

‘Walking this thin line’

Black and Minority Ethnic (BME) Experiences of Mental Health & Wellbeing in N. Ireland

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Abbreviations

ACSONI	African and Caribbean Support Northern Ireland
BCRC	Belfast Conflict Resolution Consortium
BHSCT	Belfast Health and Social Care Trust
BME	Black and Minority Ethnic
BNP	British National Party
CANS	Counselling All Nations Service
CWA	Chinese Welfare Association
DHSSPS	Department of Health, Social Services and Public Safety
EU	European Union
HSC	Health and Social Care
NHS	National Health Service
NHSCT	Northern Health and Social Care Trust
NI	Northern Ireland
NIAMH	Northern Ireland Association for Mental Health
NICEM	Northern Ireland Council for Ethnic Minorities
NIHE	Northern Ireland Housing Executive
NISRA	Northern Ireland Statistics and Research Agency
PSNI	Police Service Northern Ireland
SHSCT	Southern Health and Social Care Trust
STEP	South Tyrone Empowerment Programme
UK	United Kingdom
UKIP	United Kingdom Independence Party
WHO	World Health Organisation
WHST	Western Health and Social Care Trust

Executive Summary- Literature Review

Background

- The 2011 census indicated that 32,400 people in Northern Ireland (1.8% of the population) belonged to ethnic groups – more than double the proportion 10 years earlier, when the figure stood at 0.8% (NISRA, 2013).
 - Section 75 and Schedule 9 of the Northern Ireland Act (1998) stressed the need for public authorities to promote equality of opportunity, regardless of an individual's background (ICR, 2009). As a consequence, more evaluation of the lived experiences of BME communities is required; to better assess their current and future needs.
 - Mental health problems are among the most common forms of ill-health in the country and the cost of mental illness in the region has totalled nearly £3 billion (NIAMH, 2007).
 - Black and Minority Ethnic (BME) communities are generally considered to be at increased risk of poor mental health (Bhui and McKenzie, 2008; UK Department of Health, 2011; Fernando, 2012) and frequently have less confidence using available services (Rooney, 2013).
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Methodology

- In addition to a key word search and trawl of academic journal articles, chapters and books on the subject of mental health and minority ethnicity, the authors contacted a range of government departments, social health and care service providers and practitioners to seek out relevant materials and data – these included:
 - Action Mental Health NI, NICEM, Belfast Friendship Club, Family Trauma Centre, Welcome Organization, Embrace NI, NI Alternatives, Bryson Intercultural, Prison Service Headquarters, DHSSPS, Aware, CWA, NIAMH, BHSCT, WHSCT, NHSCT, SHSCT, ACSONI, Addiction NI, Stronger Together, STEP, CANS, BCRC, Newry Ethnic Community Support Centre and Northwest Migrants Forum and Mental Health Foundation.
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Challenges

- There are a number of challenges faced by individuals from BME communities and their families who require mental health care provision in Northern Ireland:

1. Language

- Effective communication in health care settings, between clinicians and service users, is a basic requirement for building trust to provide quality care (Carnvale et al, 2009).
- Over a third of BME respondents in Ballymena indicated that they would likely have problems accessing mental health care in the region in anticipation of 'language difficulties' (Rooney, 2013).
- Attempts by health care trusts to engage with BME groups have included: mapping minority languages, *In Other Words*; and the subsequent recruitment of 397 interpreters by the Belfast HSCT offering support in 33 languages (Holder, 2013).
- However, studies evaluating the usefulness of interpreters in mental health care settings throughout the UK have found mixed results (Kwong, 2011).
- Other problems existed with young people being asked to translate on behalf of older family members (Mind, 2009), or men interpreting on behalf of their partner (Jarman, 2009 and NICEM, 2011).
- Increasing the quality of options for individuals who have language difficulties needs to be better addressed, as the failure to do so could constitute indirect racial discrimination under the Race Relation Order (1997) (Belfast Health Development Unit, 2010.)
- An inconsistent approach by healthcare providers has meant few improvements in the quality of care experienced by BME individuals – despite a range of UK wide programmes and initiatives (Knifton, 2014).

