Delivering Race Equality in Mental Health

Final Project Report September 2011

LOOKING BACK MOVING FORWARD

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EXECUTIVE SUMMARY

The National Department of Health Programme Delivering Race Equality in Mental Health has been implemented in Lincolnshire during 2007 – 2011 through a project commissioned to LCDP, a Lincolnshire based community development organisation. The project employed six community development workers, reflecting the ethnic diversity in Lincolnshire, to support the development of a better and more responsive mental health service in Lincolnshire for members of the Black Ethnic Minority Community.

The Black Minority Ethnic population in Lincolnshire has risen from 21,000 in 2001 to 49,000 in 2009, an increase of 135%. The increase is mainly due to the in migration of residents born in Eastern Europe after the expansion of the European Union in 2004. Boston is the second highest ranked local authority for in migration, with South Holland in fifth place. Overall the BME population in Lincolnshire has increased from 2% in 2001 to 7% in 2009.

COMMISSIONING BRIEF

There were three objectives around which the efforts of the BME Community Mental Health team were structured:

- the development of better more responsive mental health services
- improved engagement with the local communities
- better information to influence the development and provision of mental health services

BME communities were engaged through workshops, surveys etc., to explore their mental health needs and coping strategies using community development methods. Partner organisations and other stakeholders were engaged through workshops to identify their issues with the BME communities as (potential) service users.

Language and Culture emerged as the two main issues or barriers to access and improve mental health services. These were issues for both the BME communities and for the health services, but were affecting a much broader range of services (housing, benefits/tax, education, etc.).

ACTIVITIES

a) For BME communities

- Support individual clients to access services (±950)
- Organise informal language learning activities (±300)
- Organise health and wellbeing events (±700)
- Regular drop ins in Sleaford, Boston and Grantham (±45 per week)
- Co-production and distribution of a Lincolnshire Health Guide in 6 different languages
- Set up a mental health self-help book prescription scheme with books in English and Polish (±15)
- Produce and update a service directory for BME community members
- Train BME community members as Wellness Recovery Action Plan facilitators (15)
- Workshops and survey BME prisoners in HMP Lincoln (±76)
- Conducted a BME client survey 'Tell us what you think…' (96)
- Support community groups:
    - Create and update a community directory (100 entries to date)
    - Help set up or support BME community groups (10 groups or ±150 people)
    - Referred two groups to LCDA/Business Link for advice on becoming a social enterprise or charity

b) For health service providers:

- Cultural Awareness and Race Equality & Cultural Capability training (±160)
- Co-produced a DVD training package 'Easy Access for All'

c) For voluntary sector organisations/community groups:

- Cultural Awareness and Race Equality & Cultural Capability training (±40)

d) For Delivering Race Equality in Mental Health in Lincolnshire Stakeholders:

- Workshops in 2007 (2)
- Conference in 2008
- Stakeholder day in 2009
- Celebration event in 2011 (total of ±212 participants)

CONCLUSIONS

- Language issues remain key to improve the access to mental health services, e.g. the GP services in particular. Interpretation facilities are available, but their use, both by services and by patients are problematic and figures are not available. People need to be made feel welcome and not a nuisance or a hindrance for the service.
- For BME communities informal language learning activities are valuable to improve confidence, create awareness about (mental) health issues and meet other people and make new friends. Although not all people want or can learn English most people realise that learning some English is important as it affects all their communication and interaction with other community members and their quality of life.
- Service professionals are generally interested in cultural diversity and its implications in the work practice and the training has been appreciated
- Around 2,500 BME members have been in contact with the project, and around 550 professionals. This means that at least 5% of the BME population has been reached.

RECOMMENDATIONS

- To further improve the use of language interpretation facilities at GP practices. Using the DVD training package Easy Access for All in particular for frontline staff (receptionists and GP's).
- Increase informal English learning activities for BME communities, and stimulate BME groups to integrate this as an activity of the group.
- Improve choice for BME and other community members to deal with mental health issues by supporting self-help initiatives such as Wellness Recovery Action Plan training and the Book Prescription scheme.
- Other services (than health) to increase their cultural awareness and language access issues.
- Consider how the Single Equalities Act implementation affects the mental health issues in combination with a protected characteristic.

FOREWORD

The DRE action plan was designed to reduce inequalities in how people from a range of communities access, experience and achieve outcomes from mental health services.

This report summarises the many achievements of the programme in Lincolnshire and although now completed there remains much to do to deliver the ideals of both the local and national programmes. This report reflects back on the journey that started in 2007 and will continue with the introduction of new legislation and guidance. It has raised the profile of Mental Health services within BME communities and challenged those services to become culturally competent and accessible to meet the obligations of the Equalities Act 2010. It has raised the need to address language, cultural barriers and conceptual difficulties, where mental illness and health may not be perceived in a universal way.

It has been a privilege to work with and support this programme and I have learnt much over the last three years. I recommend this report as a solid foundation upon which to move forward with the equalities agenda. It raises as many questions as it answers and rightly so as this will be an evolving and developing theme to ensure everyone has equitable access to mental health services that meet their needs accordingly. I hope you will read this report with interest and reflect upon your own practice to ensure that these issues are fully addressed.

Colin Warren
Mental Health Programme Manager
NHS Lincolnshire

CHAPTER 1 INTRODUCTION

This report summarises the work of the LCDP BME Community Development Mental Health project (2007- 2011). It contains four sections, three of which are taken from the project's initial brief and a fourth section that contains the conclusion and further work to be done.

Data has been collected from the project work, based on the project's commissioning brief, quarterly reports to the Lincolnshire Delivering Race Equality (DRE) steering group, and additional data collection efforts, such as reports on support to individuals, language barrier support activities, cultural training events, client feedback survey, and feedback on the drafts of this final report.

1.1 PROJECT CONTEXT

The project has been funded through Lincolnshire Health as a roll out of a national Delivering Race Equality programme that aimed to improve access to and delivery of mental health services using community development workers. In Lincolnshire LCDP a Lincolnshire based Community Development voluntary sector organisation was selected to deliver the programme from 2007-2011. A team of 6 community development workers of different cultural and ethnic backgrounds were employed to develop and implement the projects outcomes. A steering group, consisting of the commissioner and various other stakeholders have supported the project (see Appendix 3).

1.2 THE PROJECT BRIEF

The implementation of the community development project will result in the following outcomes:

- the development of better more responsive mental health services
- Improved engagement with the local communities
- better information to influence the development and provision of mental health services

The brief was operationalised in an action plan that contained four objectives, and quarterly reports produced for the steering group to monitor progress and provide support.

1.3 BME POPULATION IN LINCOLNSHIRE

In 2001 the total population in Lincolnshire was 697,900 and increased to 703,000 in 2010.

The percentage of the BME population in Lincolnshire has increased from 3% to 7% over that same period. In numbers of people this means a rise from 20,910 to 49,210 which is an increase of 135%.

Ethnic Group	Change (%)	% of total population 2001	% of total population 2009
All Groups	8		
White: British	3	97.0	92.7
White: Irish	18	0.6	0.6
White: Other White	94	1.1	1.9
Mixed: White and Black Caribbean	100	0.2	0.3
Mixed: White and Black African	175	0.1	0.2
Mixed: White and Asian	150	0.2	0.4
Mixed: Other Mixed	138	0.1	0.3
Asian or Asian British: Indian	353	0.2	1.0
Asian or Asian British: Pakistani	900	0.1	0.6
Asian or Asian British: Bangladeshi	233	0.0	0.1
Asian or Asian British: Other Asian	433	0.0	0.2
Black or Black British: Black Caribbean	300	0.1	0.3
Black or Black British: Black African	520	0.1	0.4
Black or Black British: Other Black	150	0.0	0.1
Chinese or Other Ethnic Group: Chinese	64	0.2	0.3
Chinese or Other Ethnic Group: Other	660	0.1	0.5

1.1 ETNIC MINORITY BREAKDOWN

SOURCE: POPULATION TRENDS LINCOLNSHIRE 2010, JULY 2011, LINCOLNSHIRE RESEARCH OBSERVATORY

The White: White Other category change shows the biggest increase, from 1.1% to 1.9% or from 7,667 people to 13,357. The next biggest increase is in the Asian or Asian British: Indian category from 0.2% to 1% or from 1,394 to 7,030.

The changes in the White Other category are mainly due to the expansion of the European Union in 2004 with a further eight countries (the A8 countries): Poland, Estonia, Lithuania, Latvia, Hungary, Czech Republic, Slovakia, Slovenia.

