COUNSELLING ALL NATIONS SERVICES [CANS]

“HEARING OUR NEEDS”

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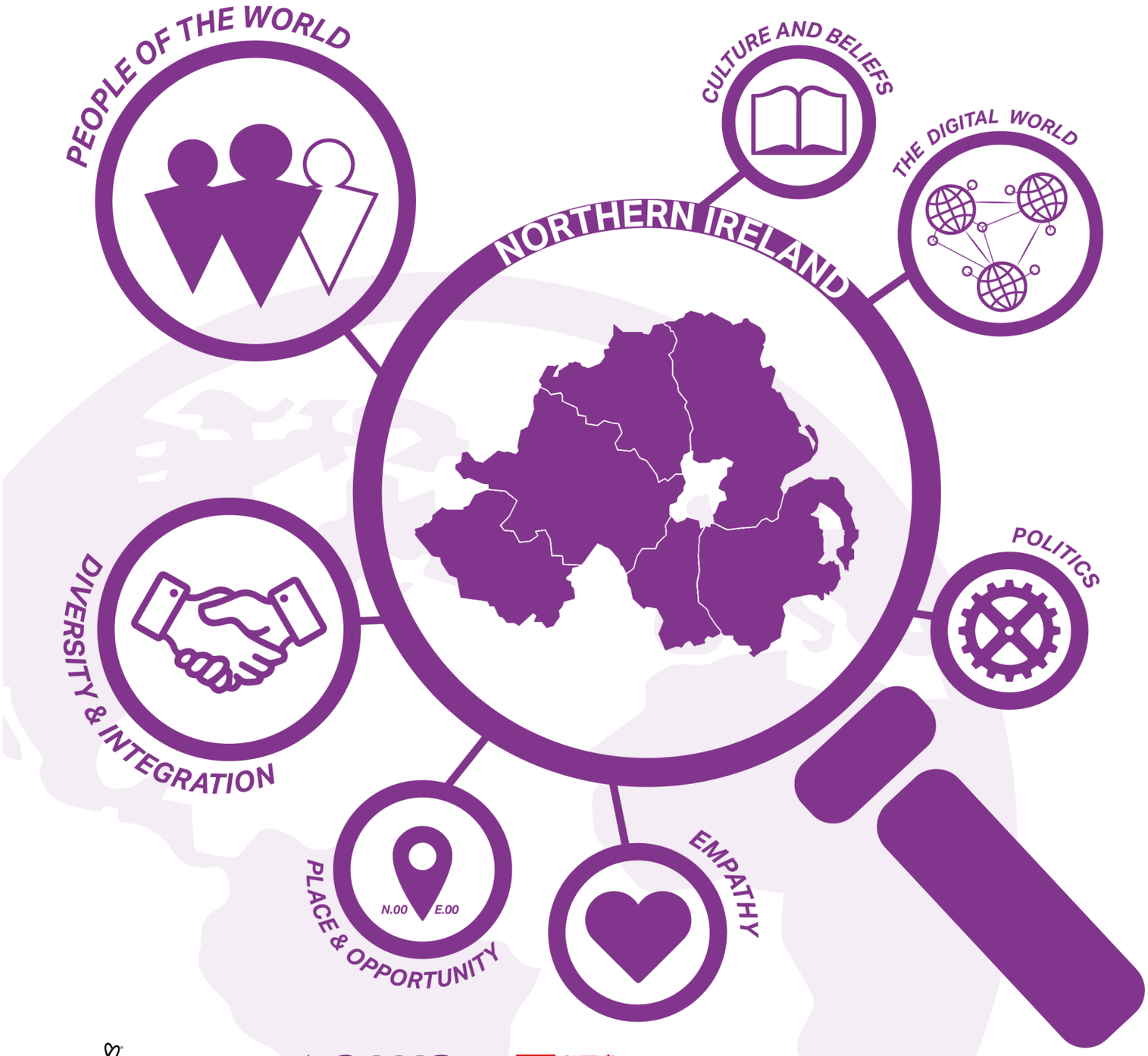

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contents

what is CANS?

With a vision to improve and enhance the lives of Black, Asian and Minority Ethnic individuals and communities, **Counselling All Nations Services (CANS)** are a charity actively providing mental health interventions to those in need within Belfast and the Greater Belfast area. The aim of the charity is to provide high quality culturally appropriate and accessible counselling through which individuals discuss their issues with bi-lingual counsellors of a wide range of cultural backgrounds from African and Polish, to Chinese and Arabic. Counselling All Nations Services (CANS) was originally established and recognised by HMRC as a charity on the 8th Sep 2013 Ref: NI00177 and on the 1st Sep 2014 recognised by the Charity Commission for Northern Ireland, charity no NIC 100444 in response to a clearly identified need for culturally-specific counselling for people from black, Asian and minority ethnic (BAME) communities residing in Northern Ireland.

foreword

by Professor Siobhan O'Neill

As the Interim Mental Health Champion for Northern Ireland and a Professor of Mental Health Sciences, it gives me great pleasure to introduce the **'Hearing Our Needs'** report prepared by the **Counselling all Nations Services (CANS)** in collaboration with **Queen's University Belfast**. This report is of particular interest to me as a trauma researcher, and I have long been concerned about the mental health needs of Black, Asian and Minority Ethnic (**BAME**) communities in Northern Ireland.

I am keen to promote evidence-based services and services and the Hearing Our Needs project initiated by CANS is an important resource in this regard. It describes the mental health challenges faced by those within BAME communities and identifies the mental health and emotional wellbeing needs that need to be addressed. There is a clear need to ensure that this population, who continue to experience discrimination, racism and inequality, have access to the same mental health services and support as the rest of the population.

I commend CANS for the outstanding work that they do to provide culturally appropriate and accessible mental health interventions. The Hearing Our Needs project further demonstrates how CANS is at the forefront of making sure everyone's voice is heard regardless of race, religion or creed.

I would like to thank CANS, and each and every person who participated in the Hearing Our Needs project. Your voices, experience and expertise have already changed the lives of individuals and families, and I look forward to working closely with you all as we move forward together in a more diverse and inclusive Northern Ireland.

Siobhan O'Neill
Interim Mental Health Champion

executive summary

Hearing Our Needs is a project initiated in late-May 2019 by **Counselling All Nations Services (CANS)**, an active provider of mental health interventions to diverse communities in Belfast and Greater Belfast, which sought to further understand the mental health and emotional wellbeing needs of Black, Asian and Minority Ethnic (BAME) communities across Northern Ireland. Comprising of seven workshops held across Northern Ireland - the research team invited participants from a range of backgrounds including emergency services, counsellors, community leaders, academics, union representatives, politicians and others to join the conversation and make their voices heard. These workshops were held chronologically in **Dungannon, Derry-Londonderry, Coleraine, Belfast, Bangor, Enniskillen, and Newry** and were attended enthusiastically. The methodology for the workshop was structured by three key questions: "Are we getting [BAME Mental Health Needs] right?"; "How are we getting [BAME mental health needs] right?" and at the end of each session we invited the participants to voice their recommendations for moving forward.

Participants voiced issues with regards to adequate training and skilled worker retention, **'ring-fenced'** and sustainable funding streams, accessibility to pathways to healing (including self- referral), cultural competence and sensitivity to cultural issues, communication barriers between the public sectors and community level workers, the need for centralised regulation, and more efficient signposting, urban and rural differences in BAME mental health needs, data access and data sharing, and co-design and co-production of strategic documents relevant to [BAME] Mental Health in Northern Ireland. These are discussed comprehensively in sections 2.1 thru 2.4 under 4 key themes – **Building Capacity, Securing Service Provision, Place Matters** and **Co-Production and Networking**. As a result, **12 recommendations** were deduced by the research team including: target empowered decision-making, enhanced and culturally sensitive training, greater government and council involvement, safe and community-managed spaces, sustainable and committed 'ring-fenced' funding, the provision of mental health champions, and the generation of a single regulatory body to instruct and distribute resources.

Additionally, we conducted two surveys – one asking for **feedback** on the workshops, and the other asking a small pool of participants (n=45) about their **mental health and experiences with accessing support** in Northern Ireland. Those who responded listed a myriad of ailments affecting them including Depression, Anxiety, Stress, Suicidal Thoughts, PTSD, Addiction, Loneliness,

and work and relationship issues This also acquired data on ethnicity, age, employment, residence, what they felt mental health and wellbeing meant, and whether or not they have experienced hate crime. 42% have experienced forms of hate crime.

We ask that local government bodies, mental health services, community leaders, and the plethora of organisations actively **supporting minorities** in Northern Ireland to use this Report to produce local-specific research trajectories and nurture collaborative relationships in order to better understand what they can do to empower BAME communities – not just in Northern Ireland, but wherever applicable to the readership.

Report finalised by research team on 3rd November 2020:

DR M. SATISH KUMAR

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STEVEN J DONNELLY

preface

The fragility of one's mental health is often underestimated in the public consciousness. Whilst public acceptance and acknowledgement of mental health issues is increasing in Northern Ireland, there is still so much more to learn and to do. Over the course of collecting data and constructing the final report with the CANS research team, I met many people who are dedicating their lives to improving the wellbeing of others in communities across the province, and I learnt many new things about the relationship between culture and mental health. The sheer complexity of the policy and narratives they respectively navigate as service providers each day is unfathomable. Introducing the concept of culture made this more difficult due to the many different understandings that each participant held. Questions were met with more questions, Socratic in nature, and the trajectory of conversation shone new light on previously overlooked details. During the course of this inspiring project, we witnessed community leaders passionately speak of their struggles with everyday racism. We also saw those who are using the services becoming vulnerable and emotional as they disclosed their reality living with mental health issues. They felt safe and available to speak. As I reflect upon this project, I believe these workshops allowed a diverse group of stakeholders – encompassing policemen, counsellors, community gatekeepers, academics, politicians and others – to feel safe and available to speak. They articulated their worldview, their experience, and engaged with the themes raised in the meeting rooms powerfully and with eloquence. They were being heard and received by their peers who also shared the same values and challenges. They sat together in solidarity.

The purpose of this report, funded by Awards for All Northern Ireland, is to shine a brighter light on the current challenges faced by those actively addressing mental health needs, to become inspired and to collectively work together to co-create a shared vision of BAME mental health for the future. Let all our voices be heard in chorus and be stronger together.

Steven J. Donnelly
Project Researcher
Queen's University Belfast

1 introduction

introducing wider reading, policy and perspectives on BAME mental health, as well as our research methods.

introduction

"Our dialogues must heed the voices of the suffering; they must replace despair with hope"

(Daisaku Ikeda, 2008: 49)

Today in Northern Ireland, we are living within a paradigm of increased mental health awareness. We are actively addressing the prevalent stigmas and feelings of shame against mental health issues faced by many whilst embracing the importance of mental wellbeing towards contributing to the prosperity of society, the workplace, and one's own quality of life and participation in everyday activities (Bhui, 2013: 73). Simultaneously, we are also furthering the understanding of the infrastructure and policy currently implemented that is being used to address mental health needs throughout Northern Ireland as well as the gaps therein that create more challenges rather than solutions. The recognition of the many actors and voices debating mental health, policy reform, and governance is essential to the ecosystem that is providing life-changing services. Nevertheless, we must ask the question, is it enough? Are we getting mental health actions right for Northern Ireland with increased diversification of its population and communities, and if so, how are we getting it right for the benefit of those communities?

