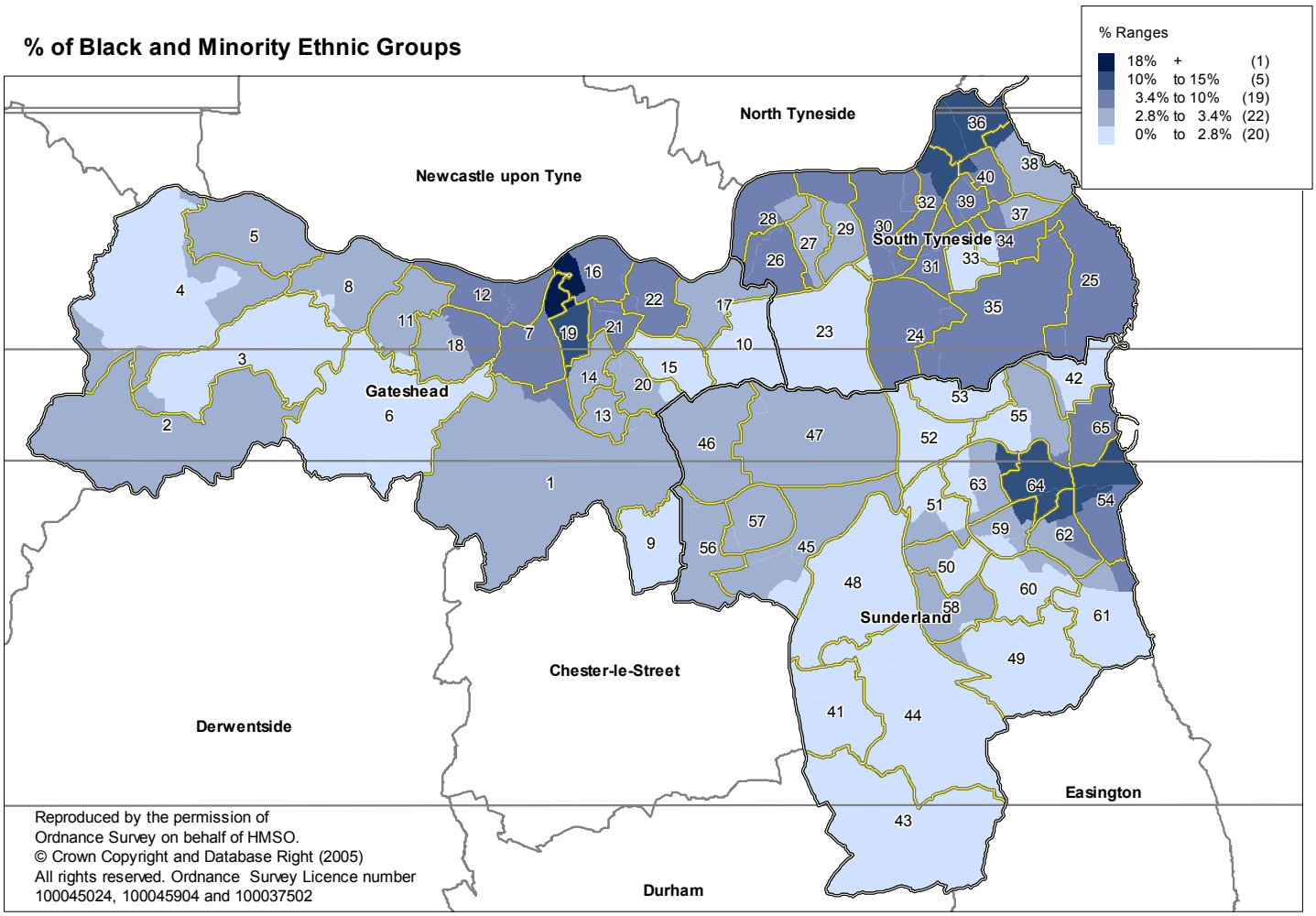
Table 1; ethnic minority population within the SoTW area in 2001 census

Ethnic Group																
Census 2001																
	All people	**Percentage of people in ethnic groups:**														
		White			**Asian or Asian British**				**Black or Black British**			**Chinese**	**Other**	**Mixed**		
		British	**Irish**	**Other White**	**Indian**	**Pakis-tani**	**Bangla-deshi**	**Other Asian**	**Carib bean**	**Africa n**	**Other Black**			**White and:**			
														Black Carib bean	**Black African**	**Asian**	**Other Mixed**
ENGLAND	49,138,831	86.99	1.27	2.66	2.09	1.44	0.56	0.48	1.14	0.97	0.19	0.45	0.44	0.47	0.16	0.37	0.31
Tyne and Wear	1,075,938	95.41	0.37	1.06	0.57	0.58	0.48	0.17	0.03	0.15	0.02	0.35	0.23	0.11	0.09	0.22	0.15
Gateshead	191,151	96.92	0.29	1.20	0.26	0.26	0.06	0.10	0.03	0.11	0.02	0.19	0.16	0.12	0.04	0.15	0.10
South Tyneside	152,785	96.52	0.24	0.53	0.63	0.20	0.53	0.22	0.02	0.12	0.04	0.12	0.15	0.11	0.11	0.23	0.23
Sunderland	280,807	97.12	0.29	0.73	0.33	0.14	0.41	0.12	0.03	0.09	0.01	0.23	0.11	0.08	0.06	0.16	0.09

Cells in this table have been randomly adjusted to avoid the release of confidential data.

Adapted from table produced by Gateshead Council; Source: National Statistics website: www.statistics.gov.uk

Figure 1; Distribution of black and minority population by ward within South of Tyne and Wear at 2001 Census



LA	Key	Ward	LA	Key	Ward	LA	Key	Ward
GH	1	Lamesley Ward	ST	23	Fellgate and Hedworth Ward	SU	45	Washington East Ward
GH	2	Chopwell and Rowlands Gill Ward	ST	24	Boldon Colliery Ward	SU	46	Washington West Ward
GH	3	Winlaton and High Spen Ward	ST	25	Whitburn and Marsden Ward	SU	47	Washington North Ward
GH	4	Crawcrook and Greenside Ward	ST	26	Hebburn South Ward	SU	48	Shiney Row Ward
GH	5	Ryton, Crookhill and Stella Ward	ST	27	Monkton Ward	SU	49	Doxford Ward
GH	6	Whickham South & Sunniside Ward	ST	28	Hebburn North Ward	SU	50	Sandhill Ward
GH	7	Lobley Hill and Bensham Ward	ST	29	Primrose Ward	SU	51	St. Anne's Ward
GH	8	Blaydon Ward	ST	30	Bede Ward	SU	52	Castle Ward
GH	9	Birtley Ward	ST	31	Biddick and All Saints Ward	SU	53	Redhill Ward
GH	10	Wardley and Leam Lane Ward	ST	32	Simonside and Rekendyke Ward	SU	54	Hendon Ward
GH	11	Whickham North Ward	ST	33	Whiteleas Ward	SU	55	Southwick Ward
GH	12	Dunston and Teams Ward	ST	34	Cleadon Park Ward	SU	56	Washington South Ward
GH	13	Chowdene Ward	ST	35	Cleadon and East Boldon Ward	SU	57	Washington Central Ward
GH	14	Low Fell Ward	ST	36	Beacon and Bents Ward	SU	58	St. Chad's Ward
GH	15	Windy Nook and Whitehills Ward	ST	37	Harton Ward	SU	59	Barnes Ward
GH	16	Bridges Ward	ST	38	Horsley Hill Ward	SU	60	Silksworth Ward
GH	17	Pelaw and Heworth Ward	ST	39	West Park Ward	SU	61	Ryhope Ward
GH	18	Dunston Hill & Whickham East Ward	ST	40	Westoe Ward	SU	62	St. Michael's Ward
GH	19	Saltwell Ward	SU	41	Houghton Ward	SU	63	Pallion Ward
GH	20	High Fell Ward	SU	42	Fulwell Ward	SU	64	Millfield Ward
GH	21	Deckham Ward	SU	43	Hetton Ward	SU	65	St. Peter's Ward
GH	22	Felling Ward	SU	44	Copt Hill Ward			

Source: Department for Communities and Local Government

Over the period 2001 – 2007 the Office for National Statistics (ONS) has been tracking population changes using 'experimental' statistics in the form of mid-year estimates from the Local Authorities (ONS, 2008 and 2009, and O'Donnell et al, 2008). They are described as 'experimental' because they have not yet been shown to meet the quality criteria for National Statistics, but are being published to involve users in the development of the methodology and to help build quality at an early stage. Table 2 lists the three boroughs in the SoTW area in order of BME proportion of the total population, using the Census definitions and mid 2006 ethnic population estimates. As can be seen, the BME populations of the three boroughs in SoTW vary widely, ranging between 6,800 and 9,900 people, and 3.5% and 5% of the local authority's total population.

Table 2; North East estimated resident population by ethnic group

	All groups – estimated population numbers	White – British, Irish and other Number & Percentage		All BME groups Number & Percentage	
North East region	**2,555,700**	**2,449800**	**95.8**	**106,000**	**4.1**
South Tyneside	151,000	143,500	95.0	7,400	5.0
Gateshead	190,500	183,600	96.3	6,800	3.6
Sunderland	280,600	270,800	95.5	9,900	3.5

Mid 2006 Population Estimates by Ethnic Group Table EE1, Office for National Statistics (ONS) © Crown Copyright

Overall, as Figure 2 shows, in the five year period between 2002 and 2006, the BME population of England increased by 2%, representing 976,900 people. Although the North East Government Office region continues to have the lowest BME population in England, during the same five year period its percentage increase has been over 68% representing an additional 34,200 people. The BME population in the North East is still relatively small, at 4.1%, but is very diverse. It should also be pointed out that for these statistics, BME is taken to mean "all ethnic groups excluding White British, White Irish and White Other." Therefore these figures are likely to be understated because they exclude, among others, East European migrant workers.