2. Access to and quality of service

- Most initiatives that have been fully developed have focused on trying to achieve a deeper understanding of key cultural issues within the service by increasing the diversity of the workforce. However, this has yet to translate into significant representation of people from BME communities in management positions (Palinski et al, 2012).
- The health system in Northern Ireland is significantly underpinned by the role of GPs, who act as gatekeepers to additional services (Kouvonen et al, 2014). This can be confusing for migrants causing them to look elsewhere for advice. Problems connected to the GP registration system have also been identified (O'Rawe, 2004; Animate, 2005; Watt and McGaughey, 2006).
- Staff members elsewhere in the UK have conceded that they have experienced challenges in dealing with members of BME communities. Palinski et al (2012) indicated that some staff often felt powerless; overworked and inadequately trained to deal with the sensitive issues related to members of BME communities.
- The UK Department of Health (2011) conceded that pathways to service provision are unclear and therefore challenging for individuals of BME backgrounds to navigate.

3. Discrimination

- The NHS *Inside Outside* (2003) document indicates that in terms of service experience and the outcomes of interventions, BME service users fare much worse than people from the White ethnic majority.
- In addition to the trend of poor outcomes for BME users, there have been two high profile and seemingly consistent occurrences of institutional racism within mental health services in the UK: 1) The elevated rate at which 'schizophrenia' is identified in black people and 2) The significant number of black people who are compulsorily detained and medicated.
- A number of studies have demonstrated that discrimination that exists more generally in society can also have an impact on the way in which individuals from a BME background access services (Bell et al, 2004).
- Moreover, the Joint Commissioning Panel for Mental Health (2014) acknowledged that 'societal experiences of racism and discrimination' faced by many individuals from BME communities led to emotional and psychological problems.
- Individuals from a BME background working in the health service in Northern Ireland have also reported problems with discrimination and racism in the workplace (Betts and Hamilton, 2006). A number of studies have suggested that it is a long-term, widespread problem (Hainsworth, 1998).

4. Tradition and Cultural Practices

- Studies have suggested that discrimination can be attributed to a lack of staff training on key issues that impact on BME communities; producing in-effect an indirect form of discrimination largely caused by how different the approaches to mental health are according to cultural and religious background as well as practices from country of origin (Fernando, 2012).
- Knifton (2014) more broadly stressed it is important to acknowledge that some mental health illness categories are Western constructs which are as such not recognised in some other cultures.
- Service providers have often struggled to understand the cultural challenges of individuals choosing to acknowledge a mental health problem due to familial and cultural pressures (Cauce, 2002; Rooney, 2013; Palinski et al, 2012).
- It is also important for practitioners to understand that many within BME communities have different coping methods for mental health illnesses, and illness in general, via their distinct cultural and religious backgrounds. This ranges from focusing on collectivist healing and resilience methods over individualist healing as found in Western cultures (Hofmann et al, 2010).

5. Stigma

- Research in Ballymena, Northern Ireland, indicated that 53% of BME community members living in the area felt there was ‘a lot’ of stigma attached to mental health issues (Rooney, 2013).
- It is important for practitioners to understand the stigma that some BME service users could face in their culture for coming forward with a mental health issue. Corrigan and Penn (1999) explained that seeking mental health care support is often a ‘clandestine, shameful or secret activity.’
- Schomerus and Angermeyer (2008) stated that people with mental health problems frequently delay seeking help for fear of social consequences or judgements from services providers.
- This fear may be particularly acute for individuals from BME communities who, as well as experiencing significant individual pressure regarding their illness, are also influenced by the wider sense of shame on their family that mental illness can produce (Knifton, 2015).
- The stigma around mental illness is also a gendered issue with individuals surveyed indicating that they would be more sympathetic of a female seeking help than a man (Stickney et al, 2015).