Recent political crises related to the Black Lives Matter movement and the global impact of COVID-19 Coronavirus pandemic on BAME populations (Pareek et al, 2020; University of Leicester, 2020) have not only explicitly presented to us the bifurcation of racial issues and disproportionate societal inequalities between groups, but also the fragility of our health system in accommodating the needs of diverse populations. Lockdowns in countries across the world disturbed our daily routines, our normality, subjected us to abrupt change, and tested our ability to build capacity towards effective adaptation in the face of new challenges and new stressors. Feelings of isolation, fear, powerlessness, confusion were dominantly expressed by those in lockdown (UN, 2020). Now, consider for a moment the idea of isolation to someone who is a refugee or someone new to Northern Ireland with limited language and no family or friend network. The beauty of empathy is that it allows us to see the world from another person's viewpoint, to appreciate one's thoughts and emotions, their actions and reactions in a given situation. It puts us in a position to comprehend that those feelings of isolation, vulnerability and voicelessness are there everyday. Fortunately, as lockdown gradually eased, we embraced the importance of

communication, inclusive narratives, solidarity, and peacekeeping in those trying times.

Conceptualisations of mental health are inherently heterogenous. Experiences are highly context dependent and the subject of many social, cultural, religious, biological, political and economic factors (Holt and Sweitzer, 2018). The needs of a Syrian refugee integrating into new surrounds following dislocation or a Polish worker coming to Northern Ireland attracted by the benefits of work have variable needs and adjustments to be made. In accordance with the **World Health Organisation**, good mental health is defined as "a state of wellbeing in which the individual realises [their] own potential, can cope with normal stresses of life, can work productively and fruitfully, and is able to make a contribution to [their] community" (Betts and Thompson, 2017: 7). Within this report, we place particular emphasis on the aspect of individual potential and culture with regards to mental health engagements in Northern Ireland. **Culture** for some researchers is defined as a determinant of one's reality, and something that encompasses the material and non-material aspects that one holds in common with other people. Culture can be shared patterns of belief and behaviours which people carry with them every day and across the world (Leighton and Hughes, 1961: 2). Culture is a such dynamic phenomenon; it is mouldable and can be expressed through a myriad of tangible and intangible mediums. Culture is not a vacuum nor static (Fakhr El Islam, 2008). It is something to be celebrated rather than feared or avoided. How one embodies and expresses their culture through life (be it as a set of beliefs, their habits and rituals, or how they present themselves) is significant to their identity - but in the context of mental health interventions it can leave them misunderstood and voiceless. Thus, a cultural lens on mental health and policy reform must recognise that interventions targeting such communities need to be re-evaluated to consider their needs sensitively and such cultural dynamics at every turn. It raises concerns with regard to cultural knowledge, training and guidance, and places great weight on the relationships between government bodies, interdisciplinary public and private agencies and communities interest groups, and charities towards addressing these issues. Each of these institutions have their own agendas and priorities, and often they are disconnected or do not share data with one another. They have their own experiences and evidence which can be useful for understanding what works and inversely what does not.

Moreover, in light of **Brexit** and the political-economic instabilities created by Britain's (including Northern Ireland) exit from the European Union - concerns about available funding streams (i.e. Peace IV, European Development Funds), and the longevity and provision of mental health services at all levels

are prevalent in discussions held by many stakeholders especially at the community level. Much of that funding was used by organisations and groups in the provision of services and mitigating of mental health issues important to their respective communities. In a report produced by the Mental Health Foundation (2016), Northern Ireland still continues to be severely underfunded compared to other UK regions despite being a hotspot for mental health issues. Whilst data provides us with important insights into the mental health crisis, it becomes even more difficult to ascertain centralised information on Black, Asian and Minority Ethnic (BAME) community mental health in Northern Ireland. Echoing the point in the previous paragraph – the information held by these disconnected institutions, organisations and charities, including the Northern Ireland Statistics and Research Agency (NISRA) can assist in this endeavour. For example, Counselling All Nations Services (CANS) as a charity providing mental health interventions for BAME communities collect statistical information of therapy progress through their CORE system.

For Bass et al (2007), the recognition of 'culture' in mental health policy and interventions can no longer be perceived as an after-thought (918). An individual or professional conceptualisation of mental health can affect the symptomatology, diagnosis and prognosis. For Rack (1982), educating existing or training specialised professionals on these needs and dynamics not only increases awareness of cultural interplays with mental health, but helps professionals better understand that some unfamiliar behaviours may not be the product of mental illness. The same behaviour can have multiple meanings in different geographies and social situations. We need to begin to accept culture in its own terms. The perception of people in terms of their cultural background is itself determined by the ways in which their cultures are perceived by others (Fernando, 1991: 52). Whilst difference can be valorised by groups as part of their unique heritage and tradition, it can lead to the othering and exclusion of groups in certain places and often unconsciously in the very institutions that are there to provide help. Those providing help in **General Practitioner (GP)** offices may not be as sensitive to BAME issues due to a lack of experience or are inflexible in what they can provide under certain regulations. The prevalence of racism, discrimination, violence and conflict, and segregation intensify the marginalisation of these groups from participating in society. Thus, the concept of mental health must also be seen within the relevant political and social context (Fernando, 1991: 77). Conceptualisations of mental health must articulate the cultural constructs of a person that contributes to their reality. Issues and adversities such as class, sex, gender, sexuality, disability, education, race, ethnicity, hierarchies amongst or between groups, conflict, and the accessibility to services (or readily available points of first contact i.e. GP) all contribute to their perception and management of mental health. Intersectionality - which

links gender, ethnicity, religion together for the BAME - allows us to situate an individual or a group in their respective domain, to produce agendas that can address relevant themes, anxieties and challenges, and better understand why groups may avoid or do not take up certain treatment pathways (Garcia and Sharif, 2015: 27). It collectively contributes to the promotion of good relations amongst groups and in turn nurtures forces of social cohesion and unity.

The construction of a reliable and articulated communication platform for all involved (Banks and Kohn-Wood, 2002) can be invaluable towards creating informed decision making, investment and interest in community-focused projects, and their subsequent integration and acceptance into those communities (Rao and Watson, 2004: 368).

In light of addressing avoided pathways to treatment - the **Jarvis Law** on the planning of mental health services in urban areas presents the observation that if the correct services and assistance are readily accessible to a community, it will be utilised (Sohler and Thompson, 1970: 503). However, how do we overcome the anxieties and stigmas of mental health that, to the US Surgeon General, remain “powerful barriers” to reaching treatment? (DHHS, 2001: 165) This can be the result of a number of factors incorporating the professional-client relationship, the dynamics of translators between the professional and client, perceptions of weakness, or health promotion campaigns overlooking certain communities. Health promotion as a process aspires to enable people to increase control over the determinants of their mental and physical health (Kirmayer et al, 2003: 21) whose uptake may be restricted by language or access to materials. The use of culturally specific information and local knowledge, grassroots engagement strategies (i.e. gatekeepers, community champions), and targeted interventions to reach those less likely to benefit from universal health strategies as presented by local government and health agencies are instrumental to their success. An understanding of community dynamics and their respective needs gives rise to cultural competence.

Possessing a degree of **Cultural Competence** empowers those working in mental health domains to demonstrate values, attitudes and policies to work cross-culturally - to value diversity, acquire a cultural knowledge and adapt service delivery to the communities they serve (Bhui, 2013: 83). This service adaptation nurtures resilience in these communities through adequate provision and through an enhanced localised understanding of how members of the community respond to adversity and stressors.

Professionals such as counsellors and therapists may face many barriers related to language and articulation of issues, translator dynamics, and cultural

filters. This distorts the narrative in the treatment room, emphasises difference in worldview and traditions, and highlights limitations to services they can provide (most often restricted to **Step Care 1** and **Step Care 2** [1]). These factors strongly influence the reliability of the treatment. In the treatment room, the aspiration is for the client to paint a picture of their lives, memories, life path, and of their present situation. Both the patient and the professional bring their own attitudes, values, worldview, and traditions to the treatment room which has significant influence on the value of the therapeutic relationship, evaluation and treatment (Revollo, 2013: 38). If there is no common language, the picture remains hazy and riddled with ambiguity (Rack, 1982: 5). Moreover, if and when translators are logistically and financially available, they may negate certain details due to internal prejudices or in the translation from one language to another. More commonly, a translator may be a family member like son on behalf of his mother, or a husband, where the client may not disclose certain details in session due to the nature of the discussion or for fear of repercussions. This places great emphasis on the needs for direct communication where possible.

Additionally, another prevalent concern is the length of treatment to adequately address the issue. For some, the initial provision of 6 weeks of sessions may not be enough, and after-care provisions become essential to help manage issues in between. Waiting lists may see individuals only getting assistance many months after making the first contact with an available mental health pathway (i.e. GP surgery, triage).

Whilst we all may not have mental illness, we all have mental health and different thresholds to stress and change, and outlining such differences and adjustments are necessary towards adequate treatment. Naturally, some professionals and stakeholders are more adequately trained and experienced, highlighting the need for effective and clear signposting to pathways of healing. Communicating to someone in your language, whom you share a culture with, and navigating similar value systems creates an inviting atmosphere. We as humans appreciate a sense of belonging (Rack, 1982: 55). When we remove the barriers of language and establish trust through the practitioner-client relationship, it is then that a reliable diagnosis can be made. Moreover, Sewell (2008) emphasises the pitfalls of assumptions and misrepresentations of what is important to the identity of groups or individuals which can lead to the perpetuation of stereotypes and unsuitable outcomes (89).

This further supports the need and incentivisation for specifically trained and

1: The Stepped Care model defines the practices and treatment an organisation can offer. Step Care 1 can offer recognition and assessment, Step Care 2 can offer treatment for mild depression and trauma via guided self-help, CBT and brief psychological interventions. Step Care 3 for the treatment of moderate to severe cases can enable treatments via medication, enhanced psychological interventions and social support. Step Care 4 and 5 are synonymous with severe, recurring and significant risk to life encompassing advanced and specialist interventions.

culturally competent bi-lingual counsellors – a critical key outcome of this report. In the face of overmedicalisation for mental health issues (i.e. anti-psychotics, antidepressants, anxiolytic dispensation and usage), as with our current understanding of cultural influences, we can take inspiration from the late Henry David Thoreau in which he states, "*there are as many ways [to do something] as there can be drawn radii from one centre*". How one manages their health and assuages their trauma is highly individualistic. A person's culture, ethnicity, and identity may distort their experience of mental health, and in turn how one may seek help or stigmatise certain pathways. Their ideation of mental health is anchored in their culture and social networks, producing different lenses through which it is seen and approached. Spirituality, ethnic values and religion are amongst significant factors associated with managing mental wellbeing and mental illness. The increased understanding of cultural determinants of mental health in modern discourse may help tailor intervention and eradicate the one-size fits all approach adopted by the many. Embracing new holistic methods and narratives – from **Talking and Play Therapies, to Art and Drama, and Yoga** - immensely widens the palette of options promoting mental wellbeing and positive mental experience in communities. Therefore, seeking help, overcoming boundaries and an individual's recovery is a journey defined by the individual and their support network, unique to their experiences and trauma, and how they progress at their own pace towards achieving personal control and the management of their symptoms (Sewell, 2008: 109). It is a process encompassing a lot of time, knowledge, empathy, confidence, adequate resources, and the correct dialogue shared by a network of specialised stakeholders, love, and acts of human kindness.

The **'Hearing Our Needs'** Project was first proposed by CANS as a way to better understand the challenges faced by numerous organisations in Northern Ireland. The report is the result of seven workshops conducted in association with various charities and organisations situated in **Dungannon, Derry-Londonderry, Coleraine, Belfast, Bangor, Enniskillen and Newry.** A summation of key findings, as discussed in succeeding sections of the report, makes reference to:

- Available **pathways** towards accessing mental health services.
- **Urban and rural disparities** in mental health service provision and training.
- The need to incentivise the **training** of bi-lingual level 4 counsellors.
- **Co-production of mental health strategies and policy reform**, which is inclusive of all stakeholders active across NI, as well as the consolidation of local targeted action plans.
- Creating **resilience** through capacity building and networking of resources

- Understanding the **value of place and local knowledge** in BAME issues
- The empowerment of **culturally sensitive services** and health pathways through **stable sustainable funding** practices, training for Step Care 3 and 4, and adequate staffing.
- The **communication divide** between government and the community sector
- Emerging **digital spaces** and new spaces of engagement.
- **Sharing knowledge, experience and freely accessible datasets** for Northern Ireland.

methodology

In May 2019, the research team conducted the first of seven workshops at South Tyrone Empowerment Programme's (STEP) offices at The Junction, Dungannon. The aim of each of these workshops – held between May and September 2019 in **Dungannon, Derry-Londonderry, Coleraine, Belfast, Bangor, Enniskillen and Newry respectively** – was to engage local stakeholders, emergency services, charities, organisations and political bodies about the challenges they face in their work within Northern Ireland and their individual constituencies.