The in-migration from these countries is the highest in Boston, which is the second highest local authority in the UK, with South Holland in fifth place on the local authority national ranking (source: International Migration and migrant workers in Lincolnshire and West Lindsey, West Lindsey District Council, January 2009).

ETHNICITY RECORDING AND MONITORING

GP practices in Lincolnshire only started to record patient's ethnicity since 2010 and only for new patients. There is no reliable ethnicity breakdown of the current GP patient population (end of 2010).

One issue with recording ethnicity using the current classification of ethnic groups is that it doesn't say what native language people speak (mother tongue). In the White Other White category many of our BME migrants can be found (Polish, Portuguese, Latvian, etc.). Further issues are that having a nationality does not have to coincide with speaking the native language of that nationality nor cultural background. People can apply for British Citizenship, which does not mean they now can be classified as having English as their first language. The only stable element in people's history is their place of birth, and

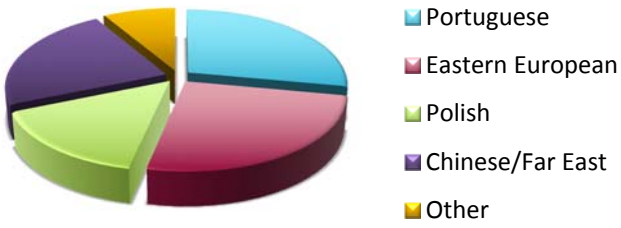
this is what the Office for National Statistics uses. Any information collected and analysed should be used with caution therefore.

For our purpose of improving access to mental health services the native language and the cultural background are two important indicators, and not nationality. As we only have the ethnicity group breakdown we cannot reliably calculate how effective we were in supporting some representative sample. Support needs of those different ethnic group will also vary, so the workers have done different activities with their individuals and groups. Whenever native language is used or BME group we have specified this as to the best of our information and knowledge. We want to show the range of ethnic diversity we have worked with rather than presenting them as a representative sample of a particular BME group.

CLIENT FEEDBACK SURVEY 2011

In 2011 the team have undertaken a survey among their clients. The ethnicity of the 96 respondents can be classified as follows:

Ethnic group	Percentage
Portuguese	33%
Eastern European	30%
Polish	18%
Chinese/Far East	27%
Other	10%
	100%



1.2 CLIENT FEEDBACK ETHNIC MINORITY BREAKDOWN

This return seems in line with the changes since the expansion of the European Union in 2004 when Eastern European people started to migrate in bigger numbers to the UK. Between the year ending December 2003 and the year ending December 2010 the Polish-born population of the UK increased from 75,000 to 532,000 (Source Office for National Statistics 2011 Polish People in the UK. Half a million Polish Residents). See Appendix 1 for a full Client survey report).

In Lincolnshire these new in migrant groups have settled mainly in Boston and South Holland (Grantham, Spalding), with Lincoln in third place (based on National Insurance Applications, GP new registrations and International Passenger Survey).

BME CLIENT CONTACTS

It is conservatively estimated that the team has reached around 2,500-3,000 BME community members over the 4 years of operation. This means that around 5-6% of the total BME population has been reached, and mainly the new arrival communities. However the Far East/Chinese communities have also been supported, as they struggle with similar issues such as language and culture, and have had longer established community groups that needed some support, for instance to become independent and improve their range of activities.

Cost per client contact is £341 (based on £1,025,000 over 4 years project expenditure). Cost per contact including professionals is £302. This figure excludes use of interpretation services (not provided), training time, etc. Benefits: people learning the language require less interpretation support and professionals helping them to fill in forms; more effective and efficient use of health service (proper early diagnosis and treatment), people are able to work and contribute to the tax and insurance system drawing less on benefit and charities for support. The investment is repaying itself over some years (3-4 years) and improve the quality of life for individuals as well as for communities (less exclusion, more cohesion etc.).

CHAPTER 2 DEVELOPMENT OF BETTER MORE RESPONSIVE MENTAL HEALTH SERVICES

2.1 LANGUAGE BARRIER ISSUES IN ACCESSING HEALTH AND MENTAL HEALTH SERVICES

Working with individuals

Mental health is usually considered as something that is relevant to an individual person and not a property or characteristic of the community. In this sense working with individuals with this 'condition' is uncommon in community development. The main aim in community development is not to take on individual 'cases' and provide 'treatment' but to support individuals to identify issues that they could take forward together with others in the community who share the interest or who want to improve their quality of life or (at the same time) their area/environment.

However, if the aim is to support people with mental health issues one first has to make contact with individuals that express these issues and would like some support in sorting them out. Individual cases were supported to explore what issues were experienced and to help people access services. At the same time the community development worker stimulate people to access their community for support, helping them to set up new groups or activities that benefit a wider range of people (who do not necessarily experience mental health issues). It is also important that people do not become dependent on the community development workers as they are only available for a limited time.

A central and recurrent issue in studying the 595 individual cases is that of the language barrier. The cases were recorded between 2008 and 2010 and are by no means all the cases that the workers have been dealing with. However, two years is a reasonable period to gain some insight into the situation and experiences of individuals and the appropriate responses or solutions that are developed.

A total of 369 cases (62%) were reported (see table below) in which the language barrier played a major role in asking the community development workers for support. In 226 cases (38%) there were issues with access but not primarily with a language barrier issue. The allocation was made on the basis of the workers insight or if not recorded, on the basis of the type of support given (e.g. not interpretation or request for interpretation).

	Language barrier			Non-language barrier		
	number		%	number	%	
Health	175			4		179
Mental health	26	201		9		35
Other services		168		213		381
Total		369	62	226	38	595

2.1 INDIVIDUAL CASES AND LANGUAGE BARRIER

2.1.1 HEALTH

In the 175 cases (see Table 1) workers helped clients through making appointments, accompanying the clients to the GP, hospitals or dentists (108), and did at times assist by interpreting and/or requested interpretation (31). See Table 2 and 3 below for an overview.

CDW support	Cases
go with client	108
bookings	29
interpretation	20
requested interpreting services	11
registration	5
forms/letters	4
Misc.	10

2.2 TYPE OF SUPPORT PROVIDED

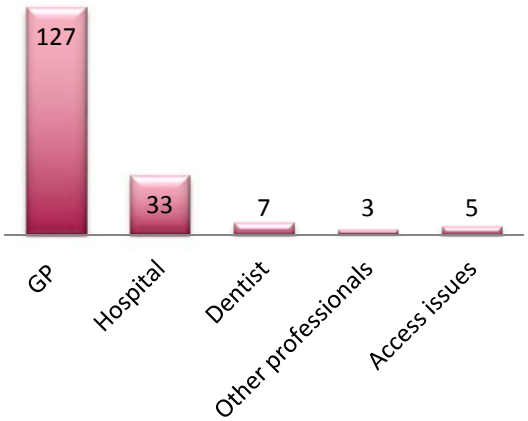
Language	Cases
Mandarin	70
Portuguese	67
Polish	12
Brasilian	9
Vietnamese	7
Cantonese	6
Italian	2
Latvian	1
Lithuanian	1

2.3 NATIVE LANGUAGE BREAKDOWN

The language barrier has been identified within the following health services:

Health Service	Cases	
GP	127	73%
Hospital	33	19%
Dentist	7	
Other professionals	3	
Access issues	5	
total	175	

2.4 ACCESS ISSUES AND OTHER PROFESSIONS



GPs are with 73% of all cases the main category in the health service in which BME patients encounter language issues. They are followed by the hospitals with 19%.

2.1.2 Mental Health

When referring to mental health it must be noted that the team's efforts were focused on or starting from the person's situation and needs as part of a community. The efforts were not focused on mental health service users, but on mental health issues of BME community members as the workers encountered them whilst engaging with them as community members. As part of supporting community members to deal with mental health issues access to mental health services and the improvement thereof is an important element. As access is such a main issue workers attend additional training to identify mental health issues, e.g. Mental Health First Aid, Assist Suicide Prevention training, Home Study Community Mental Health courses etc. Workers shadowed mental health professionals as part of their employment induction programme. This has helped workers to support community members accessing the services.

More details of the mental health individual cases can be found in Appendix 2. Of the 26 mental health related cases in which a language barrier was a major issue there were 5 depression cases identified. 3 clients were referred to mental health professionals and GPs. In the 6 cases of isolation or social exclusion the clients were supported in accessing social support groups and language classes, and were listened to or given advice on their options. In 2 cases clients were not referred for a mental health assessment or for further mental health services, and in 1 case a client was referred by the GP to a mental health service although the final diagnosis was of a physical rather than a mental health condition. In 3 cases the clients indicated their preferred service and the workers tried to assist them in making that explicit to the professionals involved. It was up to the professionals to decide whether or not a referral should be made or if an alternative was more appropriate.