Figure 2 shows the extent of change in BME populations in local authority areas across the North East, with the SoTW localities highlighted.

Figure 2

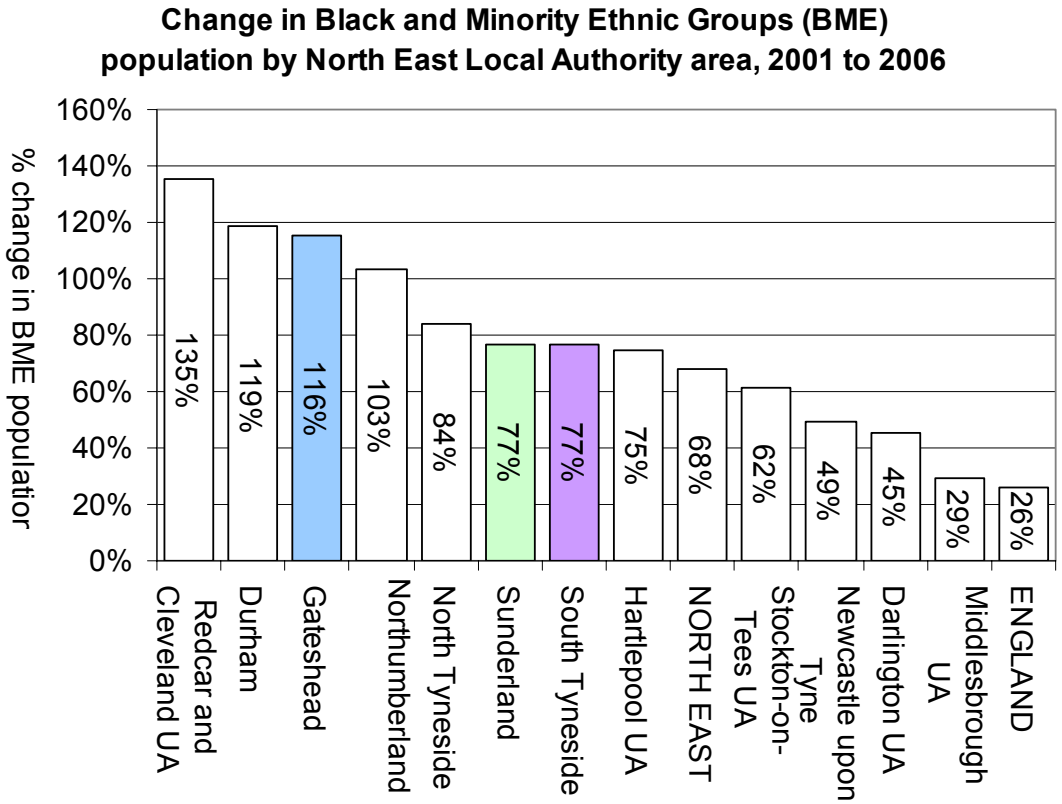

Change in Black and Minority Ethnic Groups (BME) population by North East Local Authority area, 2001 to 2006
% change in BME populatior
160%
140%
120%
100%
80%
60%
40%
20%
0%
135%
119%
116%
103%
84%
77%
77%
75%
68%
62%
49%
45%
29%
26%
Redcar and Cleveland UA
Durham
Gateshead
Northumberland
North Tyneside
Sunderland
South Tyneside
Hartlepool UA
NORTH EAST
Stockton-on-Tees UA
Newcastle upon Tyne
Darlington UA
Middlesbrough UA
ENGLAND

Table 3
Estimates of black and minority ethnic group populations - mid year 2006

Area			All Groups	White	Mixed	Asian or Asian British	Black or Black British	Other	Total of BME Groups
Gateshead	Persons	0-15	34.5	32.9	0.5	0.6	0.2	0.2	1.6
Gateshead	Persons	16-64/59*	117.1	112.0	0.8	2.0	1.1	1.2	5.1
Gateshead	Persons	65/60+**	38.9	38.6	0.1	0.1	0.0	0.1	0.3
Gateshead	Persons	All ages	190.5	183.6	1.4	2.7	1.3	1.5	6.9
South Tyneside	Persons	0-15	27.5	25.9	0.5	1.0	0.1	0.1	1.6
South Tyneside	Persons	16-64/59*	92.3	86.7	0.7	3.8	0.5	0.5	5.6
South Tyneside	Persons	65/60+**	31.2	30.8	0.1	0.2	0.0	0.0	0.4
South Tyneside	Persons	All ages	151.0	143.4	1.3	5.0	0.6	0.6	7.6
Sunderland	Persons	0-15	51.4	49.0	0.7	1.2	0.2	0.2	2.4
Sunderland	Persons	16-64/59*	176.1	169.1	1.0	3.2	1.1	1.7	7.0
Sunderland	Persons	65/60+**	53.1	52.7	0.0	0.2	0.0	0.1	0.4
Sunderland	Persons	All ages	280.6	270.7	1.7	4.6	1.3	2.0	9.9

Source: Office for National Statistics, Population Estimates by Ethnic Group

Percentage change in black and minority ethnic group populations - 2001-2006

Area			All Groups	White	Mixed	Asian or Asian British	Black or Black British	Other	Total of BME Groups
Gateshead	Persons	0-15	-6.5%	-8.4%	66.7%	50.0%	100.0%	0.0%	60.0%
Gateshead	Persons	16-64/59*	1.2%	-1.4%	60.0%	122.2%	450.0%	140.0%	142.9%
Gateshead	Persons	65/60+**	0.8%	0.5%	-	0.0%	-	-	200.0%
Gateshead	Persons	All ages	-0.4%	-2.3%	75.0%	92.9%	333.3%	114.3%	115.6%
South Tyneside	Persons	0-15	-11.0%	-12.8%	25.0%	42.9%	0.0%	0.0%	23.1%
South Tyneside	Persons	16-64/59*	2.0%	-1.1%	16.7%	123.5%	150.0%	66.7%	100.0%
South Tyneside	Persons	65/60+**	-0.6%	-1.0%	0.0%	100.0%	-	-	100.0%
South Tyneside	Persons	All ages	-1.2%	-3.4%	18.2%	100.0%	100.0%	50.0%	76.7%
Sunderland	Persons	0-15	-9.2%	-10.9%	40.0%	33.3%	-	0.0%	50.0%
Sunderland	Persons	16-64/59*	-0.2%	-2.1%	42.9%	68.4%	175.0%	88.9%	79.5%
Sunderland	Persons	65/60+**	2.9%	2.7%	-	100.0%	-	-	300.0%
Sunderland	Persons	All ages	-1.4%	-3.0%	41.7%	58.6%	225.0%	81.8%	76.8%

Source: Office for National Statistics, Population Estimates by Ethnic Group

(2007 figures are now also available, at http://www.statistics.gov.uk/downloads/theme_population/Tables_EE1-EE6_PCO2007.xls)

It is clear that the trend for the North East, as for the rest of the country, has been a steady increase (see Table 3). It is probable that this trend continued in 2007 and 2008.

The changing nature of the population owes much to a growing number of migrants, including those from the 'new' European Union countries who are not included in the figures above. Recent Labour Force Survey figures show that since early 1997, the increase in the number of non-UK born workers has been 1.8 million, or 55% of the total increase of 3.2 million (Clancy, 2008). However, it will be interesting to note what impact the current global economic crisis will have on these demographics.

A much smaller part in the growth of population has been played by the flow of individuals seeking asylum, a proportion of whom are granted refugee status. UNHCR figures give an estimated total of 292,097 refugees and 14,500 people currently applying for asylum, as at January 2009 (www.unhcr.org), although this may be an under-estimate given the unknown number who have 'disappeared', and will often be destitute or living on charitable support after asylum applications have failed.

As pointed out by the Department of Health, (DH, 2005a)

> "As well as experiencing the issues associated with the BME groups to which they belong, refugees have often been exposed to severe physical and psychological trauma as a result of war, imprisonment, torture or oppression. In their new host country they can then experience social isolation, homelessness, language

difficulties, hostility and racism, all of which are strong predictors of poor mental health."

A detailed study undertaken across the river in Newcastle (Crowley, 2003) pointed out that some community surveys using diagnostic tools have found that up to 32% of asylum seekers were suffering from mental illness, especially Post-Traumatic Stress Disorder (PTSD), although studies varied greatly in their estimates and his own work in Newcastle provided lower figures. Crowley highlighted the importance not just of trauma experienced before leaving their own country but the significant level of mental distress experienced by Asylum Seekers as a result of how they are dealt with in this country. The legal uncertainty, cultural bereavement, isolation, poverty and stress all contributed to the levels of mental illness. This provided clear pointers on measures to prevent mental illness amongst this group which should include; working in such a way as to increase self-sufficiency, develop social support, develop peer groups, tackle racial harassment, improve economic wellbeing (including the right to work), improve housing and facilitate communication with their families. The social and economic needs of asylum seekers should be uppermost in the minds of those delivering health services to them, and an awareness of the impact of racial harassment on their mental health was vital (Fay 2007).

Figures for the number of asylum seekers registered with their local authorities, and those in housing provided by sub-contractors such as Jonast Housing Group, are available from the asylum seeker teams in each local authority. However, these do not include individuals in private housing, 'failed asylum seekers' who have not been deported back to their own countries, or those who have had refugee status confirmed and are therefore now accepted for settlement.

Accordingly, recent statistics suggest around 350-400 registered asylum seekers in Gateshead, and in Sunderland, and a rather smaller number in South Tyneside. Gateshead Council, however, estimated in 2006 that there were around 1,000 asylum seekers in its area (Gateshead Council, 2006). In addition, the figures available show only a 'snapshot' of the numbers at one particular point in time; there are no statistics on the annual flow into and out of each borough, which will be considerably higher.

There is a wide spread of nationalities and language groups, including small numbers from a number of African countries.

None of the three local authorities counts migrants, but Pillai, (2006), counted European migrants registered to the worker registration scheme between May 2004 and February 2006. Her figures therefore do not take account of, for example, those joining family in the UK following marriage, or those working in the informal economy. She found that 338 migrants were registered in Gateshead, 110 in South Tyneside, and 316 in Sunderland.