The seven workshops were enthusiastically attended by a myriad of representations linked to local organisations and charities, Community Interest Groups, political bodies such as Alliance, members of relevant Health Trusts, the Public Health Authority, emergency services (PSNI, NIAS), and private practitioners. At times, we were

WORKSHOP LOCATIONS

1. DUNGANNON
2. DERRY-LONDONDERRY
3. COLERAINE
4. BELFAST
5. BANGOR, CO. DOWN
6. ENNISKILLEN
7. NEWRY, CO. DOWN

also joined by service users. Each participant brought their experience and expertise working with BAME communities to the cabaret-styled format in order to address two questions **"Are we getting it right?"** and **"How are we getting it right?"**

The utilisation of the cabaret-table format was to enable participants to mix and discuss the questions together, sharing their experiences and perspectives with others. After discussing the two questions, the workshops then were reconfigured into an open forum format to discuss and collect recommendations to address key challenges and issues from those attending.

1.1A *Are we getting it right?*

The purpose of this question was to engage service users to think critically about themselves (or their organisations), other organisations or bodies, and the current policy framework addressing BAME Mental Health Needs. The question aspired to provide insight into the ways in which professionals are conceptualising mental health in Northern Ireland, as well as the ways we are approaching components such as culture, community, diversity, and the pathways of intervention available to different BAME communities which is geographically specific.

1.1B *How are we getting it right?*

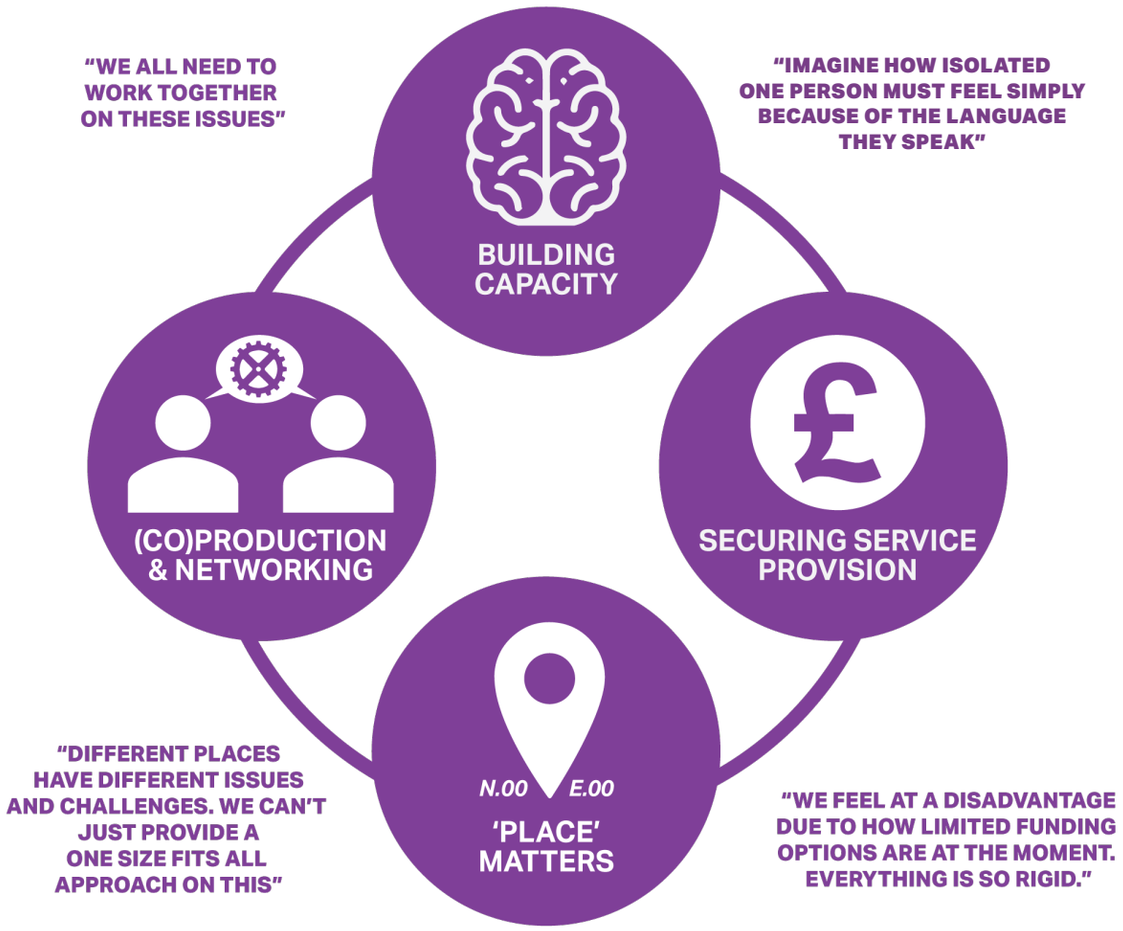
The purpose of this second question was to discuss methods of best practice and case studies that each participant has seen being used or are currently being utilised in their own work. It was formulated to gain insight into how service users are engaging with BAME communities with regards to their mental health needs, health promotion and outreach, provision of services to communities, signposting to pathways, and networking and co-production with other bodies on projects.

1.1C *Recommendations*

Following two periods of in-depth discussion and debate, participants came together to produce a number of recommendations which we have taken into this report. The recommendations were provided to help address key issues faced by service users in their daily efforts, or to collectively address a gap in policy or resources. Amongst the recommendations were new ideas for signposting, informative literature, regulatory practices, digital outreach, policy reform, shared communication platforms, and demands for freely accessible data about their communities and Northern Ireland in general. The data collected from each of the seven workshops was then processed at Queen's University Belfast, where 4 main themes emerged that frame this report [See Section 1.2 overleaf].

1.2 – Emerging Research Themes

The voluntary contributions of all workshop attendees were highly informative, underpinned with a wealth of experience, and rich in detail. They addressed an extensive range of issues, challenges, barriers and factors faced by both service users and active service providers for Northern Ireland's BAME communities. The four parent categories are presented as follows:



Building Capacity [Section 2.1 – p. 19]

This research theme primarily engaged with attendee contributions related to communication issues between organisations, crisis intervention, public compassion and education; Factors contributing to the stigmatisation of BAME mental health, self-help awareness and practices; Effective first points of contact for BAME communities, the professional-client relationship, translators, resource provisions for BAME workers; Approaching the concept of cultural competency, language and cultural barriers; and available research and distributable literature. This section stresses the over-pressurised and overstretched Northern Ireland Health System.

Securing Service Provision [Section 2.2 – p. 23]

'Securing Service Provision' examined contributions from attendees relevant to sustainable funding streams for service providers, Brexit and service adaptations, resilience, parliamentary and local government barriers for legislation reforms, political and economic priorities, reformed cultural and mental health strategies, and datasets.

Place Matters [Section 2.3 – p. 27]

This research theme places heavy emphasis on local knowledge and the enhancement of local services available in Northern Ireland.

This section also examines new emerging digital spaces that can be utilised for mental health interventions and accessing help as well as discussing recommendations related to devolved governance, local gatekeepers and mental health champions, perceptions of mental health and othering of BAME communities. Anti-social behaviour and drug-alcohol abuse, making sense of local identity, BAME integrating into new spaces, and embracing diversity together are also discussed.

Co-Production and Networking [Section 2.4 – p. 32]

'Co-Production and Networking' speaks to the need to begin shared dialogues and narratives on BAME mental health needs and challenges.

It discusses the creation of intercultural groups and forums, a centralised regulatory platform for service providers, effective communication and resource pooling, BAME inclusive production of legislation and strategies, revised training practices, self-referral systems, diverse stakeholder groups, and the development of safe spaces for expression and intervention.

1.3 - A note on research trajectories

The following four sections present a number of points and issues raised by the workshop participants. Whilst the report tries to be as encompassing as possible, we do recommend that local government, services and organisations use the report to produce local-specific research trajectories and collaborative relationships to better understand what they can do to empower BAME communities – not just in Northern Ireland, but wherever applicable to the readership.

2 emerging themes

2.1 - building capacity

the challenges of engagement

Recent sounds on the radio discussed the need for more semi-skilled and trained workers to "build capacity" in the fight against COVID19. Likewise, amongst participants of the workshops, the concept of capacity building was a topic stimulating and steering conversation.

Capacity building can be defined as meeting the needs of a myriad of networked stakeholders, whereby a mental health system's development, efficiency, effectiveness, equitability and ability to be tailored to the needs of people with mental health problems in a certain area is empowered (Semrau et al., 2018: 1). Whilst toolkits exist (PHA, 2015) - capacity building ultimately strengthens asset delivery and enables services to do more for their respective communities.

It enables organisations and practitioners to maximise their efforts and benevolence. Moreover, the concept of capacity building is recognised as a key driver of UN global **Sustainable Development Goals** for 2030 (emphasis on SDG 3 referencing good health and wellbeing) to achieve a more sustainable and better future for all. Fricchione et al. (2012), much like the workshop participants, recognises training workforces, resource availability and partnerships as among key drivers of capacity building (47) – but is it being done effectively? Are training programs and resource pools fit for purpose? Are we all on the same page?

Each participant and their respective association or institute had an example of capacity building to articulate how they address mental health. These ideas and strategies range from the **Northern Ireland Ambulance Service** and **Police Service of Northern Ireland** [PSNI] employing mental health workers to join visiting constables on active crime scenes and incidents. The establishment

of the government **'Protect Life'** strategy (Department of Health, 2019) as a priority in addressing growing statistics on suicide. To stimulus packages such as **Peace IV EU funding** and **Good Relations** funds, or therapists employing different modes of engagements such as play or dramatization, and even the local government cultural strategies (i.e. Belfast City Council, 2014 and 2019; Derry City and Strabane Council, 2019; Ards and North Down, 2019) linking a range of themes to mental health loosely (but improving nonetheless). Other organisations such as **South Tyrone Empowerment Partnership** [STEP], **YMCA Bangor**, **The Confederation of Community Groups** in Newry, and **Building Communities Resource Centre** [BCRC] in Ballymoney are also actively engaging a plethora of stakeholders and communities to understand what works best and how to increase the potential of their efforts, and many are linked under the PHA Stronger Together Network which aspires to build capacity of BME focused interventions through the sharing of information and identification of partnership opportunities amongst its 150-strong membership.

To quote a participant attending the Newry, and concurrently the final, workshop of the series - capacity building starts with "*the need to educate ourselves about each other*". Whilst a sense of empathy gives compassion to those of all backgrounds affected by mental health issues and assists towards removing stigmas on addressing mental health. Having an understanding of how diverse cultures and identities engage mental health allows us to focus our interventions and connect resources effectively, and therefore our capacity to improve one's life and wellbeing. It ultimately colours our shared vision for future strategies and approaches for supporting and integrating BAME people into policy and our communities. However, there are challenges to achieving those visions rooted in local geography, and the economic and political spheres. We thus identify two lenses on building capacity: one belonging to the service providers in networking, training, and using resources; and the other belonging to service users to ensure they are given the tools to build their own capacity to support themselves after treatment.