Below an example of how a client was supported by a team member to navigate the care system and managed to cope with the help of the service.

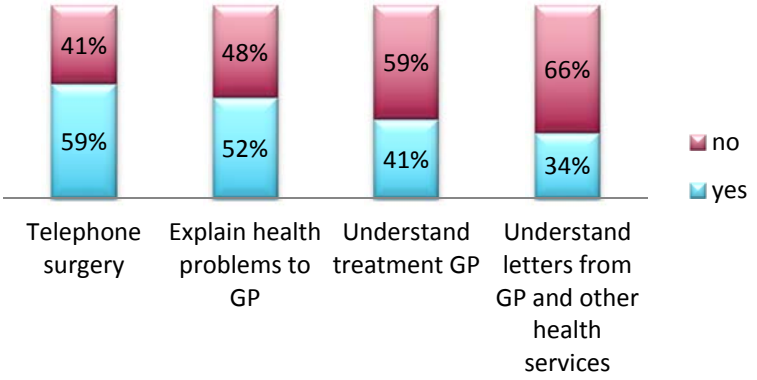
"A lady with a drugs and alcohol past had been a victim of racial harassment and was about to have her little child taken from her. As she was severely depressed with multiple problems, she came to us for emotional support and advice. After some meetings involving Police, Social Services, GP, Council and Mental Health Services she was able to take control of her life. She is now attending a College course, she is being supported by the Mental Health Services, she does some voluntary work for her church, she managed to keep her little one and as she says: "You helped me to get straight on my feet … Changed my life to happiness."

2.5 EXAMPLE OF SUPPORT TO NAVIGATE THE CARE SYSTEM

2.1.3 CLIENT FEEDBACK LANGUAGE BARRIER HEALTH SERVICE & SUPPORT RECEIVED

The survey 'Tell us what you think….' has been conducted during the summer of 2011 and 96 respondents/clients of the community development workers returned the questionnaire. One section asked them about their experiences with accessing mental health services, although most respondents referred to health services. See for the results of the survey and the survey itself **Appendix 1**.

The respondents had, all but 1, not English as their first language (99%). They rate their ability to communicate with the GP health service as follows:



2.6 ABILITY TO COMMUNICATE WITH GP HEALTH SERVICE

Whereas little more than half of the respondents (59%) are able to telephone a surgery (to make an appointment for instance), the situation is quite the contrary for understanding written communications, where 66% feel they are lacking in ability. More than half (59%) have difficulty to understand the treatment that the GP is prescribing them. The ability to explain health problems is more equally distributed with near half feel unable to (48%) and a little over half stating (52%) they are able to explain their health problems. However, it is what happens after their initial explanation of the health problem that makes it more difficult (without interpretation or better knowledge of English).

When asked about their experiences with accessing GP and hospital services clients referred to language issues as the main element in 8 cases, compared with mainly service issues (receiving a health diagnosis/treatment) in 10 responses.

Ease of use/happy	cases
Easy & happy	4
Difficult & happy	2
Neither & happy	2
Neither & neither	3
Difficult & neither	2
Difficult & unhappy	4
Difficult & very unhappy	1
Very difficult & very unhappy	1

2.7 EASE OF USE AND SATISFACTION WITH HEALTH SERVICE

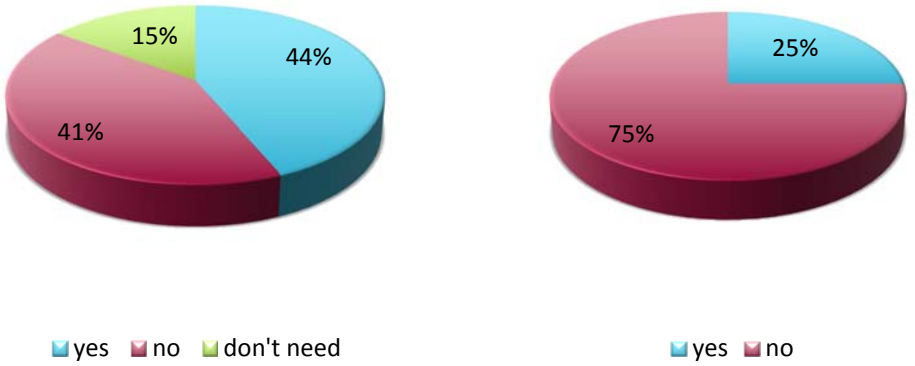
The language barrier is the main difference for BME communities whose first language is not English. It makes it very difficult to access services compared to other groups in the community. Below an example of a patient experience illustrating what the impact of the language barrier entails. Some details have been omitted and one word has been replaced with 'xxx' to prevent identification.

> ***"My experience using the service is not very good. Firstly, despite knowing I have a right to use an interpreter during medical appointments; this fact was often being ignored. I am not saying I should have an interpreter every time but when it comes to my son's health or my life I think that, where the communication fails, the interpreter should definitely be provided. Many times I was refused access to an interpreter and only when I started crying or getting so upset that I could not say a word was I given a xxx-English dictionary.***
> ***Once there was a situation where the doctor left the room saying nothing and leaving me half naked for about 20 minutes. I kept waiting like that and then another doctor came. The first doctor had asked me 2 questions and when I couldn't respond well she just left.***
> ***(…)***
> ***I think that because my English is not good and gets worse when I'm nervous the doctors simply ignored me. (…..) I know cases where the patient is English or speaks English very well and these kinds of situations do not take place. Recently my friend who's 6 weeks pregnant went to the hospital with bleeding, received detailed examinations and a scan within 2 weeks - I think it's because she was able to be firm or communicate with them."***

2.8 RESPONSE TO AN OPEN QUESTION IN THE TELL US WHAT YOU THINK… SURVEY 2011

KNOWLEDGE AND USE OF AN INTERPRETER

The experiences reported above highlight an important access issue. When asked if they knew about the free interpretation facility at medical appointments many clients (41%) didn't know that this is or should be available. Slightly more clients (44%) knew about this facility, but when asked if they have ever used it 75% (30 of 40) said they have not used it. A positive reason for not using it would be that they didn't need to see the GP so far, other reasons could be more difficult to identify, but maybe people are afraid to ask if it is not clearly offered?



2.9 KNOWLEDGE AND USE OF FREE INTERPRETATION AT HEALTH APPOINTMENT

2.1.4 NON-HEALTH CASES WITH A LANGUAGE BARRIER

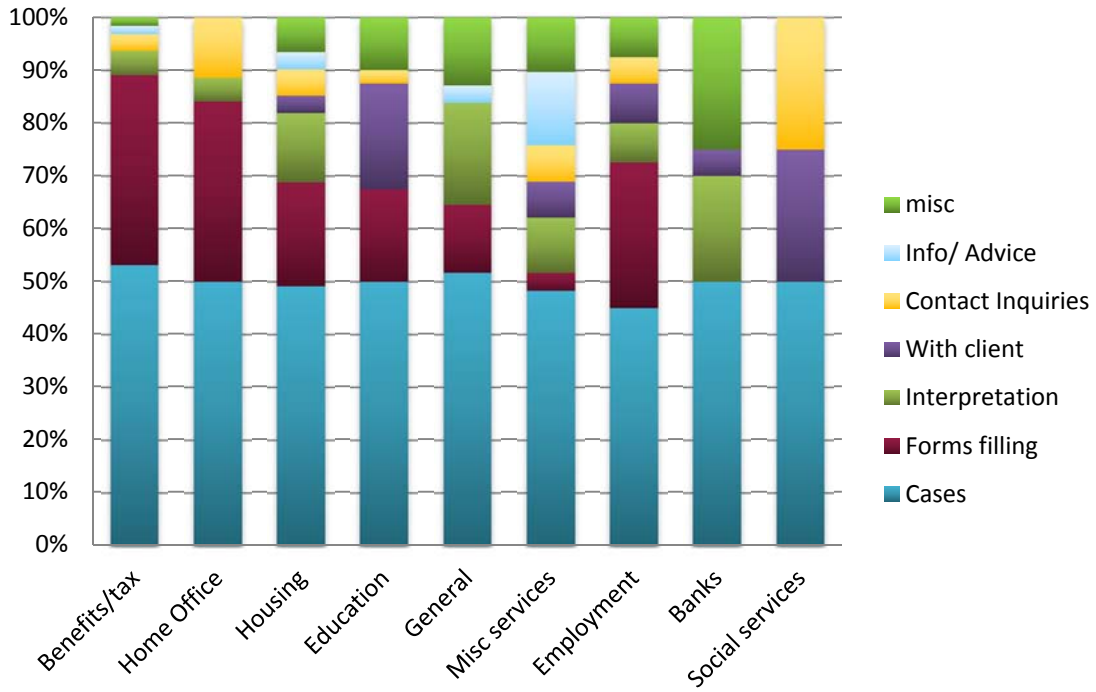
The language barrier is not only an issue for the health services, but also in at least 168 cases reported for other services (see Table 1 and Table 7 below), e.g. the Home Office, tax/benefits, education, housing, employment, banks, retail services etc. Interpretation facilities are not offered by most of these services. In contrast the LPCT and the LPFT have a system in place that provides telephone interpreters and do offer in appropriate cases interpreters on site. The Police and the Prison Service also have language interpretation facilities in place.