The North East Public Health Observatory (2008) commented that migrant numbers are 0.1-0.2% of the population. They tend to be young, male, often have language difficulties, have little understanding of UK culture and are polarised in terms of skills and education, being either highly skilled or unskilled.

Demographics within the three boroughs

The demographic make-up of the three boroughs varies somewhat, as discussed below.

Gateshead

According to the National Statistics estimates (ONS, 2009) for 2007, the largest minority groups other than White British are Other White, at approximately 3,000 followed by Black African, approximately 1,200 people. The Asian Indian community is estimated at 1,100 people, the Pakistani community at 900 people, the Chinese at 800 people, and the number of White Irish is estimated at 700. The number of Mixed White and Asian community members is estimated as being 500, Mixed White and Black Caribbean community members are estimated at 400 and the estimated number of Bangladeshi community members is 300. The percentages of black and minority ethnic community members have increased across the spectrum in Gateshead since the 2001 National Census, with the exception of the percentage of White Irish community members, which has fallen. The most notable change is in relation

to the number of Black African community members, which is estimated to have increased five-fold since 2001.

The 2001 National Census figures for faith groups also show that there were 1,529 Orthodox Jewish community members in Gateshead. Anecdotally, however, this number is thought to be much higher, around 4,000, not least because Jewish educational establishments, such as Yeshiva, are among the biggest in Europe, thus resulting in a significant student population in the Orthodox Jewish community. The 2001 National Census shows the number of Muslim community members as being 1,141 in Gateshead.

South Tyneside

Mixed, Asian, Asian British, Black/Black British and Chinese or other groups collectively total 2.7% of the population. The largest minority group is Asian Indian, estimated at 3,100, followed by Other White at 1,400, and Bangladeshi at 1,200. The Pakistani community is estimated at 700, the Chinese at 300, and the White Irish community at 300.
The two most established Black and Minority Ethnic groups in South Tyneside are the Bangladeshi and the Arab communities. The Yemeni Arab community is the most longstanding Minority Ethnic community. The Bangladeshi community is one of the youngest and fastest growing communities in the UK. The Indian community is the largest as there is a significant student population in South Tyneside. The majority of the BME population is Muslim, and there are 3 mosques within South Tyneside and a school for Islamic studies. The Sikh community uses the Gurdwara Temple. There are approx 200 Hindus living in South Tyneside and although there is a community leader representative there is no forum for contacting the community directly. Languages spoken include Sylheti, Arabic, Gujerati, Bengali, Chinese, along with the many others spoken by asylum seekers. (Hearn, 2007).

Sunderland

The 2007 population estimates show the Other White group as the largest, at 3,500, followed by the Bangladeshi community and Indian communities each at 1,600, the Chinese community at 1,400, and the Black African community at 1,200. The majority of the Bangladeshis in Sunderland originate from the same area in Bangladesh.

While the percentage of the BME population in the city is still small compared to the nation as a whole, there has been considerable growth since the 2001 census. For example, the Asian communities comprising those of Indian, Bangladeshi and Pakistan origin, has increased by 15.5% and the Chinese community has increased by 14.4% (ONS 2007, Billet 2008).

In addition to the natural increase among the long settled communities, notably the Bangladeshi community, there have been a significant number of new arrivals. Since the start of the implementation of the government dispersal policy, it is estimated that up to 400 asylum seekers have been relocated to the city (Horton, 2007). Many of these remain to start a new life as refugees. This group speaks a number of languages of which Albanian, Arabic, Czech, Farsi, French, Kurdish, Portuguese, Romanian and Russian have been identified as the most widely spoken at present. According to Magoye and Ohlson, this group has experienced difficulty in accessing health services in Sunderland. (Magoye and Ohlson 2007, Billet 2008)

In addition, Magoye and Ohlson (2007) have pointed out that significant numbers of students and health workers now live in the city. The university has 19.4% of around 15,000 students from the BME community. The Filipino community is estimated to be around 1,000, mostly families of workers within the NHS. Another increasing group is comprised of residents classified as 'White other' in the census. This group includes many of those coming to work from European Union (EU) countries and countries of the former Russian federation.

Key issues

The Office of National Statistics (ONS) has published a 'snapshot' of the BME population nationally, combining data from the 2001 Census and other sources (*Focus on Ethnicity and Identity*, ONS 2005). Much of the material in this section is taken from this publication and, as with other ONS material in this publication, uses their terminology.

Older people

Nationally, the White Irish group had the oldest age structure of all ethnic groups in 2001, with one in four aged 65 and over. Black Caribbeans had the second largest proportion of people aged 65 and over (11%.)

The Mixed group had the youngest age structure - half (50%) were under the age of 16. The Bangladeshi, Other Black and Pakistani groups also had young age structures: 38% of both the Bangladeshi and Other Black groups were aged under 16, and 35% of Pakistanis also fell into this age group. By comparison, the White British group had 20% under the age of 16.

Differences in mortality rates mean that women aged 65 and over normally outnumber men over 65. This can clearly be seen in the White (58% women), Mixed (55%) and Chinese ethnic groups (54%). However for some ethnic groups the gender pattern has been affected by differing immigration patterns. In particular, only one third of the Bangladeshi group (34%) of those aged 65 and over were women, while for the Pakistani group, women made up 45% of the 65 and over age group.

Education

People at higher risk of common mental health problems include those with no or few qualifications and the unemployed. This relationship extends to people who attempt suicide or have a psychotic disorder (Social Exclusion Unit 2004). There is a well established link between learning and mental health beyond the school years, with participation in learning opportunities leading to increases in human, social and individual capital, in terms of knowledge, skills, trust, dependency, positive self-image, assertiveness and confidence (APHO 2007). Adult learning has an important part to play in promoting health and wellbeing (Hammond and Feinstein 2006).

In 2002 Chinese pupils were the most likely to achieve five or more GCSE grades A*-C in England, with 77% of Chinese girls and 71% of Chinese boys respectively. Indian pupils had the next highest achievement levels: 70% of Indian girls and 58% of Indian boys achieved these levels. The lowest levels of GCSE attainment were among Black Caribbean pupils. Only 23% of Black Caribbean boys and 38% of Black Caribbean girls achieved five or more A*-C grade GCSEs. Pupils from the Other Black, Black African and Pakistani groups had the next lowest levels of attainment. Within each ethnic group a higher proportion of girls than boys achieved five or more GCSE grades A*-C (or equivalent).

In 2001/02, Black pupils were more likely to be permanently excluded from schools in England than children from other ethnic groups. The highest permanent exclusion rate was among Black Caribbean pupils, at 42 per 10,000. This was three times the rate for White pupils. Chinese and Indian pupils had the lowest exclusion rates, at 2 per 10,000 and 3 per 10,000 respectively. For all ethnic groups, the rate of permanent exclusion was higher for boys than girls.

Employment

People in employment from Pakistani and Chinese groups are more likely to be self-employed than those in other ethnic groups in Great Britain. In 2002/03, around one quarter (23%) of Pakistanis in employment were self-employed, as were around one fifth (18%) of Chinese people. This compared with around one in ten (12%) White British people and fewer than one in ten Black people.

In 2002/03, three-fifths of Bangladeshi men and two-fifths of Chinese men in employment worked in the distribution, hotel and restaurant industry, compared with one-sixth of their White British counterparts. Pakistani men were the group most likely to work in the transport and communication industry − 25% of them worked in this sector compared with 10% of employed men overall. White Irish men were more likely than other men to work in the construction industry – 21% compared with 12% overall.

Bangladeshi and Chinese women are also concentrated in the distribution, hotel and restaurant industry. Two-fifths of each group worked in this industry in 2002/03, compared with one-fifth of all women in employment. Half of Black Caribbean and Black African women (52% and 51% respectively) worked in the public administration, education or health sector.

Those most likely to be employed in professional occupations were from the Indian, Chinese, White Irish, and other non-British White groups (between 16 and 18%). White British people

had relatively low rates of people working in professional occupations (11%). The groups with the lowest proportions of professionals were the Black groups, Bangladeshis and Pakistanis, each with less than 10%. The pattern was similar for managers and senior officials.

One in six Pakistani men in employment were cab drivers or chauffeurs, compared with 1 in 100 White British men. One-third of Bangladeshi men were either cooks or waiters, compared with 1 in 100 White British men. The proportion of Indian men working as doctors, at 5%, was almost 10 times higher than the rate for all White British men. Among women in employment, around one in ten Black African women and 1 in 12 White Irish women were working as nurses in 2002/03, compared with around 1 in 30 White British women. Pakistani women were eight times more likely than White British women to be working as packers, bottlers, canners and fillers. Indian women were almost seven times more likely than White British women to be working as sewing machinists.

Locally, the tight-knit Bangladeshi community in South Tyneside is heavily concentrated in the catering and restaurant industry.

Unemployment

As discussed in the overall Mental Health Needs Assessment for SoTW (Mackereth, 2009) there is substantial research showing the links between poor mental health and unemployment. Those not in work are likely to suffer more mental ill-health and those who have mental health difficulties are less likely to work, thereby potentially exacerbating their problems. Members of the BME population with mental health issues are significantly less likely to move into work than their white counterparts, and have less support from services for getting people into employment (SESAMI 2006).

ONS (2005) reported that unemployment rates for people from non-White ethnic groups were generally higher than those from White ethnic groups. However, Indian men had a similar level of unemployment to Other White men (7% for each group). In 2002/03, men from Bangladeshi and Mixed ethnic backgrounds had the highest unemployment rates in Great Britain, at 18% and 17% respectively. The next highest male rates were among Black Africans (15%), Pakistanis (14%) and Black Caribbeans (13%). These were around three times the rate for White British men (5%).

Unemployment rates for Indian and Chinese men, at 7 and 6% respectively, were similar to those for White British or White Irish men (5% for each group).