Service Providers in the workshops identified insufficient or inflexible funding, a lack of training opportunities towards the provision of Step Care 3 interventions, the failure to retain trained individuals (level 4 education and above) in the local economy or incentivise bi-lingual persons to enter the healthcare sector, insufficient face-to-face consultations and limited referrals with clientele, and a lack of legible pathways and poor networking between community-level and the public sector as primary limiting factors towards securing or improving capacity. Each of the above were mentioned at every workshop by a number of participants. However, whilst these may be broad

categories that highlight deficits, it also highlights opportunity for further research trajectories to understand how they can improve on these deficits to fit into a wider vision of support. Each of these challenges are echoed in 2.2, 2.3 and 2.4 below.

> *"If you are a person coming from a different country or different background, you are in a wilderness. You do not know what services are available. In a community, they may have services for [one culture] but not fully complimented for others. [People from BAME backgrounds] may not know what services their new surrounds may offer them" – Marie Louise McClarey, BCRC Ballymoney*

Whilst we build the capacity of service providers to intervene effectively and efficiently with the BAME communities - there is also the need to reaffirm self-help narratives and aftercare in supporting interventions. They are inseparable, fundamental towards bringing a patient through their trauma, and ensure they have a lifeline when they leave treatment room or system altogether. As we will discuss, the current treatment cycles may last only 6-12 sessions and require admittance to long waiting lists to re-enter the system. A myriad of potential pathways exist for self-care and it is agreed that self-care plays a critical role in the management of chronic illness (Becker et al, 2004: 2066). Continuing Becker's observations, there are particular values, idea systems and behavioural practices ascribed to self-care practices by different cultures, and there is also opportunity for cross-cultural exchange in self-care narratives (Becker et al, 2004: 2066). Such pathways include exploring their spirituality, establishing intracommunal support networks, participating in non-pharmaceutical interventions, 'men-sheds' and knitting groups, exercise programmes, gastronomy, artistic outlets, Yoga and Tai-Chi, and even as far as knowing what the patient likes to do in their own time so long as it doesn't carry negative health implications. As a significant argument within the BAME mental health narratives, a lack of active intervention and services correlates directly to a lack of self-care and adherence to guidance and their aftercare (Sulaiman et al., 2010). Thus, it is important to understand (a) self-care practices of different cultures by means of being culturally competent, and (b) empowering narratives of self-care within communities and divorcing it from stigmas linked to their concepts of mental health, and (c) understanding the abilities of the individual to produce enjoyable suggestions. It is important to emphasise the need for established self-care practices amongst practitioners and ensure a culture of self-care is maintained across all institutions involved in

mental health provision as it can lead to burnout, vicarious trauma, depression, and reduced competency and performance (Barnett and Cooper, 2009: 16). This was unanimously agreed by all participants, some sharing stories of their own burnouts and absences from work. It is a double-edged sword for service providers and service users.

The **interpreter-practitioner-client relationship** and its inherent interpersonal dynamics can define the level of information disclosed during sessions - directly affecting the success of interventions for the BAME community. Corresponding with the introduction to this report – a translator can be either a hired professional with proficiency in the language (and culture depending on their origin), or a family member such as a child or a partner. A client may be somewhat proficient in English, but not enough to express themselves confidently. Whilst a translator can effectively overcome the language barrier, and support is available for practitioners to hire them, there is an issue with information being lost in translation between the client and practitioner. There is also the issue of cultural censorship whereby some disclosures may be negated by the translator (who is expected to remain impartial) due to the nature of the translation or culturally anchored prejudices. Moreover, the client may not want to disclose certain information (i.e. gender and sexuality specific issues, wider family matters) to a family member translating in anxiety of being seen differently or fear of repercussions (i.e. domestic abuse, ostracising). This highlights an issue regarding trust and unreliability, and whether or not the client is in control of the session.

On the contrary, a practitioner with no experience working with people of different ethnicities and cultures will have a steep learning curve towards understanding their perceptions and reactions to mental health issues, and wont effectively engage with the client. Their capacity to intervene is a limiting factor in providing successful treatment and will require further assistance and guidance to progress. Unanimously, workshop participants voiced the need for specialised training for existing practitioners and organisations, but also the need to incentivise the training of skilled bi-lingual practitioners in all parts of Northern Ireland.

Unfortunately, Northern Ireland continues to be the victim of a “brain drain” of professionals migrating to other countries and cities to find work and opportunities – leaving gaps in the workforce and resource pool. These skilled and culturally sensitive bi-lingual counsellors and practitioners will be able to overcome the language and cultural barrier, improve the capacity of dedicated organisations to intervene, rely less on family or community translators, improve client confidence and the fullness and reliability of their

disclosures, client retention during the treatment programme, and ultimately foster an air of familiarity, appreciation and ease in the treatment room.

The provision and distribution of easy-to-understand literature to communities that can signpost individuals to points of contact for mental health intervention was voiced at all workshops. Participants specified that literature should be informative, available in many languages, widely available in key places where BAME communities meet or consume services, assure prospective clients that it is safe to contact these organisations, and clearly signpost to the right stakeholders in their local area.

2.2 - securing service provision

thinking about longevity and sustainability

The securing of sustainable and flexible funding was a major priority shared by all groups present in the workshops. At the time when the research group were collecting the data for this report, we were approaching the 31st January 2020 Brexit deadline – when the United Kingdom officially left the European Union. The implications for immigration and mental health services, especially in the event of a no-deal Brexit, created a lot of anxiety for both service users and service providers when considering the economic impacts, policy changes, migration and workforce barriers, and widespread service disruptions that the withdrawal would inevitably cause. The need for contingency, guidance, and support in delivering services and challenging shortages is critical and anchored many points vocalised at every workshop. Thus, securing service provision became a key theme.

Service provision finds itself at a complex crossroads between building capacity, place, and networking. It heavily relies on a suitable mixture of these components to generate compatible funding and service delivery to tackle issues on the national scale right down to the community level – as section 2.3 illustrates below. The pressures created by Brexit with regards to ambivalent government guidance, the effect the withdrawal will have on EU funded programmes, what legacy components are being implemented to ensure their longevity in their respective communities nationwide, and on visas, refugees, freedom of movement and naturalisation statuses created considerable worry

and negative mental health impacts on community members and staffing. It is important however to acknowledge that all these issues are not exclusively the product of Brexit politics and policy but a product of how Northern Ireland's dedicated governmental bodies and grassroots/community level BAME organisations are working against one another.

They are not engaging one another; they are not sharing knowledge or data, or coproducing narratives. Rather, they are working to different timelines and with conflicting priorities – producing strategic decisions which later face a multitude of criticism from one party or create inflexible conditions to improve interventions and practices.

As a consequence of this communicative barrier between community and government organisations related to mental health (and in turn BAME mental health needs), participants also elaborated on parliamentary barriers which stand in the way of community organisations bringing forward new legislation, legislative reform, and empowering narratives at higher political levels. Throughout the course of the data collection period, the Alliance Party NI were the only political body to send a representative to the workshops. Their representative highlighted the importance of political prioritisation and its impact on engaging with certain communities and their needs. Alliance discussed their thoughts and standing on issues related to migration, mental health, and human trafficking in Northern Ireland. Calls were made by participants for greater collaborative efforts to be made between the council, government bodies (including the **Office of the First Minister and Deputy First Ministry/OFMDFM)**, and community service providers in preparing strategies, producing sustainable and more flexible funding streams, and towards narratives of mental health that reach higher political agendas. With emphasis on the funding streams, many participants believed that available funding was too stringent for what it's intended for, and whilst assisting on aspect of their work, other issues many not benefit from addition funds entering charities.

Moreover, the areas which we were working in have produced a number of documents and strategies on the cultural landscape. Some of these strategies encompass elements from the built environment to cultural displays, and some have connected mental health and wellbeing to the cultural landscape and civic pride - albeit very lightly. An example anchored on the Belfast Cultural Plan 2019 'A City Imagining' and the Belfast Agenda 2030 for community planning, highlights the benefits of participation in cultural events and the need for ambassadors to promote diversity, but both documents minimise health inequalities to a minute portion of the strategy's contents. The efforts tend to be largely tokenistic in nature and the provision of a BAME perspective cannot

be reduced to dances and provision of ethnic cuisine. Participants did voice during workshops that current strategy requires a greater engagement with all communities, and the research team associated with this report emphasises the requirement to significantly increase the representation of BAME communities and mental health in general within future published reports. This will assist in contributing to producing strategic goals that reach into diverse communities, and enable new funding practices which contribute to the longevity of service providers directly.

When raised as a discussion topic during the **"how are we getting it right?"** section of the workshops – **data** availability, its usage, and conceptualisations of data brought a mixed response. In unanimous agreement – information is power. To a small minority of participants, it was something described as overwhelming to approach - not only in regard to the array of data available or that can be created by organisations but navigating and extracting the right information. This highlights a skills gap issue pertaining to the capacity of individuals and organisations to process information. It is something that could be fulfilled and generate many long-term benefits to those active in BAME matters. Despite bodies such as Northern Ireland Statistical Research Association (NISRA) making large data sets and census data available to the public, Kumar et al. (2018) reiterated that there is a deficiency in data available for analyses on the impacts of mental health and community prosperity in Northern Ireland.

NISRA currently offers a large array of information that is outdated or embargo important datasets that may aid BAME and mental health organisations in their activities. Free availability of datasets can become versatile cross-sector policy instruments empowering public, private and community-based organisations to become more informed, digitally capable and empowered to act upon strategic decisions. The strengthening of data collection capabilities for public policy echoes the Strategic Development Goals of the **New Urban Agenda** and combines local and globally harvested data

for promoting data-driven governance (NIUA, 2017: 11-12). **Data is a starting point for all points of inquiry.**

However, as previously raised in section 2.1, the communication gap between organisations also manifests with regard to a fragmented pool of data that can become resourceful for all organisations active in Northern Ireland. Each organisation (including CANS through their CORE system that tracks patient progress anonymously) collects information or can signpost to other locally applicable sources. Communication can enable local organisations to collaborate and learn together, share data about their immediate surrounds and communities, and help better anticipate the needs of all. Quantifiable and anonymised results can greatly help inform practices, operative capacity, and help attract funding. Whilst much of the information collected may be more qualitative in nature, where it is more effective for organisations to disclose their findings through reports and conferences - there is always opportunity to present data on patient intake, sessions held or treatment retention, confirmed diagnoses and key words, trauma, domestic abuse and racial crime, issues affecting communities, number of phone enquiries, funding and financial loss, demographics and origins, and whether or not patients have sought help before. **Section 4** highlights the importance of this theme more prominently. A simple methodology that participants felt comfortable with was creating their own surveys as it gave them full control over what they would like to find out.

However, this method is inherently limited in its scope, its reach to others not using their specific service, or by sustaining language and cultural barriers which make it inaccessible to some communities at risk. This is where collaboration with key stakeholders becomes significant towards strengthening interventions and securing service provision through informed practices.

Resultantly, the development of a central regulation platform for strategic guidance was recommended and enthusiastically discussed amongst participants. Participants felt that the communication, practice, knowledge (by extension - data), and policy gaps affecting the community sector and government level, and competition and pressures for limited funding and resources could be resolved through centralisation and monitoring by a structured independent body and through the formation of an intercultural panel to discuss concerns and bring new legislation directly to the parliamentary level. This centralised platform would play a key role in the post-Brexit strategic development of Mental Health and BAME services whilst fostering collaboration between organisations and trusts in efficient and effective delivery of services.

2.3 - place matters

geography plays its part

Anecdotally speaking, the production of the **COVID-19** mobile app provides us with an asset to monitor the spread of a deadly virus locally in order to protect ourselves, but it is only successful if a number of people in your area understand its importance and also use it adequately. An apprehensive public may view it as an invasion of privacy and therefore treat it as unwelcome thus rendering it ineffective. Akin to the **Jarvis law**, if no services exist or remain inaccessible at the local level, then they are not effectively combatting the issues and challenges affecting their communities. Place and the public are significant influencers in BAME mental health interventions and general wellbeing. However, urban areas present their own unique challenges, signifying a strong heterogeneous spatial geography, which have detrimental impacts on residents of all ethnicities and minority groups. Such factors include crime rates, violence, neighbourhood deterioration, exclusionary spaces and fragmentation, and infrastructural segregation.