The total number of cases where the language barrier played a major role on other than health services is 168 or 46% of the individual cases.

Below is an overview of those services and the support that was provided. The 226 cases in which the language barrier was not health related, were not further analysed.

Other services	Cases	Forms filling	Interpretation	With client	Contact inquiries	Info/ advice	misc
Benefits/tax	34	23	3		2	1	1
Home Office	22	15	2		5		
Housing	30	12	8	2	3	2	4
Education	20	7		8	1		4
General	16	4	6			1	4
Misc services	14	1	3	2	2	4	3
Employment	18	11	3	3	2		3
Banks	10		4	1			5
Social services	4			2	2		
Total	**168**	**77**	**26**	**18**	**17**	**8**	**24**

2.10 OTHER NON-HEALTH LANGUAGE BARRIER CASES AND SUPPORT PROVIDED

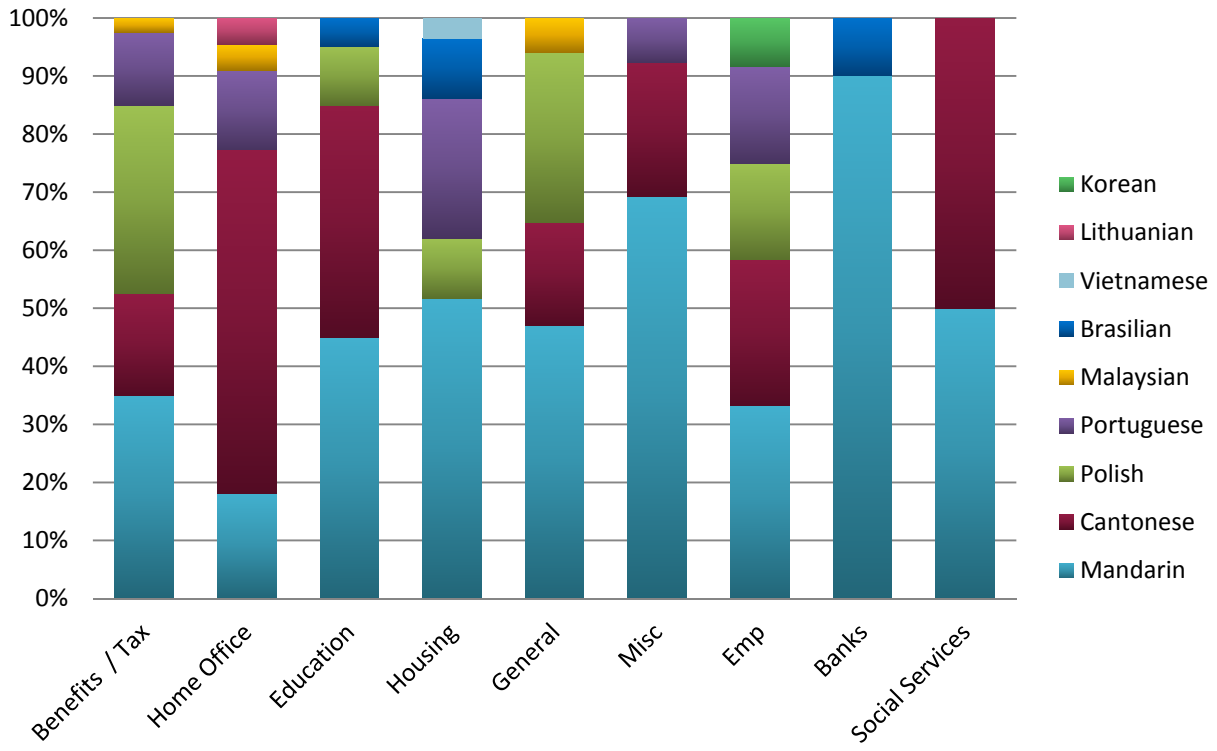


NATIVE LANGUAGE

Native language per service accessed

	Benefits / tax	Home Office	Education	Housing	General	Misc	Emp	Banks	Social Services	Total
Mandarin	14	4	9	15	8	9	4	9	2	74
Cantonese	7	13	8		3	3	3		2	39
Polish	13		2	3	5		2			25
Portuguese	5	3		7		1	2			11
Malaysian	1	1			1					3
Brasilian			1	3				1		2
Vietnamese				1						1
Lithuanian		1								1
Korean							1			1
Total	40	22	20	30	17	13	12	10	4	168

2.11 LANGUAGE PER SERVICE ACCESSED



2.2 LANGUAGE BARRIER SUPPORT ACTIVITIES

2.2.1 COMMUNITY LANGUAGE LEARNING ACTIVITIES

As the language barrier is such a central issues in many of the individual cases, and more generally in accessing services and social life in the community, the team members have organised a number of language activities. These are not primarily meant as language courses to obtain certificates, but to offer semi structured courses or meetings in which people can explore their language abilities and talk about issues that are relevant to them (mental health or health related). At the same time it brings people together and offer the opportunity to meet new people and make friends or engage in further activities.

Name of course/meetings	BME	Period
Lincoln		
Easy English for Beginners	Chinese, Japanese, Brazilian	Sept 09-11
Simply English Belmont group	Polish, Japanese, Slovakian, Brazilian	Feb -Sept 11
Cantonese Learning Class	Chinese Mandarin speakers	Sept 09-Sept 10
Gainsborough		
ESOL summer school Health and Wellbeing	Bangladeshi, Chinese, Polish, Hungarian, Romanian, Latvian	2009-July
Practise your English	Latvian, Lithuanian, Turkish, Hungarian, Chinese, Polish, Turkish (Kurdish), Romanian, Iraqi (Kurdish), Slovakian, French	Sep 09-Sep10
English in the Evening	Lithuanian, Chinese, Latvian, Iraqi (Kurdish), Hungarian, Romanian,	Apr10-Sept 10
Sleaford		
Conversation classes	Polish, Lithuanian, Latvian, Russian, Chinese, Portuguese, Indian, Czech	May 09-Sept11
Total beneficiaries	268	
Support to Language classes		
Portuguese school Grantham	Portuguese	2008-2009
Polish School	Polish	2008-2009

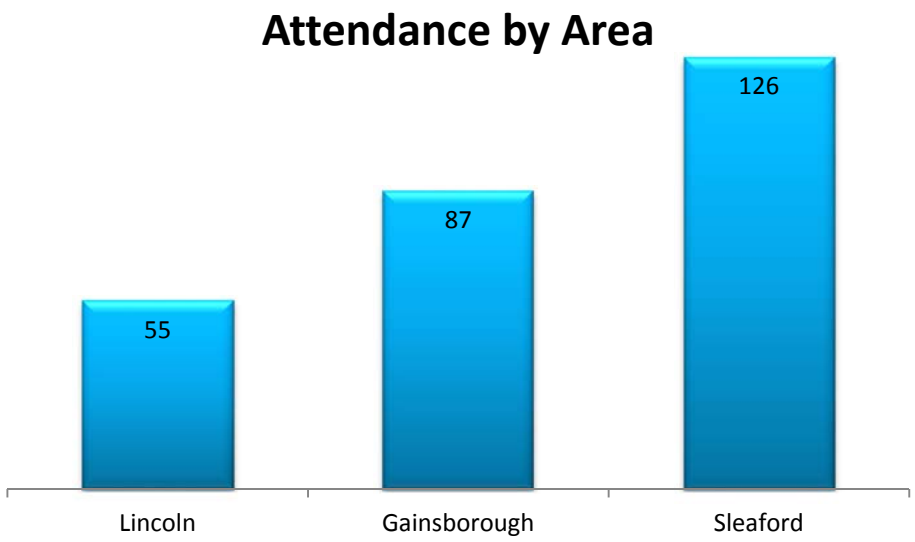
2.12 LANGUAGE ACTIVITIES, BME INVOLVED AND PERIOD

The language learning activities in Lincoln and Gainsborough were structured, and had health and mental health content incorporated. The conversation classes in Sleaford were more of an informal nature with topics of conversations agreed with the participants.