Among women, Pakistanis had the highest unemployment rates (17%) . Unemployment rates for women from the Black African, Black Caribbean and Mixed ethnic groups, at around 12%, were also relatively high and around three times the rate for White British women (4%).

Working-age men and women from non-White ethnic groups were generally more likely than those from White groups to be economically inactive, that is, not available for work and/or not actively seeking work. In 2002/03, Chinese men had the highest male working-age economic inactivity rate in Great Britain, at 35%, twice the rate for White British men. The vast majority of inactive Chinese men were students. Bangladeshi and Pakistani women had the highest female economic inactivity rates (77% and 68% respectively). The majority of these women were looking after their family or home. Within each ethnic group women were more likely than men to be economically inactive.

CREST (2005) found that BME unemployment in South Tyneside was high at 20%, four times that of white males at the time; there is nothing to suggest that this differential will have changed with the higher national level of unemployment today arising from the recession.

Asylum seekers whose refugee status is as yet undecided are not allowed to take employment. Comments made in the public consultation (see Part III, section A) highlighted both the unhappiness created by such enforced idleness, and the frustration felt by professional and skilled migrants who had to take jobs well below thier abilities.

Poverty

It has been recognised for a long time that wider economic, environmental, and social determinants of health have a major impact on morbidity and mortality (DH 1998, Wilkinson 2005). Inequality has a spill-over effect, being associated with:

- Increased crime rates
- Poor productivity and economic growth
- Decreased engagement in representational democracy (Wilkinson 2005)

The relationship between high levels of deprivation and high rates of mental ill-health is well established (Payne 2000). Studies have found an association between mental health and socio-economic status, showing higher rates of psychiatric admissions and suicides in areas of high deprivation and unemployment (Kammerling and O'Connor 1993, Gunnell et al 1995, Boardman et al 1997, Croudace et al 2000). People living in 'economic hardship' on a long-term basis have been found to more likely to be suffering from clinical depression, anxiety and phobias (Lynch et al 1997, Meltzer et al 1995b). Regardless of age or gender, there is an increased risk of mental ill-health for the poor when compared with the non-poor (Payne 2000). As Weich and Lewis (1998) comment: 'financial strain is a powerful independant predictor of both the onset and maintenance of episodes of common mental disorders, even after adjusting for more objective measures of standard of living' (p. 118). In 2004, the prevalence of mental health disorders was twice as common in deprived areas than in wealthy areas (Melzer et al, 2004).

ONS (2005) figures show that people from minority ethnic groups were more likely than White people to live in low-income households in 2000/01. There was however considerable variation between ethnic groups, especially when the impact of housing costs was taken into account.[1]

Pakistanis and Bangladeshis were much more likely than other groups to be living on low incomes. Almost 60% of the 1 million people in this group were living in low-income households before housing costs were deducted. This increased to 68% after housing costs.

A substantial proportion (49%) of Black Non-Caribbean households also lived on low incomes after housing costs had been deducted. However, the risk of low-income for this group was much less pronounced in comparison with other ethnic groups if income before housing costs is used. The White population were least likely to be living in low-income households, 16% did so before housing costs were deducted and 21% after housing costs.

Although estimates of the number of children living in poverty have been stable since 2005, those in Pakistani or Bangladeshi households are considerably more likely to live in poverty than the average UK household (58% compared with 22%).

Health

Poor quality of life due to physical ill-health is closely related to poor mental health. People with mental health problems are up to twice as likely to report long-term illness or disability (Meltzer et al 2002) and over two-thirds of those with long term physical illness or condition also have a mental illness (Singleton and Lewis 2003). This has implications for the management of these conditions.

People with severe mental illness are at greatly increased risk of coronary heart disease, diabetes, respiratory disease and higher rates of obesity (Brown et al 2000, Cohen and Phelan 2001, Nocon 2004). Those with mental illness are likely to have physical illnesses undiagnosed, unrecognised and poorly managed (Phelan et al 2001).

In the 2001 Census, Pakistani and Bangladeshi men and women in England and Wales reported the highest rates of 'not good' health. Pakistanis had age-standardised rates of 'not good' health of 13% (men) and 17% (women). The age-standardised rates for Bangladeshis

[1] The numbers of people in low income is always lower on a 'before deducting housing costs' measure than on an 'after deducting housing costs' measure. This is because people who might not otherwise be in the low-income group, will be pushed into it by their housing costs if these are above average. As a result, the proportion of people in low income in Southern England (particularly London) is much higher on an 'after deducting housing costs' measure than on a 'before deducting housing costs' measure, and so the figures above partly reflect the concentration of the BME population in London and the South East. For further information on this see website www.poverty.org.uk, from which this explanation is taken.

were 14% (men) and 15% (women), around twice those of their White British counterparts. Chinese men and women were the least likely to report their health as 'not good'.

Women were more likely than men to rate their health as 'not good' across all groups, apart from the White Irish and those from Other ethnic groups.

Reporting poor health has been shown to be strongly associated with use of health services and mortality. White Irish and Pakistani women in England had higher GP contact rates than women in the general population. Bangladeshi men were three times as likely to visit their GP than men in the general population after standardising for age.

There were marked variations in rates of long-term illness or disability which restricted daily activities between different ethnic groups in England and Wales. After taking account of the different age structures of the groups, Pakistani and Bangladeshi men and women had the highest rates of disability, around 1.5 times higher than their White British counterparts. Chinese men and women had the lowest rates.

In the Indian, Pakistani, Black Caribbean and Black African groups, women had higher rates than men. In the White British and White Irish groups it was men who had higher rates than women.

Broad census figures by no means tell the whole story. For example, in 2001 the Chinese population reported the lowest rates of 'not good health'. However, Huang and Spurgeon (2006), researching in Birmingham found that over 60% of the Chinese population reported symptoms of poor mental health. Their experiences could be divided according to their occupational roles. Those employed in catering were heavily dependent on the local Chinese community, with minimal contact with the wider society. In contrast, professional workers reported a high need for integration. Overall, the mental distress experienced by the Chinese population was largely invisible.

Other information comes from the Health Survey for England (Erens et al, 2001), which each year takes a different theme within which to do some more in depth analysis. The theme in 1999 was the health of black and minority ethnic groups. Based on responses to a standard questionnaire assessing psychological wellbeing (the 12 item General Health Questionnaire or GHQ-12), the study found that

- Bangladeshis and Pakistanis were more likely than the general population to have a high GHQ12 score (4 or more, indicative of possible psychiatric disorder). Black Caribbean women and Indian women were also more likely to have a high GHQ12.
- People of Chinese origin were significantly less likely to have a high GHQ12 score than the general population.
- In all minority ethnic groups except for Indians, men were more likely than women to be classified as having a severe lack of social support.
- South Asian and Chinese men and women were at least twice as likely as the general population to have a severe lack of social support.
- As in the general population, those in non-manual social classes were less likely to be classified as having a severe lack of social support than those in manual social classes. Bangladeshis were the exception to this.

Carers

Hearn (2007) comments that BME families and communities generally hold to a belief in 'caring for your own'. She adds that can mean that members of the family and the elderly do not get the additional support they need. Caring for an elderly relative often puts added pressure on the family and increases the vulnerability of the person being cared for. There is often indirect poor care of elderly relatives due to reasons such as stigma, lack of awareness or understanding about different services, and financial reasons. Physical health issues such as tremors, or memory loss are sometimes not addressed as they are accepted as a sign of 'getting older'. This lack of awareness and understanding also includes issues around learning disabilities and mental health issues,

In April 2001, 0.8% of the population of Great Britain were resident in hospitals or other care establishments. This percentage varied greatly by ethnic group from 0.1% among Bangladeshis and Pakistanis to 1.0% among the White Irish group.

People from White British and White Irish backgrounds together with Indian people are most likely to be providing informal unpaid care to relatives, friends or neighbours. 10% of each of

these groups in Great Britain provided informal care in April 2001. Those least likely to be providing informal care were people from Mixed backgrounds (5.1%), Black Africans (5.6%) and the Chinese (5.8%). This pattern to some extent reflects the different age structures of the different ethnic groups, as informal care is most likely to be provided by people aged 50 to 60. The White groups have older age structures and are therefore more likely to both provide and need care.

In April 2001, 109,000 children under the age of 16 in Great Britain were providing some informal care. Indian, Bangladeshi and Pakistani children were the most likely to be carers, around 1.5% of each group, a much higher proportion than among White British children, of whom 0.9% were providing some unpaid care. Black African children were least likely to provide care, at 0.7%.

Types of household

The 1999 Poverty and Social Exclusion Survey (Payne 2000) found that;

- Adults living in family units with children had a higher risk of depression than those without children
- Lone parents were more likely than any other groups to suffer from depression. This is related to poverty and social exclusion (Brown and Moran 1997), but these factors do not explain the full extent of depression found in this group (Hope et al 1999).

The ONS (2005) found that 74% of Bangladeshi households contained at least one dependent child. This was the highest proportion for any ethnic group and was nearly three times that of White British households (28%). Households headed by a Pakistani or Indian person were also more likely than non-Asian households to contain at least one dependent child - 66% of Pakistani and 50% of Indian households did so.

Asians are least likely to live in lone parent households. Among households with dependent children, only 10% of Indian households and 13% of both Pakistani and Bangladeshi households contained a lone parent. In contrast, 48% of Black Caribbean and 52% of Other Black households with dependent children were headed by a lone parent. The percentage for the White British group was 22%.

The highest proportions of married couples under pension age, with or without children, were found in Asian households. Over half of Bangladeshi (54%), Indian (53%) and Pakistani (51%) households contained a married couple, compared with 37% of those headed by a White British person. Just one fifth (19%) of Black Caribbean households contained a married couple, the lowest proportion of any ethnic group. Asian households were also the least likely to contain a cohabiting couple.

The proportion of pensioner households ranged from 2% of Bangladeshi households to 27% of White Irish households. Among the non-White ethnic groups, Black Caribbeans were most likely to live in households which only contained pensioners (13%).