Pull factors such as family and friends, viable employment prospects, accessible resources such as the benefits and NHS system, affordable housing and tenancy rights, and generally a higher quality of life and stable livelihood will attract migrants of all backgrounds, classes, and ethnicities to a particular geography. With a shift in their surrounds comes a shift in how they are perceived by locals, often accompanied by an intensified sense of 'othering' due to their race, cultural background, religion, class and communication barriers. They need to integrate into their newly found social cues, and become familiar and make sense of their new surrounds. Whilst Northern Ireland is increasingly acknowledging the impacts of mental health and diverse communities - new entrants and those entering established BAME communities will carry their culture from one geography to another, and its inclusive stigmas, perceptions and behavioural responses with it. On the contrary, their newly found surroundings may have local services to tackle mental health issues unavailable to them in their previous geography, but not the capacity to intervene effectively and with respect to their cultural needs. Whilst a plethora of organisations are active in Northern Ireland – from Building Communities Resource Centre (BCRC) in Coleraine to the Confederation of Community Groups in Newry – often the first point of contact for assistance on mental health issues is through a **local GP**. For many attending the workshops, GP engagement was a repeatedly raised issue. They highlighted the inadequacy of some GP Practices to tackle BAME issues in more rural areas and a need to introduce new structures and training

to empower BAME mental health interventions within these areas. For some service users, they felt that **GP surgeries** possessed a professional prejudice, and lacked the time and capacity to intervene effectively, to overcome language and cultural barriers, age-based and gender-based needs, and to call on translation services despite available funding and a resource pool to call upon. Local BAME empowerment groups also emphasised a need to increase collaboration and produce structures between them and local medical trusts to assist increasingly diversifying communities in their districts and create pathways that lead to the best method of intervention. This was accompanied by calls for expanding entry points into the mental health system, such as what organisations like CANS are doing in Belfast. Others cited better **signposting** to services as another solution.

An example of points of contact for **BAME** communities was raised by UNISON, whereby workers in factories outside of cities often approached their union representative with mental health issues, and in turn these representatives adopted the role of facilitating support for individuals, and often signposting them to other organisations. STEP in Dungannon also raised their efforts in entering factories and distributing supporting literature with managers and key workers to communicate to all colleagues. It is also important to note that it this isn't just a phenomena of unskilled/semi-skilled work environments, but also for digital industries and universities who have been increasingly active in creating supportive work environments, making services available through direct channels with HR representatives, and running workshops and cultural events with all colleagues.

> "From UNISONs perspective, we have a significant number of [BAME] worker members, so it is important for us to know where to refer people who have mental health issues or who would be interested in hearing about projects relevant to their communities." – *Nathalie Donnelly, UNISON*

Moreover, participants of the workshops emphasised the need to improve public compassion, trust, and community cohesion through cultural events such as **Eid**, the **Belfast Mela/ArtsEkta**, or **Pride Festivals** that celebrate an area's diversity whilst inviting people from all communities to join in and learn about particular groups and cultural practices. Whilst many of these groups might be hidden or gated, it helps create an air of inclusivity that can directly improve confidence and foster a sense of belonging in new surrounds. Such key annual events bring the foreign into the familiar for local residents and generate spaces of inclusion that double as spaces of engagement and

outreach for BAME groups and activists. Participants emphasised the need to introduce **Local Champions** to raise awareness of ethnic community needs and mental health concerns in their area, acting as a conduit of confidence between the local and the communities they serve. What is considered local to one individual possesses different challenges, configurations of services, priorities, and available resources to what another considers local. Such issues and factors manifest differently from place to place and host a web of relationships intrinsic to that area. Age and Youth can further complicate this relationship. Local mental health and community champions can make sure voices are heard and navigate local policy and stakeholder networks towards efficient decision making and collaboration. Whether this is on a funded or voluntary- basis will be to the discretion of available financial resources, the responsibilities disclosed for the position, and personal aspirations for their communities. A helping hand can take many forms.

An issue raised in some of the workshops, particularly Newry, was reports from local residents of anti-social behaviour, drug and alcohol abuse linked to some minority communities living in the area. Representatives of community groups voiced concerns over such incidents colouring local perceptions of BAME groups with broad strokes whilst others sought to empower police and neighbourhood watch organisations with assistance in outreach and dispelling incidents through clear communication in their native language and through local gatekeepers.

Of particular interest when raised during the workshops was how **digital platforms** were being used by the public, service users and service providers to discuss issues in their cities and accessing mental health support. Digital platforms and the internet in general adopt a number of roles for each of these stakeholder groups. For a service user, it becomes a first point of contact to reaching services available in Northern Ireland or exclusively online with confidence and privacy they might be denied elsewhere. Online counselling services or chatrooms may overcome the language or cultural barriers more effectively than services available locally – emphasising their importance to capacity building as places where we can extract fundamental lessons from. It is also an essential communication line to their families and friends abroad and to more familiar environs, where a comforting embrace may not be readily available in their new territories. In many cases, it can also be an important stream of income to survive. For a service provider, the digital world is an invaluable communication tool creating partnerships and collaborations with other active bodies in Northern Ireland and across the world. It is a place where we can keep a watchful eye on what's happening in our own communities, as well as educate ourselves with a plethora of indexed resources available at the

touch of a button. Whilst social media can help service users find services and maintain family networks and offer service providers an alternative access point to reach clients and create relationships with others – social media can be a negative influencer. For the wider public, social media can colour perceptions of ethnic communities, villainise behaviours and groups, report on anti-social behaviour, and propagate hate and prejudice on local and national scales.

This can contribute to further segregation and anxieties felt by BAME groups which directly contributes to avoidance of empowerment programs and services

available to meet their needs or tackle group-specific issues. As we discuss ideas of civic and community pride, of improving public compassion - what can we do to further translate this compassion and empathy into the digital world?

Whilst the digital world provides new opportunities for accessing help, the use of social media and targeted advertising can contribute to signposting.

In light of COVID19, a lot of therapies were moved from face-to-face to being conducted through digital channels such as Zoom to maintain as much of the personal experience as possible and keep up with therapeutic schedules and individual progress.

An interesting contribution from workshop participants to marry the local with BAME cultural experiences and challenges was the introduction or improvement of physical spaces that enable cultural expressions, intermixing and cohesion. Some attendees registered physical spaces in communities as successful when they conform with a sense of ownership and permanence, identify with the people and needs of the community, and also offer security and freedom in their cultural expressions. These spaces can host a myriad of activities for all communities in the areas, offer a sounding board and meeting place for new intercultural ideas, and also act as a place to gain advice or as a first point of contact for assistance. Architecturally speaking, they must be legible in the community – easy to define, easy to find, and accessible to all. However, referring to 2.1 and 2.2 – the longevity of these hubs requires sustainable funding, constructive relationships with local stakeholders, and offer a range of services.

Digital worlds became a key point raised in all workshops

2.4 - co-production & networking

working together to achieve and progress

Echoing the aforementioned themes, the concepts of co-design and co-production amongst networked stakeholders is crucial towards the provision of services for the BAME communities of Northern Ireland, focused funding streams, and more informed decision making. Calls for regulatory bodies, mental health champions, and resources are responses to the need for enhanced connectivity and alignment, and strategic co-design. Participants of the workshops who work at the community level emphasised a **communicative barrier** between them and government agencies, despite the community agencies working within their guidelines. Trusts enabled a bridge to be created to access support, but ultimately it was voiced that all agencies are working to their own priorities. A key question to pose for addressing this issue is **"what are other organisations doing?"** By answering this, we can better understand where opportunities for co-production exist and create solutions together.

When discussing the concept of **co-production** through the two research questions, participants voiced that whilst groups do communicate and collaborate, there is much more to be done both locally and nationally. Networks remain divided and insular. They discussed practices of signposting patients to other services who have better capacity, and highlighted that in some regions they would meet in specialised groups to discuss issues relating to their communities or to simply be amongst people who they share an identity and culture with. Aside from communication barriers, they also voiced a **lack of appropriately trained personnel**, **a lack of understanding particular cultures in some institutions**, **competition for resources**, and the need for regulation through forming an **intercultural group** that embodies the principles and vision for their communities in Northern Ireland. Through the formation of such a group, participants discussed the value of cultural sensitivity and competency and its contribution to wider decision making and co-designing documents with the government bodies, with other charities, and at the legislative level with the Executive. This approach would also develop more flexible and sustainable funding streams, minimise resource competition, and extend to all regions – both rural and urban – across Northern Ireland. Interestingly, it also was seen as a valuable platform for complaint by way of creating accountability amongst those engaging with BAME communities. Co-Production of services, and the co-designing of strategies and services,

thus embodies ideas of place, sustainability, cultural sensitivity, professional training, community experience, and knowing you are being heard. It also accentuates compliance to a regulatory body to ensure delivery of services is consistent and completed with respect and integrity.

Participants of the workshops unanimously agreed that the employment of mental health champions in communities and the need to incentivise trained bi-lingual counsellors was vital towards moving forward and better engaging BAME communities. Many of these communities are considered hidden or gated communities whereby traditional research approaches such as interviews or surveys may be very difficult to conduct due to the sceptical nature of the inhabitants or language barriers. Whilst a bi-lingual counsellor sensitive to the cultural nuances of these communities can help address their needs, they depend greatly on gatekeepers, community group leaders and other charities to build relationships between them and their respective communities and to gain local knowledge of disadvantaged groups and negative stimuli. We are then **"training one another"** through experience and compassion by working together as a participant reflected. Such stakeholder networks enable new dialogues on issues to be safely produced and give rise to more creative engagements at all geographical scales that invite hidden communities to become open and confident. By building up the capacity of active services to provide a wider range of interventions and meaningful assistance - BAME people of all ages, abilities and backgrounds affected by poor mental health and other negative stimulants in their communities should also be given the opportunity to self-refer with signposted organisations. This will help us overcome long waiting lists, limited referrals, and the bewildering administrative maze that can confuse or not

sufficiently support the patient in their journey. This reverberates the concept of community owned hubs and safe spaces as discussed in 2.3.

Moreover, the creation of new dialogues also extends to academia and how universities and other research institutes approach the concept of BAME mental health needs in Northern Ireland. Likewise to the trusts and government, academics and researchers exploring these issues should emphasise collaboration in their works at all stages. An example of empowering collaboration in academia includes the formation of **iRise** at Queen's University Belfast (the 2020 Northern Ireland Equality and Diversity Awards 'Best Race Initiative' prize-winner) which stands for "International focused, Racial diversity, Inclusivity for all, Social cohesion, and Equality of opportunity". The iRise group concentrates on BAME issues amongst international staff and the wider university community in developing more meaningful professional relationships and research trajectories. Racial disparities continue to remain the bane in the Higher Education sector, thereby challenging the very concept of an inclusive educational institution. Sounding boards and forums such as the above can influence others to embrace diversity and become more sensitive to wider issues impacting BAME people in any setting, academic or otherwise. Forums such as iRise allow for wider engagement with grassroots workers and collectively give rise to new narratives that can be escalated to higher levels of management and governance.

Evaluation

The themes in sectors 2.1 thru 2.4 can only broadly summarise the issues faced by service providers and service users in Northern Ireland. To describe how both service providers and service users navigate the current mental health infrastructures and policy would be akin to a labyrinth – different from place to place, person to person, and culture to culture. The unquestionable disparity in communication between organisations and government-level institutions, the barriers posed by the urban-rural divide, and difficulties around sustainable and long-term service provision only begin to paint a picture of the complexities and anxieties discussed in these workshops. Whilst we did stress a myriad of challenges and deficits, and a number of future research trajectories to inspire change, we must not forego the positive work, solidarity and strength of those working together for BAME communities, towards providing a better future for all regardless of ethnic or cultural background, and providing a helping hand to assuage their ailments safely and respectfully.