6. Education

- Over half (51%) of the BME community members surveyed in Ballymena, Northern Ireland, indicated they did not know ‘who to go to or what kind of help is on offer’ (Rooney, 2013).
- Knifton (2014) suggested that previous UK wide initiatives have failed to reach or engage with BME communities due to a combination of issues – such as the use of unsuitable language, imagery and media.
- Watt and McGaughey (2006) also stated that health care staff were often unaware of the support structure available to them for dealing with individuals from a BME background –many staff members were not aware of the Regional Interpreting Service.

Future

- There are a number of measures which health care providers could consider implementing in order to better meet the needs of BME community members who interact with mental health services:

1. Training

- Race equality training cannot be restricted to a one off training event (Kwong, 2011) and it must be stressed to participants that migrant communities are not homogenous – and have different needs and characteristics both between and within groups (McAreavey, 2012).
- In this regard, Palinski et al (2012) suggested that public health and wellbeing agencies could consider working together with religious institutions to identify where and how religion and spirituality could provide support in patient care.
- Another step could be the coordination of professional health services with community groups in BME areas in order to expand the awareness of available services in these communities and increase their general sense of accessibility (Lee and Turney, 2012).

2. Understanding the current context of migration

- In the past, migrant communities were simplistically considered as either permanent or temporary - now modern migration would be more accurately defined as 'fluid'.
- Research has suggested that when individuals from a BME community live in a high concentration of people from the same background this has a positive impact on mental wellbeing due to the presence of a stronger support network (Pickett and Wilkinson, 2008).
- *Mind* (2009) stressed that service providers need to understand that the social context of the UK in general terms can be institutionalized racism and discrimination which creates an unwelcoming environment for refugees and asylum-seekers due largely to their negative portrayal in the media and in recent UK election campaigns. This type of political and social pressure can make individuals from a BME background anxious about approaching service providers in the UK for personal matters.
- Understanding the current context of migration appears particularly significant in Northern Ireland, as it is a society that has traditionally been defined by the two distinct Protestant and Catholic communities.
- *Mind* confirmed that the social environment that new migrants find themselves in has a considerable impact on their mental health. Migrants are often placed in deprived housing estates with significant social problems and little previous diversity.

3. Sensitive consideration of the Pressures of Migration

- The Joint Commissioning Panel for Mental Health (2014) felt that there were several factors that likely led to members of the BME community having high rates of poor

mental health and wellbeing throughout the UK – the increased likelihood that they would be in poverty, suffer higher levels of unemployment and obtain poor educational outcomes in comparison with the general population.

- For a wide number of BME patients, their mental health disorders are closely correlated to ‘exposure and proximity to pre-migration and post-migration traumatising events’ (Fenta et al, 2004) including ‘family absence and acculturation’ (Myers et al, 2005).
- In the particular case of Northern Ireland, McAreavey (2012) indicated that society has struggled to create conditions that would be ‘conducive to migrants’ positive adjustment’ exacerbated by disagreement over what model of ‘integration’ should be applied (Canoy et al, 2006). Some migrant groups here have endured significant and consistent aspects of racism-despite an internal sense that racism is not a problem in the country (Farrell and Watt, 2001).
- The Belfast Health and Social Care Trust (2011) indicate that mental health is one of the key health issues affecting the Polish community- the largest ethnic minority group in Northern Ireland. The report suggested that Polish migrants may be at higher risk of depression, substance abuse and suicide than other migrant groups.
- Irish Travellers are another migrant community of concern. Risk factors include; a feeling that their distinctive culture and nomadic tradition is being threatened (ni Shuinear, 1994), experiences of low social status and exclusion (Helleiner, 2000), the disintegration of family ties, problems with finding work, a decline in religious certainty and belief, the restrictions of a close-knit community, and significant alcohol abuse (WHO, 2008).

4. Greater representation of BME communities in the health care system

- One of the most effective ways to increase the level of understanding that exists of mental health issues within BME communities is to create an ethnically diverse health service.
- Other research has indicated that in addition to trying to achieve greater equality in the workforce, it should also be considered how BME service users can better contribute to the design and delivery of mental health interventions (NHS *Inside Outside*, 2003).