Households containing more than one family with dependent children are most likely to be headed by people from Asian ethnic groups. Among the Bangladeshi community, in particular, they made up 17% of households compared to just 2% of all households in Great Britain.

Use of Alcohol

Binge drinking and subsequent anti-social behaviour has a significant impact on crime and disorder, including violent crime both outside and inside the home (see section on violent crime).There is an increased association between alcohol consumption and mental illness, each being a cause or a resulting factor (APHO 2007).

White Irish men and women were more likely than any other ethnic group to drink in excess of government recommended guidelines (no more than 3 to 4 units per day for men and 2 to 3 units per day for women). 58% of men and 37% of women from a White Irish background drank in excess of the recommended daily levels on their heaviest drinking day in the week before interview in 1999. All other minority ethnic groups were much less likely than the general population to have consumed alcohol in excess of the daily guidelines.

Victims of Crime

Those living in poverty are more likely than the average to be victims of crime, suffering more home break-ins, vandalism or deliberate harm to their home or car or experience personal theft. Fear of crime is also greatest amongst the poor and the elderly, and this is linked closely to poor mental health (Payne, 2000).

Crime, especially violent crime, is linked to mental health issues in a number of ways:

- Links with drugs, alcohol and deprivation
- Victims of crime are more likely to suffer mental health problems
- Violent crimes which are committed by people with mental disorders are more frequently reported

Consequently, areas with high levels of violent crime are likely to have higher levels of mental illness (APHO 2007).

In 2002/03, according to the ONS (2005) adults from a Mixed race or Asian background were more likely than those from other ethnic groups to be victims of crime in England and Wales. Almost half (46%) of adults of Mixed race had been the victim of a crime in the previous 12 months. This compared with 30% of Asians. Black adults and those from the 'Chinese or other' group experienced similar levels of crime to White people.

However, after allowing for their younger age structure, Asian adults were no more likely than those from other groups to be victims of crime. In contrast, Mixed race people still had higher risks of crime after allowing for age and the type of area in which they lived.

17% of Mixed race people had been the victim of a personal crime (common assault, robbery or theft) compared with 7-9% of people from other ethnic groups. A third (34%) of Mixed race people had experienced household crime compared with between 18 to 23% of people from other ethnic groups. In 2002/03 10% of Mixed race households had experienced a burglary in the previous 12 months compared with 3-4% of other households. People from Mixed race backgrounds were also at greater risk than other ethnic groups of violence. 11% reported being the victim of a violent crime in the previous 12 months, compared with no more than 5% in any other ethnic group (ONS, 2005).

Domestic violence

According to a statistical summary provided by Women's Aid (2009) domestic violence accounts for between 16% and 25% of all recorded violent crime, and 45% of women and 26% of men have experienced at least one incident of inter-personal violence in their lifetimes. However when there were more than 4 incidents (i.e. ongoing domestic or sexual abuse) 89% of victims were women. In any one year, there are 13 million separate incidents of physical violence or threats of violence against women from partners or former partners.

In all communities, however, capturing statistics on domestic violence is extremely complex for a number of reasons, a major one being the huge numbers of victims who conceal their suffering due to shame or embarrassment. The British Crime Survey (Home Office 2007) found that 34% of the women and 62% of the men who reported that they had suffered domestic violence since the age of 16 years had probably never told anyone other than the survey.

Local research has explored the needs of and provision for BME children and women in South Tyneside. Donovan et al (2004) identified the particular cultural constructs of 'shame' and 'honour' that can play a major part in these women's experience. They have a commitment to marriage and are reluctant to disgrace their families, despite living with domestic violence. They may be subject to abuse from the extended family and experience racism as well. The research also found that BME women lacked access to services because of language difficulties and were not aware of their rights or the existence of services.

Attitudes to mental illness

Hearn (2007) has pointed to a general lack of understanding and awareness surrounding mental health issues in community leaders and the BME communities. Common perceptions are mental health issues being described as people being "possessed by the devil",

"shameful", "crazy" (the idea of 'crazy' being extreme mental ill-health which is not considered to be treatable). Faith-based treatment is usually culturally accepted.

In nearly all cultures there is a stigma attached to mental health issues. Within most BME communities the reaction of the community increases the stigma and discrimination the person may encounter. Having the stigma of mental health issues may affect employment for themselves and/or their family (which is already a barrier), marriage prospects of their children, and their position and acceptance within the community.

A particular issue is post-natal depression, which is often not recognised or considered within BME communities. Post-natal depression is one of the most common forms of mental ill health associated with maternity, but this is not reflected in the number of BME mothers being identified and receiving help. National research has also highlighted greater prevalence of post-natal depression within specific BME communities (Onozawa et al, 2003).

Research undertaken by Cowan et al (2007) in Greater Manchester, about the mental health service needs of the Orthodox Jewish Community , also significantly highlights the barriers community members face in placing trust in mental health services. This lack of trust arises from a real concern among community members that mental health practitioners could make serious errors of judgement if they lacked understanding of the cultural and religious needs of community members.

Exercise and physical activity

There is substantial evidence that physical activity is effective in preventing mental ill-health and improving the quality of life for people with mental illness, and as a treatment for mild to moderate depression (Biddle et al 2000, Halliwell 2005, APHO 2007). A major review (Whitelaw et al 2008) of the relationship between physical activity and mental health highlighted a range of themes, including:

- Self esteem and self concept: physical activity was found to promote feelings of 'self-efficacy, self-determination and personal control' (p. 9)
- Prevention or reduction of mental health problems (particularly anxiety and depression).

Hearn (2007) points out that while a wide range of activities is available in South Tyneside, in general BME communities make little use of these facilities for a range of reasons including:

- The majority of BME communities reside in areas of social and economic deprivation, so there may be financial barriers to accessing activities;
- If the classes are mixed sex then this would be a barrier for females;
- The time of classes is an issue for those who work in restaurants, or unsocial hours more generally;
- There are cultural views on what mental health is and how undertaking activities and staying healthy can impact on wellbeing;
- There are also cultural views on females making use of services, and taking exercise.

Part III; Local views on mental health needs

A. Public consultation

A number of studies were carried out for the purpose of this Mental Health Needs Assessment by the DRE Community Development Workers. In addition, there are two slightly older studies, from South Tyneside (Hearn 2007) and Sunderland (Magoye and Ohlson 2006), which report on extensive community work and consultation, and have therefore also been included. They are all qualitative studies, and indicate a number of common and important themes.

Gateshead

Discussions were held by the GVOC BME workers with a number of ethnic minority organisations, while a number of individuals also filled in a questionnaire and two small focus groups were held. Participants were more from asylum-seeker/ refugee groups than from the longer-standing BME communities, but one of the focus groups involved young people who were university students and unemployed. (GVOC, 2009b)

Key findings were that;

- barriers to accessing mental health services were greater for women than for men, with language, childcare problems, transport and culture all creating problems;
- the first point of contact was generally family, friends, religious leaders, or the GP;
- Smaller communities found religious leaders more helpful, as compared to more established communities who feared stigma;
- Individuals generally felt more connected to their own ethnic community than to the wider community;
- Knowledge of mental health support services was typically limited to primary care services with little or no knowledge of secondary or tertiary services;
- There was a lack of opportunity to have access to culturally sensitive recreational & support services;
- There was a lack of basic understanding of mental illness;
- Asylum seekers experienced more serious and prolonged mental illnesses due to the uncertainty of their immigration status;
- There was a lack of support for access to clinical services.

Tyneside Women's Health has provided demographic information for 112 of their Black and Minority Ethnic service users, showing that they came from 22 different countries of origin, the most prevalent being Eritrea (16 women) and Iraq (14 women). A smaller sample of 33 service users showed that low confidence, anxiety and isolation were major issues that affected their wellbeing, each reported by one-third of those sampled. These items were followed by accommodation, childcare, depression and immigration/ asylum issues.

Anecdotally, the Tyneside Women's Health Community Development Worker reports that mental health issues are often not raised by women directly for quite some time, both due to language reasons, and because of the need to develop trust over time. For example, repeated use of the word "tired" to explain how one is feeling in response to the question "how are you" may point to a deeper underlying mental health or wellbeing issue, but without developing a knowledge and understanding of the individual, this underlying mental health/wellbeing issue might not be identified.[2]

South Tyneside

A *Survey Of The Wellbeing And Health Of BME Groups In South Tyneside* was carried out in March 2009 (Ngituka, 2009) in order;

- to investigate the BME community's view of health and wellbeing;
- to establish the level of reported of physical and mental illness and disability among this group; and
- to investigate the extent of access and perceived usefulness of relevant services.

Questionnaires were distributed to 460 people at a variety of events, and the full survey is available on http://www.sunderlandtpct.nhs.uk/content.aspx?id=2352. Overall, the survey found that wellbeing related strongly to relationships with family and friends, and to having a routine. Cultural activities and exercise came much lower on the list. In terms of what kept people well, however, a rather generalised category of 'family, people, hobbies, activities, work and pets' scored highest, with access to training and employment activities coming next. In terms of what made people feel unwell, lack of choices/ lack of control scored joint equal with unemployment, with 'other people who are unhelpful' in third place. In answer to the question "what can services do to help?" the top answer was 'Be more visible and culturally appropriate', with other questions that also related to visibility and helpfulness also receiving very positive answers. There was also some interest in joining a steering group that would meet to address the health and social care needs of the community.

[2] In relation to public consultation for the purposes of this needs assessment, the absence of specific engagement with members of the Orthodox Jewish Community is acknowledged. However, the authors note the encouraging developments taking place in relation to partnership work between Gateshead Council, the Primary Care Trust and the Jewish Community Council of Gateshead, which includes early discussions on the possibility of a sample household survey in the near future. This survey would capture comprehensive data on wide ranging issues from housing needs through to financial inclusion, social care, mental health and wellbeing in order to ensure appropriate services are commissioned and delivered.