Their voices are the spirit of this document.

3 recommendations

12 recommendations deduced from the information provided by the helpful participants from the seven workshops

3 - recommendations

Echoing many of the components discussed in section 2, the research team presented **12 recommendations** deduced from the information collected during the workshops. The recommendations placed great emphasis on factors such as increased and empowered decision-making, greater flexibility of service and more training opportunities, highly networked stakeholders, the provision of key resources namely bi-lingual counsellors, better signposting and updated literature, and more flexible long-term funding opportunities and provisions for project work and collaboration.

These recommendations primarily highlight the deep frustrations of those active in the community sector and non-governmental institutions and charities - those with limited funding and scope to intervene in the communities they represent and care for. Despite being essential gateways and guardians for BAME community interests, many of these organisations wish to become more involved in the decision-making and strategic design that inform and anchor their diverse practices and aspire to enhance their own abilities to provide training, new services, treatments, and grow their network to collaborate with others across Northern Ireland. This was especially highlighted with regards to the provision of detailed and spatialised datasets for their communities and Northern Ireland – to better understand themselves, to provide further evidence of their work, and tailor their future interventions effectively. Upscaling the needs of BAME communities becomes critical for future interventions, particularly in a post-COVID scenario.

Without funding, without assistance, without guidance - these invaluable grassroots organisations and service providers face unsustainable pressures and instability especially in the changing post-Brexit landscape. This directly affects the health and wellbeing of those employed and the communities under their care through the loss of jobs and shared assets – which to some might be the only help they receive. This report is the first comprehensive overview on the status of BAME mental health providing specific parameters towards inclusive engagement with communities residing in Northern Ireland.

The report and its recommendations assist in the challenges of representing and foregrounding equality whilst providing congruence to the cultural backgrounds of BAME communities.

1. **Empower-decision making and community action** through greater public availability and diversification of current data sets and info packs.

2. Introduction of **cultural competency training** and greater provision of educational resources on BAME mental health needs across all sectors.

3. Empowerment of BAME mental health service providers to offer **Step Care 3 and 4 level interventions** to all clients.

4. **Wider stakeholder involvement** and **community participation** within the development of strategic documents and policy assets which affect them.

5. **Better communication** between community organisations and government bodies towards effective action in addressing all BAME needs.

6. Greater council and institutional involvement within affairs related to mental health needs, and the generation of committed **ring-fenced funding** and available resources for BAME communities in their respective areas and annual budgets.

7. More **bi-lingual and specifically trained counsellors** – incentivise more people to generate a larger and more accessible resource pool closing the urban-rural divide.

8. Greater investment into **enhancing safe spaces** and the **empowerment of community level services** across Northern Ireland to increase the effectiveness of their practices and opportunities to provide services.

9. **Sustainable, longer term, and highly flexible funding options** for organisations and programmes addressing mental health needs in Northern Ireland communities.

10. Curate and empower **BAME mental health champions** to promote good mental health and emotional wellbeing within their respective communities.

11. Greater availability of **materials signposting important services and offering self-care options** in many languages. More resources tackling stigma and isolation.

12. Generation of a **support platform and single regulatory body** for BAME support workers to use for funding, training, instruction, and care for their own mental health and emotional needs.

4

survey feedback

the results of 2 surveys, the workshop feedback survey, and the BAME mental health survey

4 - survey feedback

At the end of each workshop, participants were sent a link to a questionnaire. The questionnaire consisted of **9 questions** (see appendix 1 for full details) addressing usefulness, enjoyment, potential to stimulate conversation around BAME mental health needs, professional networking opportunities, and general room for improvements in future workshops or research projects. **50 surveys**

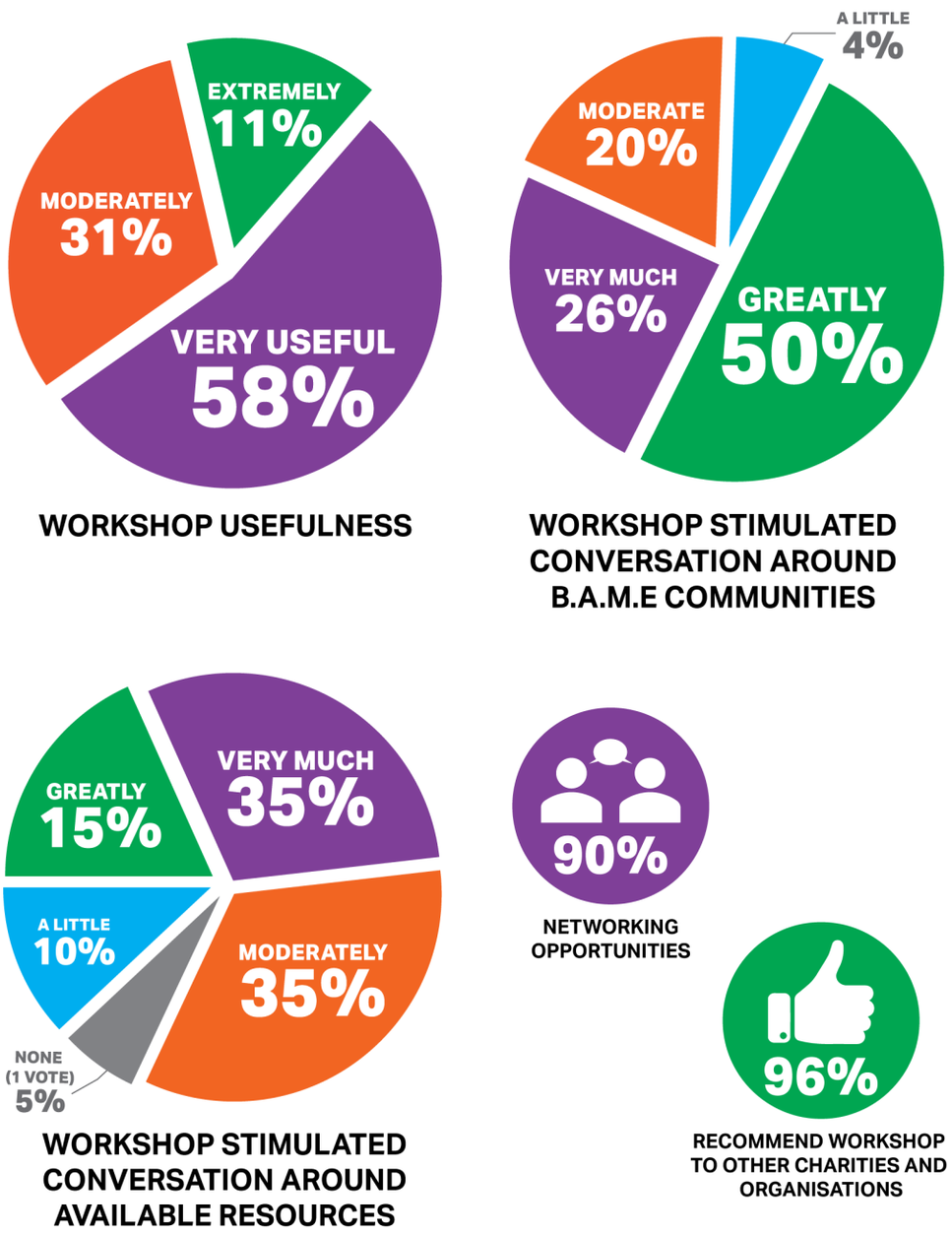


Figure 1: Visual summary of participant feedback on workshops

taken between May 2019 and September 2019 were returned in full by willing participants, and the data was summated into Figure 1. Upon evaluation of the statistics gathered, we found that 58% of participants found the workshop very useful, and a further 11% finding it extremely useful. Likewise, similar values were echoed with regard to the workshops' capacity to stimulate conversation around BAME communities, BAME mental health needs, and available resources – the main focus of the project. However, a significant statistic of 10% found the workshops stimulated little conversation on resources and a further 5% found no conversation occurred. Juxtaposing this figure with the 35% who found it to stimulate a moderate conversation on resources helped us identify that future workshops should bear heavier emphasis on resources and their importance to BAME mental health needs and interventions within the data collection phase. Resources and the impacts of uneven distribution or unequal access was a topic the report connected to many times within its introduction, sections 2.1 thru 2.4, and within the recommendations. The research team were also very pleased to hear that 90% gained networking opportunities which we hope those participants have fostered new connections to further their efforts across Northern Ireland, and 96% would recommend the workshop to a friend or colleague if it were to be repeated for a future research project.

> *"[I most enjoyed] The skilled, insightful and knowledgeable facilitation of discussions from the person leading the group I was sitting at. I learned a lot from him and from other attendees." – participant from Enniskillen*

Further analysis of feedback pertaining to what participants enjoyed most about the sessions included its informal approach to groups and themes; the opportunity to discuss issues at length and be heard; the opportunity to explore concepts of wellbeing in BAME communities; sharing experiences with other agencies and like-minded individuals; hearing different perspectives on topics such as culture and self-care; learning about the other organisations in their respective areas and those active across Northern Ireland; and the quality of the discussion initiated by and the insightfulness of the research team member presiding over each table.

> *"The focus of the workshops needs to be BAME individuals, not only organisations." – participant from Coleraine*

On the contrary, participants felt that some others were not being heard due to dominant voices and time restrictions; that future workshops should involve more service users and those who have experienced mental health interventions in Northern Ireland; more non-Caucasian practitioners; longer workshops; and a

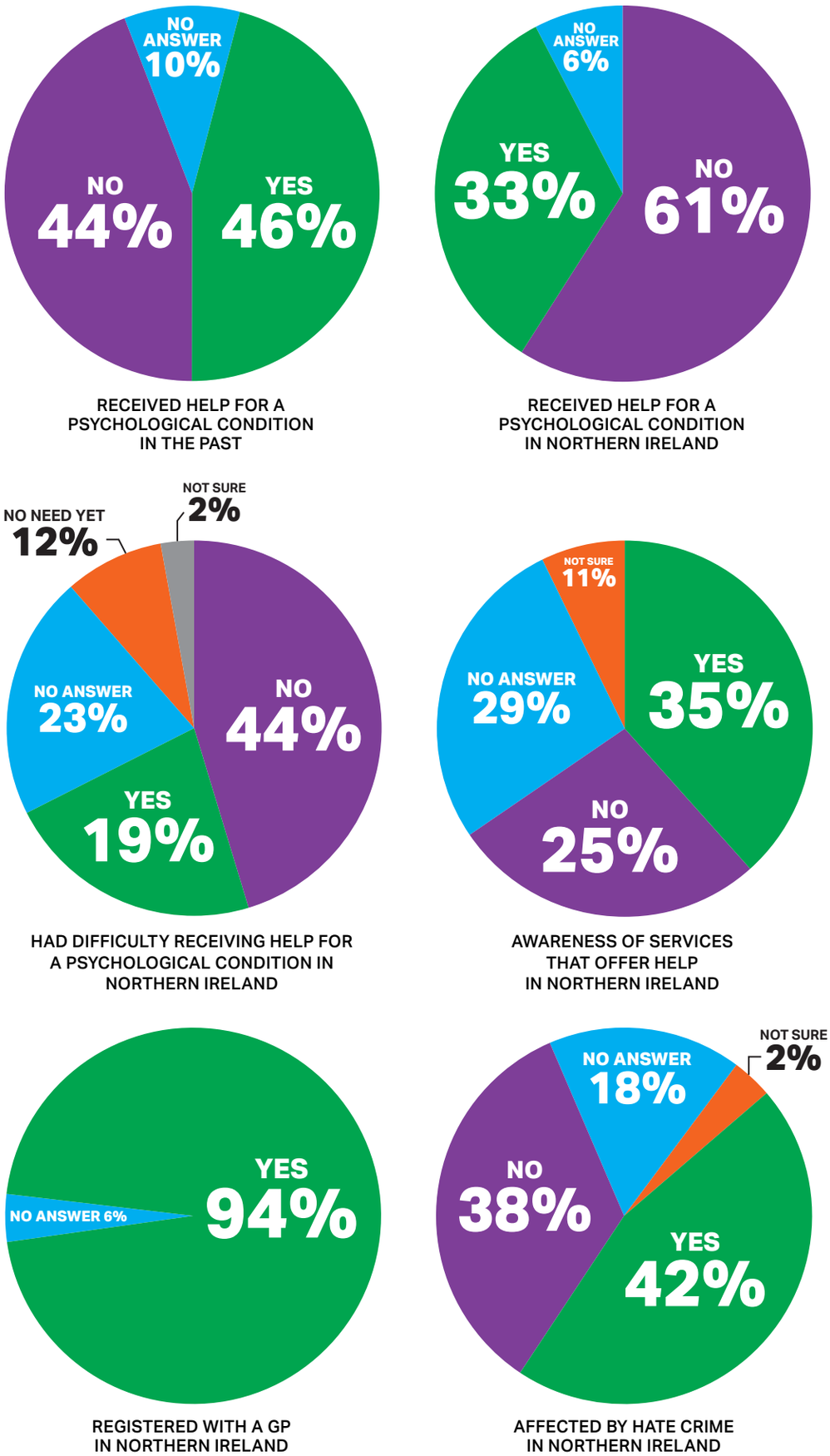


Figure A: Visual depiction of workshop survey results collected between May 2019 and September 2019