Name of course/meetings	Structure	att	frequency	volunteers
Lincoln				
Easy English for Beginners	Structured class with health content fed in	27	weekly	3
Simply English Belmont group	Structured class with health content fed in	20	weekly	1
Cantonese Learning Class	structured class and conversation	8	fortnightly	1
Gainsborough*				
ESOL summer school Health and Wellbeing	Structured classes based on health	12	Weekly for 4 weeks	
Practise your English	Structured class with health content fed in	45	weekly	
English in the Evening	Structured class with health content fed in	30	weekly	
Sleaford				
Conversation classes	conversation class with volunteers	126	weekly two groups	12
total beneficiaries		268		17

2.13 LANGUAGE ACTIVITY STRUCTURE AND ATTENDANCE

* Evaluation reports are available (see Appendix 5 Project Publications).



2.2.1.1 CLIENT FEEDBACK SURVEY

A client feedback survey Tell us what you think… was conducted in 2011 (see Appendix 1 and Chapter 3.5). The feedback relevant to the language barrier support is summarised below.

INDIVIDUAL POSITIVE IMPACTS

The role of language and the information about the service and access is very central to positive changes (44%). Language is considered more important for the individual than for the community.

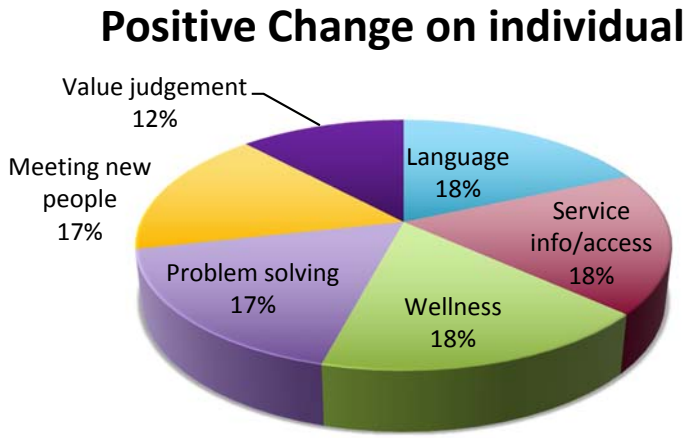
Wellness with 21% is covering things such as confidence, feeling happy, being able to do things, communicate and community cohesion (how people are feeling related to each other). This is positive for individuals as well as for the community. Solving individual problems is seen as positive with 20% on the (direct) individual level. Meeting with (new) people is for 14% a positive impact.

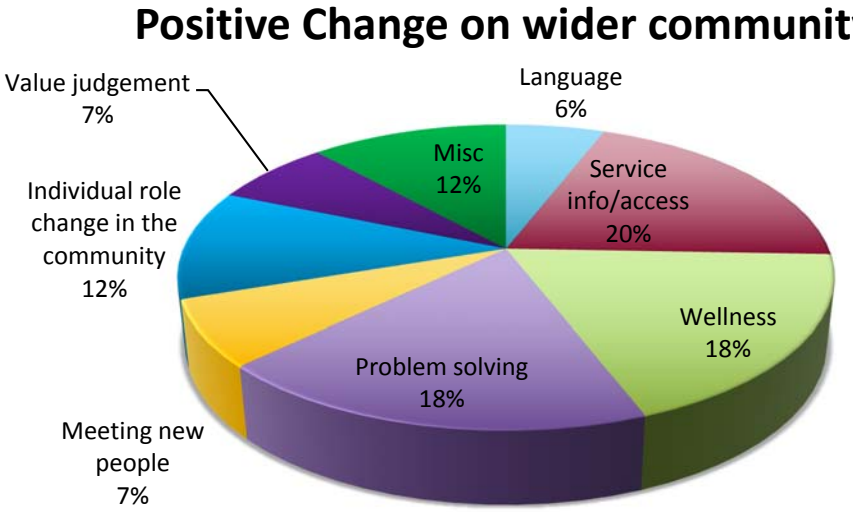
COMMUNITY POSITIVE IMPACTS

Individuals see service information and access (including potential problem solving) as the main positive impact on the (wider) community (28%), whereas impact on the wellness of the community is a close second (26%). Respondents also mentioned that they have changed their role in the community, e.g. giving information (signposting) to others and helping them along. Meeting (new) people also was seen as a positive impact for 10% of the respondents.

Positive change	You		Community		Comments
Language	20	22%	5	8%	
Service info/access	20	22%	17	28%	Includes problem solving community
Wellness	19	21%	16	26%	
Problem solving	19	21%	16		
Meeting new people	18	20%	6	10%	
Individual role change in the community			10	16%	
Value judgement	13	14%	6	10%	Good, better etc
Misc			10	16%	
Total responses	90		61		

2.14 POSITIVE IMPACTS ON BME INDIVIDUALS AND THEIR COMMUNITY





2.2.1.2 Partners and exit strategy

Two of the language activities are continued beyond the end of the project. The one in Sleaford will continue with the support of volunteers and the Sleaford partners. The Lincoln activity will be picked up through the Migration Impact Funding. The Gainsborough activity is not continued, due to a lack of funding and capacity.

Name of course/meetings	partner(s)	Exit strategy
Simply English Belmont group	Migration Impact Fund-LCDP, Neighbourhood Policing Team	Migration Impact Fund
ESOL summer school Health and Wellbeing	Lincoln / Gainsborough College	No continuation
Conversation classes	The Source Sleaford, Volunteer Centre Sleaford	Volunteers & partners Sleaford

2.15 LANGUAGE LEARNING ACTIVITY PARTNERS AND EXIT STRATEGY

2.2.2 Training activities

2.2.2.1 Training activities with Primary Care Health Professionals

To further improve or facilitate access to health services the health service professionals can be made aware of the particular issues BME members may experience when trying to access their services. Training them would help improve communication with BME patients and thus make the work of the team to intervene more superfluous. Below is an overview of training activities.

Training with LPCT	Cultural Awareness	Race Equality and Cultural Capability
No of events (days)	10	2
Participants	116	17
Feedback	Participants became more aware of cultural diversity, were going to share the handouts and learning with other colleagues. Training to be mandatory for NHS staff.	Better informed, knowledgeable about other cultures, mind opening, treat people equal, share with colleagues

2.16 TRAINING WITH HEALTH CARE PROFESSIONALS

A total of 134 LPCT staff attended the training. Two community development workers, LPCT staff members (Equality and Diversity team) and representatives from community groups, e.g. the Gypsy and Travellers groups, delivered the Cultural Awareness training. The LPCT Diversity trainer provided the coordination. Topics covered were cultural differences, ethnic minority groups in Lincolnshire, legal equality issues, Interpreting facilities, and presentations of a specific ethnic Lincolnshire group.

The team delivered Race Equality and Cultural Capability Training (RECC) covering the themes of communication, power and authority. Both RECC training events were a mix of short presentations and interactive group work. Feedback was generally positive and participants recognised the relevance for their practice, e.g. wanted to share this with others, copying the handouts for them, being more open minded or understanding about other cultures. Some participants wanted to learn more and are hoping for further opportunities.

2.2.2.2 Training material for Health Care professionals

A training packages ‘Easy Access for All’ has been developed in collaboration with the Lincolnshire Mental Health Foundation Trust with funding from the East Midlands Development Centre. It is a DVD in which a BME patient (actor) shows his interactions with health care staff. The package also includes a manual that provides suggestions on how to use this DVD in a group training and a leaflet with facts about BME access issues.

2.2.2.3 Training activities to Third Sector organisations

As Third Sector Organisations are sometimes also providing services to the public they may come across issues with the members of the BME community. Is seems relevant to them to increase their knowledge and gain experience in dealing with people from different cultural backgrounds.

Race Equality and Cultural Capability Training was delivered to 11 participants of the Voluntary Sector Services for 1,5 days in 2010. Themes that were covered were communication, power, and authority. Feedback related to an increase in awareness, intention to making others aware, but also that more training should be provided.

Two taster sessions of RECC were provided to Morton Hall HMP (12 participants) and to the LCDP AGM. These sessions lasted between 1 and 2 hours and gave examples and interactive exercises from the power, authority and communication themes.