A more extensive series of community events and consultations was held in the borough and reported in Hearn, 2007, available on http://www.sunderlandtpct.nhs.uk/content.aspx?id=2352. Seven stakeholder events, ranging from a Boys' Party for over a hundred young BME men, to a Night Out for asylum seekers and refugees, attended by over 60 people most of whom were women, were held. There was also a much larger event, on World Mental Health Day, attended by over 350 people, 80% of whom were from a BME background and included Asylum Seekers/Refugees. A variety of methods of obtaining and giving out information was used, including in-depth discussion and completion of questionnaires in some cases.

Comments showed that there was a level of sadness and depression among respondents, and that they relied most on family and friends for support when they needed it. Among asylum-seekers and refugees, sadness and depression was as high as 85%. Awareness of therapies and medication available on the NHS was not very high. Young people tended to highlight physical activity as a way of making themselves feel better, more than older respondents did. The local community centre was cited as the primary place of access for services, followed by schools and colleges.

The interpreting services provided by the NHS were in general said to be useful, with asylum seekers and refugees in particular noting that it could be crucial for them. However, while only 15% of the larger BME group had made use of the service, almost two-thirds had found themselves interpreting for a family member or friend in contacts with the health services. This suggests that in practice, it is being found unavailable or unsuitable for a large number at the point of need.

A specific event was held for asylum seekers and refugees, attended by 62 people, 57 of them women, from a variety of nationalities. Relevant findings were;

- *Women's health;* Women carry a disproportionate share of the problems of asylum seeking. They are usually responsible for the children, some may have been sexually abused, and refugee women may also be particularly vulnerable to domestic violence, as they may lack family and community support. They are more likely than men to report poor health and depression. They may be lonely and isolated but often welcome the opportunity to belong to a group, where they may benefit from the contact and support;
- *Men's issues;* Enforced unemployment during their asylum-seeking years has a significant adverse effect on both physical and mental health. They have difficulties with engaging in discussion. Some have limited knowledge of health services; men's health beliefs may differ from those of service providers, and services planned for the majority are not always appropriate. Those with poor English experience particular difficulty in gaining access to care even with the support of an interpreter;
- *Immigration issues;* The immigration process itself can be stressful and increase frustration amongst those within its system. Some asylum seekers' children and families and unaccompanied children are detained in South Tyneside; this has potential adverse health consequences. There are mental health implications for asylum seekers detained who have previously been exposed to trauma including torture, and the possibility that conditions of detention may act to re-traumatise those who are held for indeterminate periods. Asylum seekers live in fear for their own safety and security.

Sunderland

Research by Sangini Project

In June 2006, Sangini a BME-led women's voluntary sector health organisation produced the Sunderland BME Health Needs Assessment (HNA) Report (Magoye and Ohlson, 2006), which had been commissioned through the Healthy City Partnership of Sunderland Teaching Primary Care Trust.

This Health Needs Assessment was carried out to identify the health needs and priorities within BME communities, to look at mechanisms which would acknowledge the diversity of the BME populations within Sunderland, and to put forward recommendations to support those health needs and at the same time endeavour to remove the barriers experienced by the ethnic community in obtaining access to health care services.

A total of 237 BME residents participated in the consultation exercises, which included focus groups, questionnaires, activity sessions, and discussion groups. A number of recommendations were put forward within the report, but only those relevant to mental health are highlighted here. The report found that;

- 86% of respondents practiced a religion. Practicing religion was linked to good health, both mental and physical
- expression of good health equated with feelings of happiness and wellbeing, and emotional fitness and peace of mind
- happiness was the most important pre-requisite and indicator of good health
- physical exercise promotes good mental health
- poor health was equated to sadness, loneliness and a need to be taken care of
- there was a fear of rejection because of a individual's ethnicity
- there was a lack of awareness of services available within the Health Service
- people felt unease at using family members as interpreters
- there had been experiences of racism and its effects on mental health

There was a perception that professionals did not always acknowledge and address issues around racism

Research by Sunderland DRE Team

One of the Sunderland DRE team's priorities was to revisit the research carried out by Sangini, to evaluate progress (http://www.sunderlandtpct.nhs.uk/content.aspx?id=2352). Sangini had identified that mental health within the BME community was a major concern. It was agreed that the Sunderland DRE team would undertake a BME Mental Health Needs Assessment across Sunderland.

In early 2009 the DRE team in Sunderland therefore approached a number of ethnic minority communities to take part in consultative workshops, using informal community development approaches to encourage participation. 12 workshops were held in all, with 90 people taking part in the consultative workshop exercises. Countries of origin of the participants included Angola, Albania, Bangladesh, Burma, China, Eritrea, Zimbabwe, Pakistan, Philippines, Poland, South Africa, Congolese and Zimbabwe. Around two-thirds of the respondents were female, and ages ranged between 18 and 54. A separate Health Survey questionnaire was also filled in by 18 other individuals. In all 108 people were consulted for this piece of research.

Although participants were from varied ethnic backgrounds, responses to questions about what made people feel good, or feel positive or negative, were common across all groups. For example, everyone stressed the importance of family and friends, as well as being in employment, as major contributory factors in their sense of wellbeing.

Responses about what had a negative effect on their mental wellbeing were also generally the same across all ethnicities. They included; racism, lack of cultural awareness, language barriers and the fear and stigma associated with mental health in general. There was also a general lack of understanding about what support services were available within mental health services.

The barriers to access health services in Sunderland which were discussed in the Sangini report during 2006 are not dissimilar to those identified within the work undertaken by the DRE Team during 2008/09. They included;

- General lack of cultural competence and awareness from frontline staff and health professionals when dealing with people from ethnic backgrounds
- Language barriers, and lack of available or adequate interpretation, with children, family members or friends being used as interpreters, giving no privacy or confidentiality;
- Lack of awareness within the BME community of the term 'mental health' and the mental health services
- Stigma and discrimination linking into social and cultural restrictions around mental health

When the workshop groups were asked about improving access to mental health services the feedback was generally the same, being more information, use of media TV and radio, increased awareness of services, more workshops and awareness events within the BME community.

It was interesting to note that when the question "What is Mental Health?" was asked, all respondents gave negative feedback, However, when the question "What is Wellbeing?" was asked, the responses were all positive aspects of mental health. Terminology and stigma appear to have major associations within an individual's concept of mental health and this in turn, may be a major contributory factor which affects their confidence and ability to access mental health services.

Bangladeshi young men's focus groups

A consultation workshop with 20 young men from the Bangladeshi community, aged between 13 and 18, was held in a well-established youth project 'Young Asian Voices'. The workshop posed questions to the young people around mental health and services. The themes that emerged were around

- Barriers around family, social and cultural restrictions
- Racism within schools within communities instilling fear in young people.
- The need for a youth voice including young people in designing mental health services

From the discussions, it was clear that the young generation still faced the same ongoing issues as previous younger generations, in relation to family, education, work and general social life. The young people expressed the view that there was no specific meaning for the term "mental health" in the Bengali language, and when they tried to translate it meant psychosis, hallucinations and pain. This report is available on http://www.sunderlandtpct.nhs.uk/content.aspx?id=2352.

B. Professionals' views

There was insufficient time to undertake a full consultative review of professionals across the three boroughs. However, it is hoped the findings from community consultations and the needs assessment recommendations will stimulate debate among professionals in each area and that the Needs Assessment will be tabled at relevant forum and network meetings.

In earlier phases, the *North East, Asylum Seeker, Refugee and other Migrants Health Study 2007* (Horton, 2007) collected information on what the PCTs knew about the health needs of these groups. In terms of mental health issues, points raised included;

Asylum seekers

- incidence of Post Traumatic Stress Disorder, trauma, isolation;
- position of women in society here very different from that in home country for many. This can cause conflict within the family, and prevent integration and adequate access to health services;
- sexual difficulties, unwanted pregnancies, and low self-esteem due to some women (and men) having experienced rape. This is especially difficult for women many of whom are unable to tell their husbands or families due to shame and the possibility of their husbands divorcing them.
- anxiety and depression, exacerbated by poor healthcare, civil unrest and abuse in the country of origin, and alienation in the host country.

Issues were also identified around language as a barrier to effective use of services with failure to attend hospital appointments common. Lack of understanding about NHS services and system causes further issues.

Refugees

The issues were as above, but in addition refugees found the process of transition very stressful – finding a tenancy, managing on a low income, finding work or college placements. After the initial euphoria, mental health problems could become apparent especially if the person is separated from family members or there are family members missing or killed. Feelings of isolation, loss and mourning could actually be worse for some than during the asylum process.

Other migrants

Much less information was available on them, but it was commented that national evidence suggests that issues of major concern in European immigrant populations included mental ill-health and psychosocial issues.

Priority issues

Priority issues, for all the groups, were considered to be;

- *Primary care access*: Getting GPs to register new arrivals, not turn them away;
- *Secondary care access:* responding to the needs of asylum seekers and refugees was difficult without constant assessments to assess current need. Helath Needs Assessment were occurring but the health needs of this population were dynamic and services must be able to respond to this;
- *Educating GPs* so that they understood the needs of this client group, for example the need to ask for interpreters in clinics or when referring into hospital.

Other suggestions from PCT staff, made in response to the questionnaire, included

- Access to education is not offered to adults, which is especially hard for professionals who cannot work such as lawyers and doctors. This leaves them feeling unsupported and their self-worth is reduced;
- Lack of translated material and access to interpreting services;
- High hospital 'failure to attend' rates, possibly because letters are sent out in English, and so people may not be able to understand their letter, and also possibly because of a lack of understanding of the NHS system and services;
- Access to services: linked to pressures on GP registers, language, communication barriers, perception of services as "unhelpful"; transport and gender issues;
- Health maintenance and preventative services will not be the primary concern for these populations, especially if they enter the country with pre-existing health needs. Robust data collection processes nationally and locally could be improved;
- Family members are frequently used to interpret, which is poor practice & dangerous;
- Destitution for some failed asylum seekers is leading to an increase in poor health, poorer access to secondary care, safe guarding issues, prostitution, exploitation, unsafe working conditions and crime.