formal structure. A challenge which was stressed was improvements in attracting BAME service users to these workshops where the language barrier, work commitments, or feelings of vulnerability and insecurity may discourage them from attending and discussing their experiences. Moreover, a workshop of this nature will most likely be of greater interest to service providers than service users, of whom we did have a small group attend across the seven workshops. The need for more non-Caucasian service providers being mentioned in the improvements was greatly welcomed by the research team as it further supports our recommendation for mental health champions and bi-lingual and culturally competent service providers in Northern Ireland.

4.1 - Service User Questionnaire

To address the lack of service users attending the seven workshops, the research team developed a comprehensive survey targeting service users who sought assistance for their mental health at CANS in Belfast. The **31-question survey** (see appendix 2 for full details) engaged aspects of age, ethnicity, gender, country of origin, nationality, employment, registration to a Northern Ireland GP, languages, relationship status and dependents, educational attainments, sexual orientation, diagnosed (or inferred) and historic mental health ailments, encounters with racism and hate crime in Northern Ireland, and whether or not the individual had sought professional help in their country of origin or in Northern Ireland. The survey also asks whether the individual found it difficult to access help in Northern Ireland at any time during their residency, who would they generally talk to about mental health, and what does mental health and wellbeing mean to them personally.

45 surveys were returned in full to CANS. Demographically, the survey was predominantly answered by individuals aged 35-44 with other age groups (18-24; 45-54; and 55-64) also represented. The survey collected responses from a diverse range of nationalities including **Polish, Chinese, Iraqi Arabian, Nigerian, Indian, Irish, British, Lithuanian, South African, and Portuguese.** The majority of those surveyed were either married or single, with some being in domestic partnerships, separated or widowed. Many had dependents in the form of children and were engaged in full time or part time employment. Some had high school education, with other reaching to higher degree attainments (i.e. Masters degree). The majority identified as heterosexual with one identifying as bi-sexual. Interestingly, the survey was answered dominantly by females (<75%).

Our findings are summated in Figure A and B and detailed further in the imminent discussion. Figure A detailed that a 46% of survey participants had received help for a psychological condition in the past, with 33% of the cohort specifying that

they received that help in Northern Ireland. 67% responded NO to receiving help in Northern Ireland inferring they either had access to services back home or are yet to receive help in Northern Ireland via available pathways. 35% of respondents are aware of services that they can approach for mental health support, 11% said they were unsure, and 29% of answers were registered as 'No answer' which could be statistically significant to being unsure of services or to the 25% who registered an answer of no awareness of services in Northern Ireland – supporting the need for more legible pathways for mental health services assisting BAME communities. Moreover 44% said they had no difficulty accessing services where available whilst 19% said that they had experienced difficulty. 12% are yet to experience the Northern Ireland mental health infrastructure whilst 23% registered 'No answer' which can be interpreted as having no experience with the mental health system or services available to them. A staggering 94% were registered with a Northern Ireland GP in their community which the research team received as both reassuring and a strong indicator of what pathway is most legible to BAME communities. Finally, 42% of survey respondents registered Yes to experiencing **racism or hate crime** in Northern Ireland. 2% remained unsure which can indicate that racism can be multi-faceted, institutionalised, manifesting itself in a number of forms from hate speech to exclusion and microaggressions. 38% registered a NO answer and 18% didn't answer the question which can be interpreted as those surveyed haven't personally experienced hate crime at any time during their residency in Northern Ireland. The survey did not ask respondents what form of hate crime they had experienced, which can be a statistical territory to explore in future research if paired with larger datasets from the PSNI or NISRA.

With respect to Figure B, a range of mental illnesses were disclosed in the surveys. These were categories listed for selection. As these surveys were taken with the assistance of a mental health consultant or key worker, the reliability of answers provided would be considered greater and effectively categorised. The recorded ailments included conditions relating to **stress, relationship issues, work-related issues, Post Traumatic Stress Disorder [PTSD], Anxiety, Depression, Low Mood, Loneliness, Obsessive Compulsive Disorder [OCD], Suicidal Thoughts, Addiction, and symptoms associated with bereavements.** Analysing the collective results - 14% of respondents recorded no issues [2], whilst stress (21%), anxiety (14%), low mood (7%), relationship issues (10%), and work-related issues (9%) dominating the statistical feedback. Evidence of depression (5%), PTSD (5%), issues relating to bereavement (1%), loneliness (7%), OCD (1%), Addiction (2%) and suicidal thoughts (4%) were recorded amongst BAME respondents. Further differentiation of the data into male and female responses can support possible assumptions on the role of females and males in these communities.

2. This figure could have statistical significance towards exemplifying anxieties and distortions of narrative due to cultural barriers and newly formed therapeutic relationships.

Both male and females responded similarly to no recorded issues. Females responded slightly higher to conditions relating to stress (21%), Anxiety (15%), Addiction (2%), and Bereavement (1%). Men, in contrast, recorded higher statistics for relationship issues (14%), depression (9%), low mood (9%) alongside stress related issues (14%), anxiety (14%) and work-related issues (13%). Moreover, no males recorded indication of suicidal thoughts or issues linked to OCD and addiction unlike females (5%, 1% and 2% respectively) and females recorded no responses to PTSD unlike male respondents (4%). Men would often come to new territories alone for economic stability and hold a significant role as a breadwinner for BAME families contributing to high levels of stress and work-related issues, especially with regards to informal or casual work and new living arrangements. Females may commonly adopt a maternal role or have come to the country after their partners have consolidated their economic activities. Moreover, loneliness was recorded equal weighting between males and females. Whilst the majority of respondents were registered as married, isolation at home, reduced social cohesion and lack of social opportunities may serve to increase the prevalence of loneliness amongst BAME communities. Likewise, this may also correlate with levels of depression and low mood. Prevalent figures of stress and anxiety amongst females may correlate to recordings of relationship issues, which were disclosed more openly by males.

Whilst the statistical information above may provide an insight into BAME issues, it would require a larger statistical base and therefore opens opportunities for new research trajectories to explore issues relating to mental health ailments in respective communities residing in Northern Ireland. The above study was employed as a scoping device to understand issues affecting **BAME Service Users** who were not present during the workshops. The mechanisms and stimuli causing such issues would require a firm empirical base derived from interviews and other qualitative and interpersonal research methods.

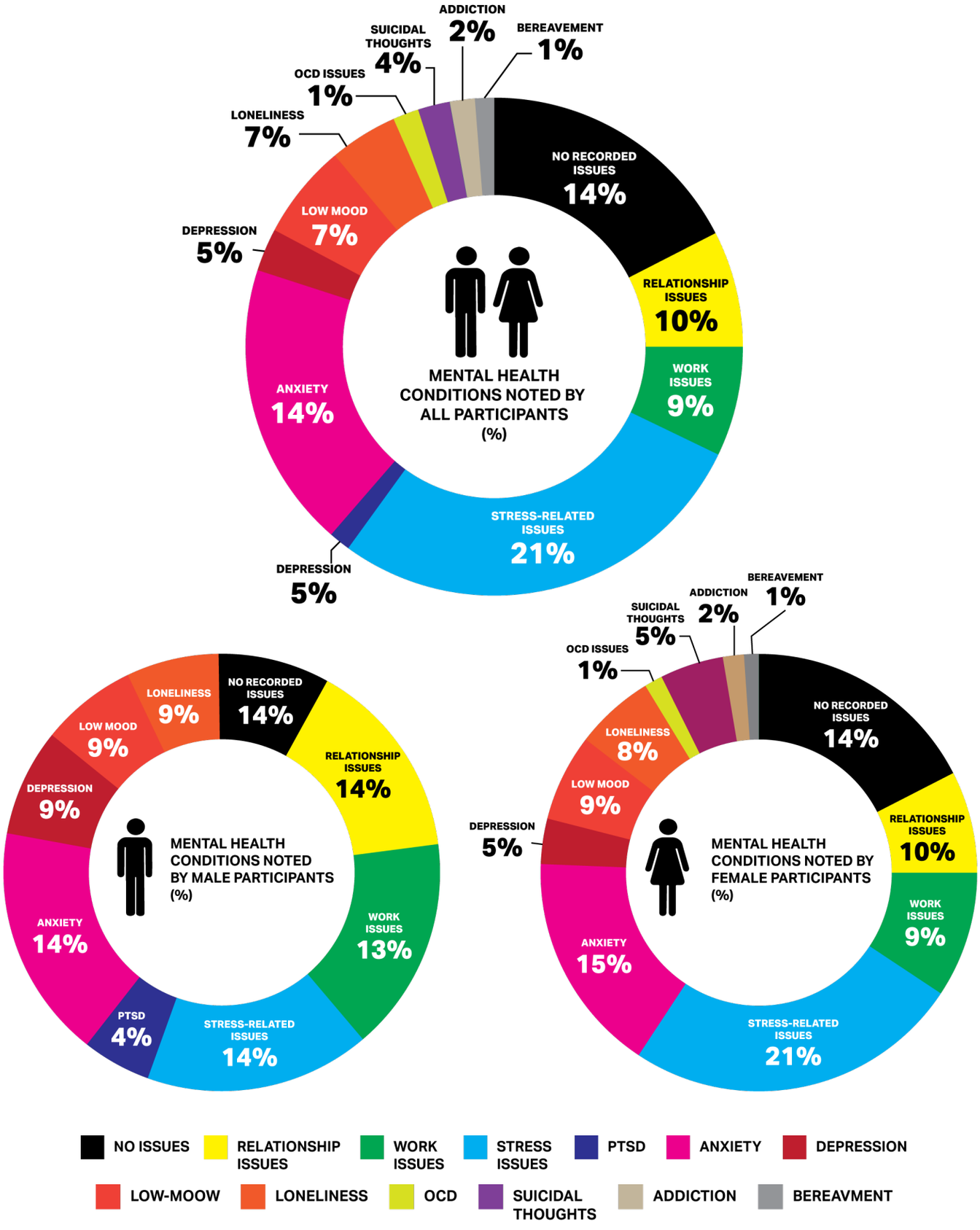


Figure B: Visual statistical depictions of BAME service user mental health and wellbeing survey results (late 2019) with gender differentials

5 - conclusive remarks

Northern Ireland is currently within a paradigm of increased recognition of parity of esteem, by way of valuing mental health equally with physical health (Royal College of Nursing, 2018), and wide-spread mental health awareness amongst its population. However, mental health cannot be generalised into a series of tick-boxes and non-specific frameworks. Within the literature obtained from wider academia and UK specific publications, there is still much to do to meet BAME (Black, Asian and Minority Ethnic) mental health needs and understand the role that culture and ethnicity plays in the recognition, understanding and treatment of conditions. Culture can distort mental health narratives where certain behaviours can have multiple meanings or stigmatise engagements with professionals. Age, Gender, Sexuality, Class, Religion and other intersectional components can further complicate mental health narratives. This creates two perspectives – that of the **Service User**, someone who is experiencing poor mental health, and that of the **Service Provider**, who can provide professional stepped care approaches and a myriad of interventions or signpost to other organisations.