2.2.2.4 Training activities for communities: Wellness Recovery Action Planning (WRAP)

Under this heading the support for communities to help themselves with mental health issues is the main focus. You can improve and optimise the services, but it is also worthwhile to build community owned capacity to deal with mental health issues in the language they prefer to talk about and ways they can develop to deal with this.

WRAP is a structured way of monitoring uncomfortable and upsetting symptoms or experiences and by planning responses to these difficulties reducing, changing or getting rid of them. In our approach WRAP is used as a community self-help method, which implies that individuals are part of their community and provide support resources for each other in terms of sharing experiences and taking responsibility.

Six half day training sessions were provided to BME community members in Boston and Lincoln, in particular those from African descent and the Muslim community. They have been trained in using WRAP for themselves and as a facilitator for (new) community groups. A report of this training will be available shortly.

2.3 Health and Wellbeing promotion activities

2.3.1 BME specific activities

These activities were initiated as part of engaging with communities around wellbeing and health related issues. The emphasis is on providing information about what is available and on exploratory activities and workshops to increase people's interaction with the information and with each other.

	Health wellbeing Taster sessions	Wellbeing workshops	Oriental Wellbeing Club
Period	April, May, June 2010	2010 & 2011	Since 2009
Area & group	Gainsborough Gypsies and Travellers	Lincoln & Grantham East European	Lincoln People from Far East Origin
Participants	11 participants, 1 LGLG volunteer 1 LGLG staff	15	Since it established about 50 people benefited

2.17 WELLBEING EVENTS BME SPECIFIC GROUPS

Lincoln Women's Get together event is organised by the Chinese women group. They meet regularly for activities, like playing badminton, having a meal in order to promote physical health and emotional wellbeing of Chinese women. They have become less reliant on the worker to organise these activities.

2.3.2 Cultural diversity promotion in Mental Health Wards

These events were partly funded through a small Mental Health Promotion Grant.

	Period	Venue	Att.
Diwali	12-Nov-08	PHC Lincoln	18
Chanuka	06-Jan-09	PHC Lincoln	18
Chinese New Year	20-Feb-09	Elm Lodge, Grantham	11
Eid Celebration	24-Sep-09	Acorn Day Centre Boston	11
Eastern Orthodox	09-Dec-09	PHC Lincoln	5
Paganism	13 -Dec 09		0
Culture, Spirituality and Wellness event	16-Oct-10	St Mary Le Wigford, Lincoln	130
Total			193

2.18 SPIRITUALITY EVENTS IN MENTAL HEALTH WARDS

The events were structured with a presentations, quiz, food, games, symbols, displays, music and aimed to inform people about the cultural spiritual dimensions of the particular topic. The Paganism event was not attended. Participants who returned the feedback form generally enjoyed the events and learned a lot about the topic.

All events were organised in mental health wards except for the Culture, Spirituality and Wellness event, which was held in a church and was open to the general public. It had a number of activities and workshops (e.g. an African drumming session) and was well attended.

2.3.3 BME PRISONERS IN HMP LINCOLN

As national figures show that BME prisoners are over represented in the prison it made sense to explore the situation in HMP Lincoln.

Working with the Prison staff a number of plans and activities were devised to identify and improve mental health issues of inmates from BME backgrounds. After explorations with inmates and staff suggestions were made to improve the resources that inmates have or can create to manage their mental health.

78 Inmates (13% of the Prison population) returned the survey at the Prison were surveyed about their mental wellbeing. 59 of them identified their ethnicity as White British and 2 did not disclose their ethnicity. BME inmates thus were 17.

Respondents self-identified more mild types of mental health issues and they accessed the services significantly less than their White British respondents and they had a lower satisfaction with the service if used than their White British counterparts. BME inmates favour informal support, talking to others and maintaining contact with family.

Recommendations include an health information pack in different languages about available services and how these operate, to provide mental health related literature in various languages, to offer wellbeing workshops, and to explore better access to religion, befrienders, listeners, and communication with family who are abroad or far away.

A report Inmate Wellbeing Survey, Lincoln Prison July 2010 is available (see Appendix 5 Project Publications).

2.3.4 THE LINCOLNSHIRE SERVICE DIRECTORY

The first edition of the Lincolnshire Service Directory was produced in 2008, the second in 2011. It was part of the drive to inform BME people of what is available in the different geographical areas, e.g. information and advice services, health services etc. Having this information at hand should make it easier for people to access services as a contact name and details are provided for each service entry. The second edition is updated until 2011.

2.3.5 THE BOOKS PRESCRIPTION SCHEME

A number of books around mental health self-help issues are available for community members on loan through LCDP. Topics are around anxiety, depression etc. Used by Chinese and Polish BME members. The book prescription scheme has also been advised and introduced to the HMP Lincoln, with books in Polish.

CHAPTER 3 IMPROVED ENGAGEMENT WITH THE LOCAL COMMUNITIES

This section presents the manifold of activities that were undertaken to make, keep and improve contact with the local BME communities. This type of activity is central to the community development practice. It follows the format for engagement that is simple but offers the most open approach. In this project it is running in parallel to the individual cases that workers dealt with, e.g. these follow on from each other (individuals attending groups, or individuals who come forward out of a group to discuss a particular issue that they do not (yet) want to share with others).

3.1 DROPS INS

This is the simplest format for community engagement, with a venue, some coffee and advertising, people are invited to attend (to have a coffee or a chat). From there on, groups may form with an interest, e.g. to have informal English classes, to invite a health visitor to answer questions or to give information about the service. They may also have a chat with the worker to get information and advice.

The project has initiated regular (weekly) drop-ins for Polish and Portuguese community members in Sleaford, Grantham, Boston and Spalding. On average around 15 people would attend.

3.2 COMMUNITY GROUPS DIRECTORY

The team has produced a first edition of the Community Groups Directory in 2008 and the second in 2011. It shows how much change there has been in the range and extent of community groups in Lincolnshire, and some other (language) support organisations. In 2008 there were 49 entries, and in the 2011 edition this figure has risen to 66. Like the service directory it is geographically organised.

3.3 COMMUNITY GROUPS SUPPORTED

A) LINCOLN CHINESE COMMUNITY ASSOCIATION

The support to this group continued throughout the lifetime of the project. The worker attended their monthly meetings and advised them on progress, e.g. designed a questionnaire to explore what activities people would like to engage with and how they wanted to contribute to the Association. The worker has reduced her involvement gradually, so they are capable of continuing the group by themselves and with help of others.

B) Oriental Parents Group (Lincoln)

This group provides friendship and support for parents and young children. It has had support from the worker and it now run by the participants and get support from a Sure Start worker.

C) Oriental Wellbeing Club

Since 2009 support has been given to become independent and the group has now got its own bank account and has received a small amount of funding from the Co-op.

C) Lincoln Chinese School

Support parents to do a Chinese Cultural Workshop in Lincoln Priory Witham Academy School in January 2010.

D) Chinese Welfare Society

This group is supported by developing a business plan to create a Social Enterprise, offering acupuncture, advice, information and potentially an interpreting and translation services.

E) Voice PL

This is one of the first new migrants groups in Lincoln. It has been supported by the worker through help with setting themselves up as a group, a newsletter, translation, and exploring funding and venue(s). The group has ceased, but quite a few other Polish groups have emerged, e.g. the Polish Fishing Club, the Lincoln Polish School, the Polish School Parents Group, the Boston Polish School (for improving Polish language skills), the Grantham Polish School, the Eastern European Group (see community directory for details).

F) Arabic Society

Advised on organisation and funding. There are now various Islamic groups in Lincoln and Boston, focused on education and religion (see community directory for details).

G) Afghan group

Provided information and advice on formalising the group.

H) Russian speakers community group

Advised on organisation and funding.

I) Lincolnshire Gypsy Liaison Group (LGLG)

The support to this group continued throughout the lifetime of the project. The worker attended their quarterly meetings and supported them in writing funding applications and funding evaluation reports. LCDP and LGLG also worked in partnership on a series of health and wellbeing taster sessions for the Gypsy community in Gainsborough.

J) Portuguese school Grantham

Help with setting themselves up and getting support from others.

K) Homeless Eastern Europeans in Lincoln

The team has assisted a lunch club for homeless people in St Mary le Wigford in Lincoln where participants have many issues around work, benefits, loss of identity papers, etc often combined with mental health issues.