No similar questionnaire study is known of professionals' views on issues relating to the BME population as a whole. However, Hearn (2007) provided comments on the services available, as part of her report on consultations in South Tyneside. The majority of mental health and mainstream services, she pointed out, had no recorded information about the needs of BME communities, or previous work done engaging with BME communities. She also took the view that the majority of professionals working within the statutory and voluntary organisations working with BME communities had little or no understanding of mental health issues. Most workers recognised severe clinical mental health issues such as schizophrenia but did not recognise stress, anxiety or depression as being related to the term mental health.

Particular problems for asylum seekers included:

- Needing help to register with a GP;
- Needing advice about where to go with a problem, whether it be a mental health issue, a request for counselling, concerns regarding sexual health or isolation;
- Communication issues if interpreting services are not used;
- Difficulties with filling in forms and booking an appointment.

More generally Hearn found;

- a lack of service provision for men and women who are forced into marriage, and for men who were the victims of domestic violence;
- a lack of service provision aimed at BME men's health;
- inherent difficulties in supporting 'hard to reach' BME communities who did not attend existing mainstream/BME services with mental health provision;
- Representatives from services often only approached community leaders and established organisations, and information was not always disseminated.
- Services could be indirectly inaccessible if located within particular buildings; use of a church, for example, might give the impression that the service was for Christians only.
- Attempts to approach BME communities had often been one-off events, without sustained work being done, for reasons including finance, resources, lack of cultural understanding and awareness.
- At times the approach used, such as planning healthy cooking courses for BME ladies during Ramadan, had led to a lack of success.

C. Existing structures and provision

Mental health services available

A range of mental health services is available. A full list of specific services will be given in the Mental Health Directories published by Mental Health Matters (currently being updated and will be available on www.sotw.nhs.uk), and in the recently published SoTW Mental Health Needs assessment (Mackereth, 2009).

A Directory*, Services available for people of ethnic minority in Northumberland, Tyne and Wear* (NTW, 2008) covering BME organisations, groups, activities, events and services, jointly produced by the Newcastle CDW Team and the NTW Patients Information Centre, with input from the other NTW CDW teams was published in October 2008. An electronic version is available at www.ntw.nhs.uk.

Examples of recent good practice

As a result of the issues raised in Horton (2007) and Magoye and Ohlson (2006) , and other feedback, action was taken in the NTW Focused Implementation Site project which ran until the end of 2008. Its final report, *Positive Steps* (GVOC, 2009a), has been included on the National Mental Health Development Unit's website as a resource. Activities included;

- delivery of cultural awareness training programmes for NHS staff. These have continued, as explained below;
- translation of Patient Information sheets on topics such as Stress, Depression, Anxiety and Post Traumatic Stress into 17 languages, with placement on a website for use by clinicians;
- a local event in South Tyneside, and a draft report on reducing risk of mental illness and suicide, specifically aimed at BME community groups and asylum seeker and refugee groups;
- work with interpreters and service users, including workshops, training courses, and production of guidelines for professionals in mental health working with interpreters;
- 'Message on a Mug' campaign, aimed at engaging and informing staff about importance of delivering race equality in mental health; 'messages' developed with the help of BME community groups;
- provision of equality and diversity training aimed at doctors who train other doctors to be GPs and secondary care specialists, and a pilot training course in Sunderland aimed at GP practice managers and receptionists;
- provision of a training course in Active Listening Talk Therapy for frontline community staff and religious leaders in Gateshead, a spirituality, religion and mental health conference.
- An ongoing Spirituality in Mental Health North East (SIMHNE) Network was formed, and continues to meet regularly.

Training

In addition to the internal training that organisations provide for their staff, training for trainers courses are being offered to mental health providers, service user and carer networks across the North East region in the Race Equality and Cultural Awareness Programme or RECAP. At present there is a team of two trainers from Northumberland Tyne and Wear Mental Health Trust and Tyneside Women's Health and it is hoped that a wide variety of organisations and networks will avail themselves of the training for trainers opportunity so that they can deliver participant training to their own staff, volunteers, members. One training for trainer course is running in October 2009 at the request of Gateshead Forum for Delivering Race Equality in Mental Health, and at least two other regional courses will be delivered in later 2009 and in 2010.

Within the DRE team in Sunderland, a CDW is qualified as a Mental Health First Aid Instructor, and will be delivering 2 courses before March 2010. The first, scheduled for November, will be for people from BME community organisations, and people from the voluntary sector who work extensively with BME communities. The second, scheduled for February, will be aimed at faith leaders working with BME communities.

Community Development Workers

Following the publication of *Delivering Race Equality* (DH 2005a) twelve community development workers (CDWs) were appointed in South of Tyne and Wear; two in South Tyneside based with the PCT; four in Gateshead in two linked BME Community Development Work Projects; aTension, managed by Gateshead Voluntary Organisations Council (GVOC) and employing three staff, and Tyneside Women's Health, employing one worker, and four in Sunderland based In Sunderland TPCT.

The role of the CDW may vary according to local community needs but there are four key functions defining any CDW role. These are:

- ✓ **Change Agent** by identifying gaps; developing innovative practice.
  For example, the team act as change agents within local meetings these include the Local Implementation Team (LIT), IAPT project group, Equality, Diversity and Human rights group SOTW, and all CDW sit on IAG which are groups which link into the Local Strategic Partnership.

- ✓ **Service Developer** through promoting joint working, education and training.
  For example, one CDW is currently providing training to colleagues from partner agencies about Racial Equality and Cultural Awareness. Also the teams work closely within primary and secondary care mental health team and CAMHS services.

- ✓ **Capacity Builder** in BME communities
  For example, the team works closely with smaller grass roots group assisting in their development e.g. accessing funding, support in organising community events, providing workshops on awareness raising of mental health and services.

- ✓ **Access Facilitator** to services; community resources; overcoming language and cultural barriers.
  For example, the team has worked in partnership with Interpreting Services and BME Community Psychiatric Nurse in developing training for interpreters. This has involved raising awareness of the DRE programme and also mental health. This training for interpreters has been made mandatory which will assist with addressing language barriers within services. Guidance on their role was given in the *Community Development Workers' Handbook*, (DH 2006).

Organisation of Black and Minority Ethnic mental health services

A new structure was agreed in October 2008 to replace the FIS and mainstream the Delivering Race Equality agenda in the North East. Two Mental Health DRE Partnership Groups were established in order to keep the focus on race and mental health, and to feed into a North East wide structure, while maintaining links with the North and the South of the region. It is planned to maintain and develop, with CSIP/NIMHE North East Mental Health Development Unit support, the CDW Network and the CDW managers group. This new structure will also feed in to the NHS Integrated Equality Policy Framework via the NHS North East Equality Network.

As part of this, Northumberland, Tyne and Wear Mental Health Service User and Carer Network works to ensure that the voices of the service user and carer are heard in all the decision-making bodies that affect mental health.

Self help and support groups

At least as important for mental health and wellbeing are the self-help and support groups within the community. They contribute to people's mental health and wellbeing even if they are not described that way, and fulfil a role in dealing with people's need for culturally appropriate support. There is also a much broader range of cultural and leisure activities, provided by local government and statutory bodies, which can contribute to mental wellbeing - the provision of facilities for physical exercise being just one example. Below are listed a number of self-help and support groups, forums, and organisations available across the area and in each borough, for BME communities. (Although efforts have been made to collect details, it is appreciated that it is unlikely to be fully comprehensive).

Across SoTW

- North of England Refugee Service; to meet the needs and promote the interests of asylum seekers and refugees who have arrived or settled in the Northeast.
- Regional Refugee Voices
- BECON
- African Community Advice North East (ACANE)
- Medical Foundation for Care of Victims of Torture, North East office
- Association for the Promotion of African Women

Gateshead

A number of BME groups or organisations operate in Gateshead, ranging from a weekly football team to church-based refugee groups to long established faith-based associations. Examples of some of these are;

- Gateshead Muslim Society
- Projects under the management of the Jewish Community Council of Gateshead, such as the Labriut Healthy Living Centre
- The Gateshead Jewish Family Service
- Bangladeshi Outreach Project meeting at Avenues Project
- Visible Ethnic Minority Support Group, based at Bensham Grove Community Centre, and including a Refugee and Asylum Seekers drop in
- Naqshbandia Aslamiyyah Trust
- Gateshead African Community Association (Gafricom)
- African Society and Support Group, meeting at St Joseph's church and including a drop-in session for asylum seekers
- Congolese Solidarity In Gateshead, mainly French-speaking Congolese
- Gateshead Kurdish Association
- St Joseph's Asylum Group
- H2R youth group, based at the Avenues Project
- Bikur Cholim, a Jewish Women's Group who provide outreach support to fellow community members in need;
- Support groups and activities for women from BMG ethnic communities at Tyneside Women's Health, a Gateshead based women's mental health organisation.
- Gateshead Citizen's Advice Bureau has an Advice Worker for black and minority ethnic clients, concentrating particularly on mental health matters

Umbrella groups in Gateshead of relevance are

- Gateshead Diversity Forum: a forum open to any black and minority ethnic community groups, individuals and organisations who are working to benefit the lives of local BMG people. The Forum aims to provide a formal method of consultation between the Gateshead Council and members of BMG groups and communities.
- Delivering Race Equality in Mental Health Forum; a forum set up in 2009 which focuses on supporting and co-ordinated mental health providers, commissioners, service user and carer networks to ensure culturally appropriate mental health provision in Gateshead.