Counselling All Nations Services and the research team conducted **seven workshops** across Northern Ireland between late-May and September 2019 networking numerous service providers and service users to explore mental health needs of BAME communities residing in their local areas. The seven workshops were conducted chronologically in **Dungannon, Derry-Londonderry, Coleraine, Belfast, Bangor, Enniskillen and Newry** and comprised of emergency services, local counselling services, politicians, academics, community leaders and a myriad of other bodies from various backgrounds and ethnicities. The workshops were also supported by local and national organisations and Queen's University Belfast. During each workshop, we posed participants with three open questions: **"Are we getting [BAME mental health needs] right", "How are we getting [BAME mental health needs] right"** and for **Recommendations** to move forward and progress together (see section 3 for details on the 12 presented recommendations). This document combined all of this information into a comprehensive narrative. Moreover, cataclysmic ongoing events of **COVID19 pandemic in 2020** and the interjection of **Black Lives Matter** movement emanating from USA to the UK and Europe, further empowered the narrative and its relevance in today's society.

Participants discussed at length, and with passionate eloquence, issues relating to connectivity and networking between organisations, communication barriers for service users and service providers, differences in urban and rural engagements with BAME needs, the concept of cultural competence and sensitivity in different

sectors and professions, the need for more adequate training and incentivised workforce retention, self-care for service users and providers, the provision of mental health champions, sustainable and ring-fenced funding, accessibility and signposted pathways to support in all communities, safe spaces and treatment areas, the challenges of **post-Brexit** landscapes, the co-production and co-design of strategies, and the importance of space (both physical and new digital spaces) in supporting interventions. From this fortuitus amount of information, the research team were able to deduce **4 key themes**. These include Building Capacity, Securing Service Provision, Place Matters, and Co-Production and Networking (see sections 2.1 thru 2.4). The themes collectively form the empirical basis of the document. The **12 recommendations** target empowered decision-making, enhanced and culturally sensitive training, greater government and council involvement, safe and community-managed spaces, sustainable and committed 'ring-fenced' funding, the provision of mental health champions, and the generation of a single regulatory body to instruct and distribute resources.

With reference to section 4 of this document, following each workshop a feedback form was sent to participants. However, we needed to further represent the voices of service users. By way of a targeted 31-question survey addressing the mental health of BAME participants, we found that whilst 94% of those surveyed have access to a GP, 65% were unsure of where they can access help within Northern Ireland, and 19% stated they had difficulty doing so. 42% have also experienced forms of hate crime. Furthermore, those who responded listed a myriad of ailments affecting them including **Depression, Anxiety, Stress, Suicidal Thoughts, PTSD, Addiction, Loneliness, and work and relationship issues**. Whilst the statistical pool was small (n=45), it provides us with an opportunity to expand our understanding of conditions and the negative stimuli affecting BAME communities in Northern Ireland based on qualitative and quantitative measurements.

Data was a key component explored in this document where it could provide a powerful array of information to any organisation, but much of the information still remains fragmented across organisations or is embargoed, which is highly problematic in devising a scientific approach towards policy formulations and away from conjectures.

To reprise an earlier statement - we do recommend that local government, services and organisations use this report to produce local-specific research trajectories and nurture collaborative relationships in order to better understand what they can do to empower BAME communities – not just in Northern Ireland, but wherever applicable to the readership.

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APPENDIX 1: WORKSHOP FEEDBACK SURVEY

CANS Hearing Our Needs: Workshop Feedback

1. **How useful was your session?**

Extremely useful *Somewhat useful*
Very useful *A Little*

2. **What did you enjoy most about the session?**

--

3. **Did this workshop help stimulate a conversation about BAME community mental health?**

A great deal *A lot* *A moderate amount* *A little* *None*

4. **Did the workshop enable a conversation about the needs and resources specific to your area?**

A great deal *A lot* *A moderate amount* *A Little* *None*

5. **Did this session provide professional networking opportunities between you and other organizations?**

Yes *No*

6. **Is 2-hours sufficient or should we schedule more time for future workshops?**

Yes *No*

7. **Would you recommend this workshop to other organizations?**

Yes *No*

8. **What could be improved?**

--

9. **What questions would you like us to ask in future?**

--

APPENDIX 2: BAME 'HELPING OUR NEEDS SURVEY'

CANS 'Helping Our Needs' Survey

For the benefit of the survey maker, please add translations under or next to the sentence or word. Thank you.

Original survey in English: https://www.surveymonkey.co.uk/r/canshelpingourneeds

1. **AGE**
2. **WHEN DID YOU COME TO NORTHERN IRELAND?**
3. **NORTHERN IRELAND POSTCODE**
4. **WHAT COUNTRY ARE YOU FROM?**
5. **WHAT IS YOUR NATIONALITY/CITIZENSHIP?**
6. **WHAT IS YOUR FIRST LANGUAGE?**
7. **WHAT IS YOUR ETHNICITY?**
8. **WHICH OF THE FOLLOWING BEST DESCRIBES YOUR CURRENT RELATIONSHIP STATUS?**

   MARRIED
   WIDOWED
   DIVORCED
   SEPARATED
   IN A DOMESTIC PARTNERSHIP OR CIVIL UNION
   SINGLE, BUT CO-HABITING WITH A SIGNIFICANT OTHER
   SINGLE, NEVER MARRIED

9. **DO YOU HAVE ANY DEPENDENTS? (SELECT ALL THAT APPLY)**

   NO DEPENDENTS
   CHILDREN
   PARENTS
   UNEMPLOYED PARTNER
   BROTHERS OR SISTERS
   OTHER RELATIVES (AUNTS, UNCLES, COUSINS)

1

10. EDUCATION

HIGH SCHOOL
COLLEGE
BACHELORS DEGREE
MASTERS DEGREE
DOCTORATE
OTHER (PLEASE SPECIFY)

11. WHAT IS YOUR GENDER?

FEMALE
MALE
NON-BINARY
TRANSGENDER
PREFER NOT TO SAY
OTHER (PLEASE SPECIFY)

12. WHAT IS YOUR SEXUAL ORIENTATION?

ASEXUAL
BISEXUAL
GAY
HETEROSECUAL OR STRAIGHT
LESBIAN
PANSEXUAL
QUEER
NONE OF THE ABOVE, PLEASE SPECIFY

13. ARE YOU EMPLOYED IN NORTHERN IRELAND?

FULL TIME
PART TIME
CASUAL
STUDENT
PROFESSIONAL
UNEMPLOYED
OTHER, PLEASE SPECIFY

14. DO YOU TRAVEL TO ANOTHER CITY FOR WORK?

YES
NO

15. IF YES, WHERE DO YOU TRAVEL TO WORK?

2

16. HAVE YOU SUFFERED FROM ANY OF THE FOLLOWING MENTAL HEALTH ISSUES? (SELECT ALL THAT APPLY)

NONE
RELATIONSHIP AND FAMILY ISSUES
WORK ISSUES
STRESS
PTSD
ANXIETY
DEPRESSION
LOW MOOD
LONELIENESS
OCD
SUICIDAL THOUGHTS
ADDICTION
OTHER, PLEASE SPECIFY

17. DID YOU GET PROFESSIONAL HELP FOR A MENTAL HEALTH ISSUE IN THE PAST?

YES
NO

18. DID IT HELP?

YES
NO

19. IF NO, WHY?

20. HAVE YOU GOT PROFESSIONAL HELP FOR A MENTAL HEALTH ISSUE WHILST IN NORTHERN IRELAND?

YES
NO

21. ARE YOU REGISTERED WITH A GP IN NORTHERN IRELAND?

YES
NO

22. DO YOU FIND IT DIFFICULT TO ACCESS MENTAL HEALTH SERVICES IN NORTHERN IRELAND?

YES
NO
OTHER (PLEASE SPECIFY)

3

23. IF YES, WHY DO YOU FIND IT DIFFICULT?

24. DO YOU KNOW WHAT MENTAL HEALTH SERVICES ARE AVAILABLE IN YOUR AREA? PLEASE TELL US IN THE BOX BELOW.

25. WHO DO YOU TALK TO ABOUT YOUR MENTAL HEALTH?

26. WHAT BROUGHT YOU TO THIS TOWN/CITY?

27. WHAT DO YOU LIKE ABOUT YOUR TOWN OR NEIGHBOURHOOD?
28. WHAT DO YOU NOT LIKE ABOUT YOUR TOWN OR NEIGHBOURHOOD?

29. HAVE YOU BEEN AFFECTED BY HATE CRIME OR DISCRIMINATION?

30. WHAT DOES MENTAL HEALTH AND EMOTIONAL WELLBEING MEAN TO YOU?

31. ANY QUESTIONS WE SHOULD BE ASKING ABOUT MENTAL HEALTH?

notes

participants

We would like to extend our gratitude to all participants, partners and service users who helped us make this project a reality. With your efforts and passionate contributions, we wouldn't have been able to produce such a comprehensive document. **Thank you!**

PUBLIC HEALTH AUTHORITY [PHA]
CHINESE WELFARE ASSOCIATION
STRONGER TOGETHER
BUILDING COMMUNITIES RESOURCE CENTRE [BCRC]
SOUTH TYRONE EMPOWERMENT PROGRAMME [STEP]
UNISON NI
CONFEDERATION OF COMMUNITY GROUPS NEWRY
POLICE SERVICE NORTHERN IRELAND
NORTHERN IRELAND AMBULANCE SERVICE
1+1 PROJECT
BELFAST COUNSELLING SERVICE
BELFAST RECOVERY COLLEGE
ATLAS LISBURN
AWARE NI
PIPS NORTHERN IRELAND
BARNARDOS NI
LIFELINE
VICTIM SUPPORT NI
NIACRO
BELFAST TRUST - COMMUNITY DEVELOPMENT
INSPIRE WELLBEING
CONNECT2COUNSELLING
ARDS AND NORTH DOWN BOROUGH COUNCIL
ALLIANCE PARTY NI
NORTHERN IRELAND HOUSING EXECUTIVE
QUEEN'S UNIVERSITY BELFAST
MIGRANT CENTRE NI
SAI PAK CCA
EDUCATION AUTHORITY
ASIAN OVER 50 CLUB, COLERAINE
CAUSEWAY MULTICULTURAL FORUM
ERNE DISTRICT CHINESE FAMILIES AND FRIENDS
WESTERN HEALTH AND SOCIAL CARE TRUST
ACTION ON HEARING LOSS
MINDWISE NI
AISLING CENTRE ENNISKILLEN
FERMANAGH AND OMAGH DISTRICT COUNCIL
BULGARIAN ASSOCIATION OF NORTHERN IRELAND
SOUTHERN HEALTH AND SOCIAL CARE TRUST
ETHNIC MINORITIES SPORTS ORGANISATION NI
USTAWI COUNSELLING SERVICES

notes

CANS

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DATA USE AND INTELLECTUAL PROPERTY

THIS PROJECT WAS PROUDLY ASSISTED BY THE FOLLOWING ORGANISATIONS:

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STEP SOUTH TYRONE EMPOWERMENT PROGRAMME
UNISON
ymca north down
Confederation of Community Groups Newry & District
BCRC Building Communities Resource Centre

REPORT DESIGN AND LAYOUT: STEVEN DONNELLY (2020)