3.4 Events organised

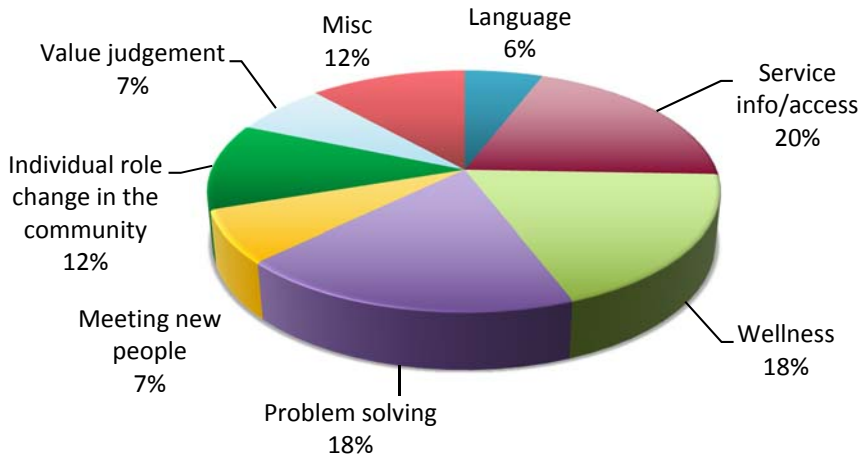
Some of the one off events that were organised together with community groups and organisations to celebrate and create engagement are listed below. These are of a more general nature than the ones that are listed under Health and Wellbeing events.

- Chinese Culture Workshop
- Karaoke Night
- Community friendship day
- International Arts Week
- Oriental Wellbeing Club Family Fun Day
- Christmas and Graduation event for ESOL students
- World Children's' Day celebration event
- International Women's Day celebration
- Cultural Passport Event (with LCC cultural services)
- Gainsborough Goes Oriental Festival
- Gainsborough Chinese Culture Event
- Women of the world event
- Ten Youth Art Project
- Community Spring Fun Day

3.5 Client feedback survey

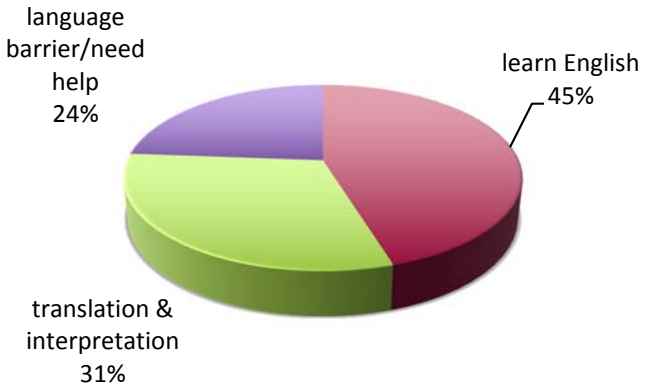
3.5.1 Sources of support

In 2008 a survey was undertaken into the mental health perceptions of BME community members in Lincolnshire which resulted in the Perceptions Report (see Appendix Project Publications for details). In 2011 a client feedback survey Tell us what you think… was conducted (See Appendix 1) and 96 beneficiaries provided responses. Both surveys had a question asking where people would go for help and what help they were actually getting. In 2008 respondents disclosed that they go for help mainly to family and friends. In 2011 the support from the team nestled in between the two main sources of (preferred) support, friends and family (see table below). There also seems to be an increase in variety of support being accessed by BME members.



3.1 SOURCES OF SUPPORT BME COMMUNITIES (100% = 230 CASES)

As mentioned, the 2008 Perceptions report highlighted the popularity of friends and family for support. In this survey 47% is made up of these people. There is now an added support in the form of a support worker from LCDP (24%), which is not surprising as the survey was distributed to clients of LCDP. Community groups are the next preferred to seek help from (13%), before the GP or health service (17%).



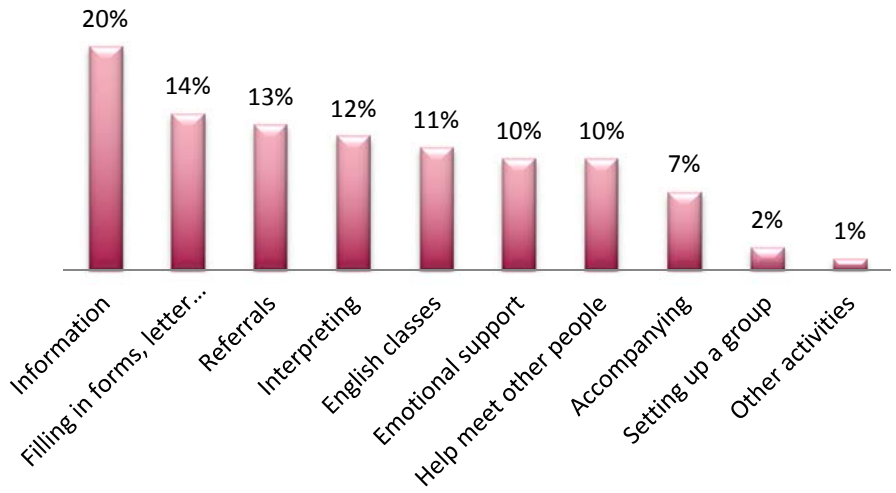
3.2 KIND OF HELP OFFERED BY SUPPORTERS (100% = 211 CASES)

Information and advice on emotional support is 90% of what kind of help is given by those mentioned as supporters in the previous question. Translation and access to services is only mentioned by 2%.

More than half (54%) of clients have heard from the BME team through friends, and 11% through referral or information from other organisations like CAB, church, college. This means that the BME social networks are existing and also passing on relevant information to other members. Leaflets and advertising represent only 7%, which is rather low, and one might assume that by word of mouth is still more popular.

3.5.2 SERVICES RECEIVED

Service received from the BME team were mainly providing information, filling in forms, writing letters and referrals. Although differences with other answers are small, it seems a fair reflection of what workers thought they were offering.



3.3 BME TEAM SERVICES RECEIVED BY CLIENTS (100% = 327 CASES)

INDIVIDUAL POSITIVE IMPACTS

The role of language and the information about the service and access is very central to the positive changes (44%), language however more on the individual level, than on the community level (see Appendix 1A).

Wellness with 21% is covering things such as confidence, feeling happy, being able to do things, communicate and community cohesion (how people are feeling related to each other). This is positive for individuals as well as for the community. Solving individual problems is seen as positive with 20% on the (direct) individual level. Meeting with (new) people is for 14% a positive impact.

COMMUNITY POSITIVE IMPACTS

Individuals see service information and access (including potential problem solving) as the main positive impact on the (wider) community (28%), whereas impact on the wellness of the community is a close second (26%). Respondents also mentioned that they have changed their role in the community, e.g. giving information (signposting) to others and helping them along. Meeting (new) people also was seen as a positive impact for 10% of the respondents.

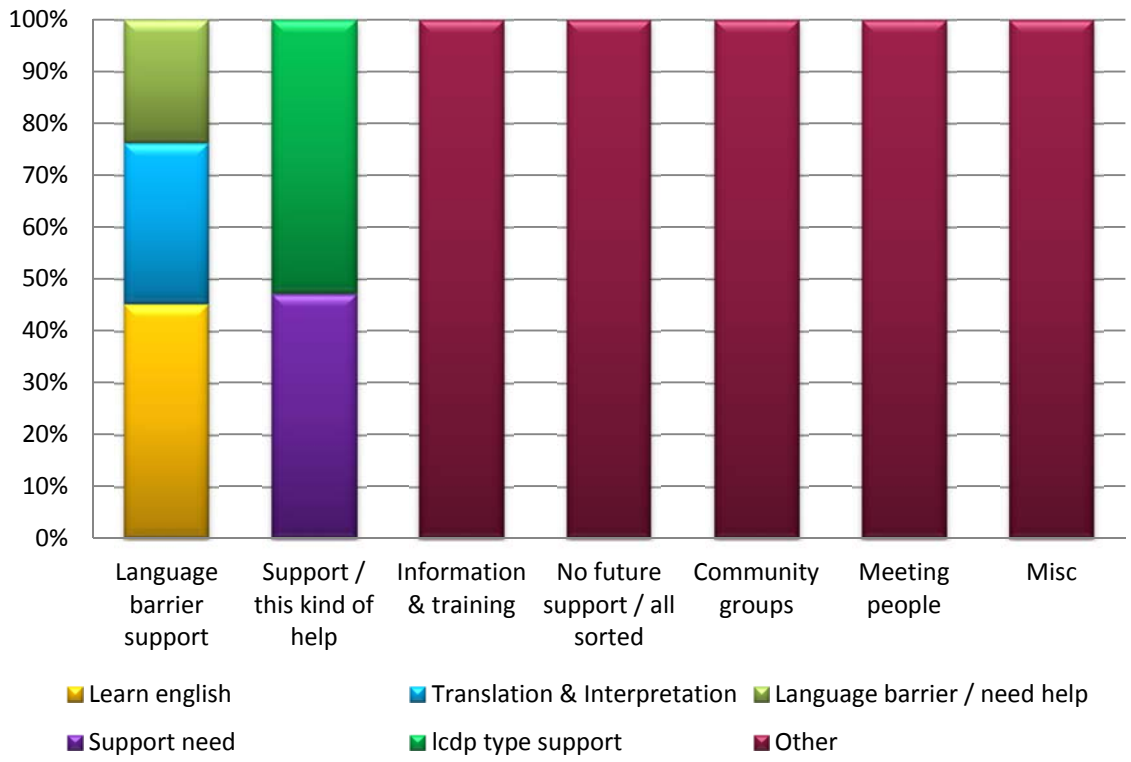
One respondent reported a ***negative impact***, e.g. someone who feels excluded and does not participate as people are judging the race and the person too quickly, e.g. before there is a chance to show him or herself.