5. Better use of Statistics

- Better use of statistics connected to mental health related deaths in BME communities is important, as it may encourage those not already receiving care to come forward (Rooney, 2013).

- The disturbing number of suicides in some parts of Northern Ireland needs to be sensitively highlighted.
- The UK Department of Health (2011) stated that better record-keeping of care experiences is required to demonstrate the level of positive outcomes that people from a BME background have had.
- Bhui et al (2003) explained that further research is required to assess if ethnic groups access mental health care services differently, with greater attention given to differences in place of birth, religion, duration of residence in the UK, place and level of education and cultural identity.

6. Perceptive Use of Advertising

- It has been suggested that the perceptive use of advertising would better inform BME communities of the services that are available to them (Rooney, 2013).
- Knifton (2014) suggested that service users have long requested 'a new model for national campaigns that placed greater emphasis on community development, cultural events, positive contact and dialogue with families, faith leaders and youth groups.'
- More effective advertising, underpinned by the better use of statistics, could also seek to overcome a number of the fears and stigmas mentioned elsewhere in this review (UK Department of Health, 2011).

Literature Review

Background

Health care provision is a complex and progressive social justice issue facing policy makers, practitioners and service providers in Northern Ireland. This includes honouring the needs of those whose mental health and well-being may be fragile. As a result of changing demographics, migration and social isolation directly related to their minority, faith, ethnicity and nation status in Northern Ireland, there are those from some communities who may be vulnerable and require more tailored mental health support.

Between July 2000 and June 2010, an estimated 122,000 international long-term residents arrived in Northern Ireland, while 97,000 left (Russell, 2012). In 2000, the majority of people arriving in the region were either workers from Portugal, from India and the Philippines (Russell, 2012). Following the expansion of the European Union (EU) in May 2004, the country experienced the largest proportional increase of migrant workers in the UK (McAreevey, 2012) and Ireland (Russell, 2012) – there was a significant increase in the A8 stock population, which rose from 30,000 in 2007 to 39,000 in 2009 (Russell, 2012). However, in the year up to June 2010 the number of people leaving the country was largely the same as those who arrived. Moreover, between July 2010 and June 2011 almost 3,200 more people left Northern Ireland than came to the country (21,700 arrived, 24,900 left) (Embrace NI, 2014). The last Northern Ireland Census (2011) indicates that 32,400 people (1.8% of the population) currently belong to minority ethnic groups (more than double the proportion 10 years earlier, when the figure stood at 0.8%) (Northern Ireland Statistics and Research Agency, NISRA, 2013). Despite these considerable developments and significant pre-existing Black and Minority Ethnic (BME) communities, including Travellers, limited research has been conducted to consider the lived experiences of these individuals – with little assessment of their mental health needs as they attempt to contribute to civic society, find support networks and access services (exceptions to this within the Irish context include Watt and McGaughey, 2006; Fanning, 2007; Mac Einri, 2007; Radford, 2010). In broad terms there are significant risks of failing to comprehensively estimate the needs of the changing demographic of the country, as there are social and economic implications. There is a significant responsibility on the Northern Ireland Executive to better assess the needs of the increasing number of migrant groups residing in the country – Section 75 and Schedule 9 of the Northern Ireland Act (1998) stress the need for public authorities to promote equality of opportunity, regardless of an individual's background (Institute for Conflict Research, 2009). As a consequence, more evaluation of the lived experiences of BME communities is required; to better assess their current and future needs.