South Tyneside

- *S.T.A.R.C.H;* a weekly drop-in centre runs by the South Tyneside Asylum Seeker and Refugee Church Help;
- *Fighting Fit*; an alternative form of youth provision, using mixed martial arts and fitness as a tool to engage with young people;
- *Surestart;* Inclusive Workers regularly visit the Drop-in, giving advice to young single parents about the services available e.g. ESOL classes with a free crèche when attending classes to asylum seeker families, Art Shop - Museum Group, swimming;
- *Compact for Racial Equality in South Tyneside (CREST); an* active voluntary group which provides advice, information and support to asylum seekers health programme in partnership with the PCT and Local Authority.
- *Rekendyke Partnership* works with voluntary and statutory sectors in Rekendyke to improve the quality of life to everyone living in the area including asylum seekers and refugees. Activities involve ESOL classes, healthy lifestyle and building stronger community cohesion.
- Bangladeshi Youth Organisation

- Apna Ghar – women's health project
- Bangladeshi Muslim Cultural Association
- Citizens Advice Bureau and Ethnic Minorities Project
- Arab Yemeni Community Welfare Association
- South Tyneside Arab/Muslim Community Centre

The main umbrella organisation is the *BME Wellbeing Forum* – aims to work in partnership to produce strategies for improving mental health services to meet the needs of BME groups across South Tyneside.

Sunderland

- Bangladeshi community centre
- Sikh women's health group
- Unity multi-cultural organisation
- St Mary's Women's group; informal activities for women on Monday afternoons
- Sunderland drop-in at St Mary's; support for asylum seekers, failed asylum seekers and refugees.
- Jambo African group; refugee community organisation
- International Community Organisation of Sunderland
- Filipino group - support and informal group meetings
- New Horizon African group; encouraging integration with the host community
- Young Asian Voices YAV; youth group
- Fight back (service for disabled refugees and asylum seekers)
- Chinese group True Jesus church; informal meeting Wednesday afternoons
- Sangini Women's health project.

The main umbrella organisation is the Sunderland BME network, an infrastructure organisation supporting the development of BME community groups in Sunderland.

Part IV; Conclusions and Recommendations

In this section, conclusions are drawn together from the various parts of this report, and the other documents that have been used in its preparation. They are followed by a shorter list of more specific recommendations for implementation within SoTW.

The national framework

The *DRE Action Plan* (DH 2005a, p. 19) states that DRE, in conjunction with other reforms in health and social care, could lead to services with 12 characteristics, of which six appear to be relevant to this Mental Health Needs Assessment

1. less fear of mental health care and services among BME communities and BME service users;
2. increased satisfaction with services;
8. an increase in the proportion of BME service users who feel they have recovered from their illness;
10. a more balanced range of effective therapies such as peer support services, psychotherapeutic and counselling treatments, as well as pharmacological interventions that are culturally appropriate and effective;
11. a more active role for BME communities and BME service users in the training of professionals, in the development of mental health policy, and in the planning and provision of services; and
12. a workforce and organisation capable of delivering appropriate and responsive mental health services to BME communities.

Using this as the framework, points that need stressing are;

Cultural competence

- There needs to be development of cultural competence in all general services, alongside specific services providing individualised care. This includes understanding of the pressures on people (including young people) in tight-knit and often isolated BME communities. It should lead to comprehensive staff training in Race Equality and Cultural Awareness, to ensure everyone working in mental health has appropriate values and

skills to work with diverse patients. Front line staff in GP surgeries, and community health workers such as health visitors, should also be included. The existence of racism within society needs to be taken seriously for the stress it puts on BME people going about their daily lives, and service providers need to keep anti-discriminatory practices at the core of their daily lives;

- There should be improved free access to interpreting services, promoting the availability of the services and ensuring that they are resourced effectively for equity of access for all sectors. Female interpreters should be provided for female patients when needed. There is also a need for more translated material;
- Priority should be given to IAPT work for the BME community, through provision of more talking therapies sensitive to traditional and cultural values, whether delivered through mainstream teams and services, or specialist groups. This will require high quality training for the therapists, whether through people from BME communities being trained, or through therapists being trained in the provision of culturally appropriate services (or indeed both).
- More robust data collection and regular monitoring is needed, with work at senior management level to ensure that shortcomings in the data are overcome and lessons learnt from the evidence provided. This should be alongside monitoring of the progress of work to be inbuilt into future action plans, with periodic collective assessment and recommendations for future action. This might take the form of an event at suitable intervals, with a forum for discussion and guidance;
- Further research is needed on issues such as forced marriage, domestic violence experienced by males, substance and alcohol misuse, post-natal depression, self-harm and suicide;
- Suggestions for new projects include;
- Development of one stop health drop-ins in localities, with a significant mental health component;
- Funding of posts of advocates from the BME communities, and/or speaking BME languages;

Community mental health work

- There should be recognition that because of the stigma attached to mental health problems, people from BME communities do not turn to members of their community for advice and/or signposting. Strategies to overcome this are therefore needed. For example, for cases of post-natal depression, advantage should be taken of the fact that health visitors have automatic and direct contact and involvement with all pregnant women. It is thus important that health visitors are aware of and recognise issues around culture, religion, faith and ethnicity in relation to mental health issues, and are also aware that Eurocentric assessment tools may not always be relevant measures for some BME communities;
- A programme of positive promotion of mental health is needed, with the use of role models who have links to the BME communities, and creative and innovative ways to engage with people. There should be an emphasis on the promotion of heath and wellbeing as a continuing process, rather than intervention only in a crisis. Particular efforts should be made to engage with communities that have a low take up of services. All this will be assisted by use of the community development approach, learning from best practice in SoTW and elsewhere;
- Suggested new projects include;
- Community Health Workers who can provide information and advice to elderly BME people. Their numbers ares set to grow sharply in the next few years, and will often be non-English speaking, expressing loneliness and depression, and with a level of substance-abuse (“paan” chewing and alcohol);
- GP surgeries developing innovative practices, using data as a tool for change

Collaboration with BME communities

- In order to build the trust and confidence of BME communities, engagement with BME communities should be established as a long-term activity. Feedback and timely responses should be made in relation to the needs voiced by communities. Support and resources should be offered to community-based groups and organisations, recognising that their communities may expect a great deal from them, so that time and resources are severely stretched;
- There should be encouragement for BME individuals and organisations (Mosques, churches, ESOL classes, schools) and interfaith groups to get more involved in campaigning and local forums to influence the shape of local mental health services for BME communities. Commissioners, strategists and mental health senior managers need to engage directly with BME communities, rather than rely on a small number of CDWs.
- As part of this, training in mental health awareness should be offered to BME community leaders, including religious leaders, and community workers in the statutory and voluntary sectors, with guidance provided on signposting and referral to appropriate bodies. Ongoing awareness-raising, education programmes and events with and within BME groups and communities should be developed in collaboration with BME community members and in single sex groups, where appropriate;
- There should be strategies to engage particularly with young people in the BME communities, involving them in the development of services. All staff working with young people (in any community) should be offered training in mental health and the promotion of mental wellbeing.

Workforce issues

- More staff training should be provided within the NHS on how better to know and understand the make up and needs of local BME communities. This should include training about asylum seekers' and refugees' countries and experiences. Members of the communities themselves should be involved in providing the training
- It would be helpful to develop workplace mental health awareness programmes in partnership with BME employers, such as Chinese, Indian, and Bangladeshi restaurants and taxi firms that employ high numbers of staff from BME Communities.
- There should be a range of projects to support employability for BME individuals, and mental health awareness to ensure health improvement.

Asylum seekers and refugees

- It needs to be recognised that Home Office and local authority figures for asylum seekers are a 'snapshot' at a particular time; because new families move in and out on a weekly basis, the numbers the specialist health services see are much higher than the number of bed-spaces allocated by the Home Office to the area;
- There is a need for more specialist mental health support for those who have experienced torture, with stronger links with the Medical Foundation for the Care of Victims of Torture.
- Access to psychological therapies (including Cognitive Behavioural Therapy) should be easily available for asylum seekers. A holistic/ integrative approach to treatment and therapy should be adopted, with emphasis given to practical support, the provision of social activities and the development of support groups. This requires a connection between those providing psychological help to asylum seekers and those who are providing social and community support.
- Specific training should be offered to mental health professionals around writing legal reports for asylum seekers.
- It would be helpful to create more asylum focus support groups, to be funded through mainstream budgets or to have managed service level agreements with PCTs. Using a focus group approach will assist asylum seekers to think about their personal health and lifestyle issues such as smoking, and allow them to be offered support programmes of their choice. Along with this, peer support and voluntary befriending should be further developed in informal community settings;
- There should be work with GPs to ensure that all take on an equitable proportion of Asylum seekers. This should include a programme of education of GPs so that they are willing to register new arrivals, and are sensitive to the needs of this client group, for example asking for interpreters at clinics and in hospitals. Additional capacity may be needed.

Recommendations

Cultural Competence

- Training in cultural competence should be available to all front line staff to increase understanding of issues that are relevant to BME communities and ensure services are culturally sensitive

- Interpreting services should be maintained and developed to ensure they are freely available to service users, affordable to services, appropriate to needs, and should include translation of material into appropriate languages

Community Mental Health Work

- Mental health services should be made accessible and appropriate, particularly within GP practices, IAPT and secondary mental health services

- Targeted early intervention services to increase social inclusion and reduce isolation should be provided to BME communities, through drop-in provision, a range of personal support including advocacy and sign-posting, with an emphasis on promoting trusting and positive relationships

Collaboration with BME communities

- Partnership working should be promoted at a local and strategic level, including continued and improved engagement of BME communities in decision making within the local authorities and PCTs

- Specific local action plans should be developed with regard to the mental health and emotional wellbeing of the BME communities

Workforce issues

- Promotion of mental well-being within the workplace should be increased through targeted partnership work and awareness raising with employers

Asylum seekers and refugees

- Specific work should be further developed to address the particular and often complex needs of these groups

Overarching Recommendations

- Positive emotional health promotion should be provided, in culturally sensitive ways, through ongoing awareness-raising, education programmes and events

- Stigma and discrimination should be tackled at a strategic level through training and campaigns and in collaboration with BME communities

- Data collection should be improved to ensure robust information is collected and collated for monitoring and planning

- Further research, particularly around issues such as forced marriage, domestic violence, substance and alcohol misuse, post natal depression, self-harm and suicide should be undertaken under the guidance and with the full involvement of BME communities

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