3.5.3 FUTURE SUPPORT NEEDS

Clients were also asked about their future support needs and the language barrier issue still features high on the support wish list. People are willing to learn the language, which seems important to reduce dependency on others and cost for the health care system. The need for translation and interpretation support will still be there though for the next couple of years. Information and training is also among the needs that people have in the near future.

Support needs		
Language barrier support		**42**
learn English	19	
translation & interpretation	13	
language barrier/need help	10	
Support/this kind of help		**36**
support need	17	
(Emotional support (8))		
lcdp type support	19	
Information & training		**15**
No future support/all sorted		**6**
Community groups		**4**
Meeting people		**3**
Misc		**3**

3.4 FUTURE SUPPORT NEEDS



CHAPTER 4 BETTER INFORMATION TO INFLUENCE THE DEVELOPMENT AND PROVISION OF MENTAL HEALTH SERVICES

4.1 STAKEHOLDER ENGAGEMENT

Initially the brief for the project was developed through the Delivering Race Equality sub group which was part of the Lincolnshire Mental Health Commissioning Board in 2007. After the tendering process was completed the BME team was held accountable to this sub group and progress and decisions were signed off by the Commissioning Board. To stimulate partnership working the team was asked to represent the Mental Health work stream during the Local Implementation team (LIT) meetings, where other organisations from a broad range of backgrounds were members, e.g. health care services, voluntary sector providers and service user groups representatives. In 2008 a new PCT manager was appointed for the Mental Health Programme and the DRE steering group (originating from the DRE subgroup) continued to be the focal point for the monitoring of progress and stimulation of partnership working.

Team members have done numerous introductory formal and informal presentations about the DRE BME project for various organisations and community groups to make them aware of the project and to seek collaboration (CAB, Addaction, MIND, Migrant workers Forum, Rethink, Home Stars, Sure Start, Advocacy Services, EMAS, Single Equalities Council JUST Lincolnshire, Healthy Hub, Linking Voices, Women's Shelter, Children and Young People Partnership, Gypsy and Liaison Group HMP Lincoln, etc.). They have also presented the project through stalls at various partner events, with displays, leaflets and featuring DVD's and other audio material on the computer.

Over the duration of the project various bigger meetings were held to engage with stakeholders. Presentations of research, progress of work and issues that required further exploration and partnership working were discussed. It is estimated that 212 participants took part in these events, which were held in various venues across the county.

ADDED VALUE MEETINGS 2007 (42 PARTICIPANTS)

The project has been engaging with stakeholders from the very early start.

In 2007 two Added Value meetings were organised in Lincoln and in Spalding. These events were attended by 42 participants. A lack of information about services, interpreting services and cultural training for staff were highlighted. Communities wanted more appropriate information about services and how to access them (Spalding).

IMMIGRANT WORKERS AND MENTAL HEALTH MAY 2008 (64 PARTICIPANTS)

Organisers: Lincolnshire NHS Mental Health Chaplaincy, LCS Chaplaincy with New Arrival Communities in SE Lincolnshire, BME Mental Health Community Development project (LCDP).

Venue: Lincoln.

Stakeholder workshop Delivering Race Equality in Mental Health 2009 (55 participants)

Progress to date was reported to the stakeholders, e.g. the result of the Perceptions survey. Further issues and collaboration with partners has been explored.

Venue: Sleaford.

Looking Back, Moving Forward September 2011 (56 participants)

Achievements of the projects were presented to our stakeholders, including 15 BME community members who participated and have benefitted from the project.

Venue: Lincoln.

4.2 Working with partners and partnerships

The team were asked to help various services with translations or designing their information materials. Examples are Phoenix (the smoke cessation service) and PALS (the Patients Advise and Liaison Service).

Equality and Diversity Teams of the LPCT and ULHT

Throughout the duration of the project regular contacts were kept to discuss BME patient issues and how best to tackle them through the whole primary care system.

Team members have shadowed health care workers to learn from their practice to better inform patients. They have also participated in Health Inequalities Impact Assessments.

Mental Health Promotion group (PCT, LPFT and others)

The team has been part of this group as this supported their own events, e.g. World Mental Health day(s), and the Book Prescription Scheme as well as those of other organisations, including the voluntary sector. The series of Spirituality events in Mental Health wards across the county was funded through the Mental Health Promotion grant. Time to Change was another national campaign to improve positive thinking about mental health that has prompted activities from partners in which the team participated.

PALS

The team has worked together with PALS as their referral path for patients in need of assistance in accessing hospital health services and advised them on promotion material in other languages.

LINk

The team has worked intensively together with the Lincolnshire Local Involvement Network in the BME Access Working group and to advise on the design and distribution of a survey into Patients Experiences.

LINCOLNSHIRE POLICE

The team has carried out a Police Ethnic minority community engagement survey with 319 respondents in 2008.

HMP LINCOLN

This relation has lasted for the duration of the project and presentations were held for staff and inmates. A BME inmate survey was carried out and a report with recommendations was prepared. A self help mental health book prescription scheme was also suggested with a list of suitable titles in Polish.

REGIONAL DRE CDW'S NETWORK

The team has organised a community focus group to assist the Nottinghamshire colleagues to collect data for construct a toolkit for how to best engage BME communities in 2010.

WRAP EAST MIDLANDS IMPACT EVALUATION

The team has assisted the evaluator by taking notes at impact focus groups and inputting data. A report is available.

LINCOLNSHIRE CARERS PARTNERSHIP

The team has attended meetings and advised on BME issues.

CHILDREN AND YOUNG PEOPLE STRATEGIC PARTNERSHIP

The team has been instrumental in improving the policy and plans of the partnership to include BME issues (mixed race). A young people's project was designed but could not be implemented due to staff changes.

MIGRANT WORKER GROUP LOUTH

The team has attended the group (there is also one in Skegness) on a regular basis to update them about progress and make contact for further support of groups.

LINCOLNSHIRE GYPSY LIAISON GROUP

The team has assisted the volunteers of the group to complete a funding bid for the Wellbeing Taster session, which was successful.

CHAPTER 5 CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS

- Language issues remain key to improve the access to mental health services, e.g. the GP services in particular. Interpretation facilities are available, but their use, both by services and by patients are problematic and figures are not available. People need to be made feel welcome and not a nuisance or a hindrance for the service.
- For BME communities informal language learning activities are valuable to improve confidence, create awareness about (mental) health issues and meet other people and make new friends. Although not all people want or can learn English most people realise that learning some English is important as it affects all their communication and interaction with other community members and the services.
- Service professionals are generally interested in cultural diversity and its implications in the work practice and the training has been appreciated
- (Around 2,500 BME members have been in contact with the project, and around 550 professionals. This means that at least 5% of the BME population has been reached).

RECOMMENDATIONS

- To further improve the use of language interpretation facilities at GP practices. Using the DVD training package Easy Access for All in particular for frontline staff (receptionists and GP's).
- Increase informal English learning activities for BME communities, and stimulate BME groups to integrate this as an activity of the group.
- Improve choice for BME and other community members to deal with mental health issues by supporting self help initiatives such as Wellness Recovery Action Plan training and the Book Prescription scheme.
- Other services (than health) to increase their cultural awareness and language access issues.
- Consider how the Single Equalities Act implementation affects the mental health issues in combination with a protected characteristic.