Several studies (Leaman et al., 2006; UK Department of Health, 2007) have emphasized the responsibility the range of relevant public authorities has in relation to the increasing diversity that now exists in Northern Ireland. The pressing need to more effectively recognise the mental health challenges faced by individuals from a BME background in the region is highlighted by the significant number of people from the general population who experience problems with ill mental health – mental health problems are among the most common forms of ill-health in the country and the total cost of mental illness has reached nearly £3billion (Northern Ireland

Association for Mental Health, NIAMH, 2007). Given that BME communities are generally considered to be at increased risk of poor mental health (Bhui and McKenzie, 2008; UK Department of Health, 2011; Fernando, 2012) and frequently have less confidence using available services (Rooney, 2013), it is clear that more evaluation of the mental health needs of individuals from BME communities is required. Moreover, the contested nature of the region can specifically pose challenges for individuals with mental health problems trying to assimilate into the country – new migrants may feel immediately emotionally and socially displaced in a the housing in city centres is often deeply segregated along binary sectarian lines. Those from both new and more established minority communities may be equally challenged when living in rural areas that are generally homogenous with little previous diversity. It also seems important for health care services to try and more effectively understand the distinct needs of different migrant groups that now reside in the region, as many new residents often hold culturally embedded attitudes and expectations about mental health challenges and treatment, which may be considerably different from the settled population (Kouvonen et al, 2014). Furthermore, the loss of direct, everyday support from networks of family, friends and colleagues needs to be carefully understood, as it is often destabilising for new migrants. Negative coping mechanisms in terms of the misuse of alcohol and other substance abuse including prescribed medication and non-prescribed drugs and pharmaceuticals can exacerbate poor mental health, as can a lack of empathetic and emotional engagement by those providing aid (Radford, 2010).

It is necessary at this point of the review to reference the fact that a wide number of migrants in Northern Ireland report generally good standards of mental health, most likely because the vast majority are young (Embrace NI, 2014). Nevertheless, this report will demonstrate that the increased risk of mental health problems, often caused by complications related to the way an individual may have left their home country and entered Northern Ireland, needs to be more effectively considered, with relevant services and support networks being further developed.

Mental health service provision can cover a range of needs, treatments and psycho-social support mechanisms provided both within community and in institutional settings. For the purposes of this report we will consider the needs of those seeking out support for:

- Addiction and substance abuse, including eating disorders
- Social isolation, loneliness and depression
- Anxieties and phobias
- Psychosis
- Dementia and other geriatric-related degenerative diseases.

Patterns of mental health and disease are profoundly bound to genetic, cultural, socio-economic and environmental factors within religion and religious expectations (Radford, 2007 and 2010). Underlying mental health conditions can often be impacted by the quality of life lived. General ill health and the way it is treated may be one component, which exacerbates or acts as a trigger. As a consequence, mental health often requires specialised models of care with complex interventions. This review will first assess some of the challenges that emerge when individuals from a BME background attempt to engage with these services in Northern Ireland. Having established some of the difficulties that exist within the system, the review will then explore how the delivery of relevant services can be improved.

Methodology

In addition to a key word search and trawl of academic journal articles, chapters and books on the subject of mental health and minority ethnicity, the authors contacted a range of government departments, social health and care service providers and practitioners to seek out relevant materials and data – these included: Action Mental Health NI, Northern Ireland Council for Ethnic Minorities (NICEM), Belfast Friendship Club, Family Trauma Centre, Welcome Organization, Embrace NI, NI Alternatives, Bryson Intercultural, Prison Service Headquarters, Department of Health, Social Services and Public Safety (DHSSPS), Aware, Chinese Welfare Association (CWA), NIAMH, Belfast Health and Social Care Trust (BHSCT), Western Health and Social Care Trust (WHSCT), Northern Health and Social Care Trust (NHSCT), Southern Health and Social Care Trust (SHSCT), African and Caribbean Support Northern Ireland (ACSONI), Addiction NI, Stronger Together, South Tyrone Empowerment Programme (STEP), Counselling All Nations Service (CANS), Belfast Conflict Resolution Consortium (BCRC), Newry Ethnic Community Support Centre and Northwest Migrants Forum and Mental Health Foundation.

The authors would like to express their gratitude to those organizations that contributed information for this review, but the paucity of available data was both a challenge and telling of the need for an increased discourse and literature on the issue of the mental health and wellbeing of those from black and minority ethnic communities and faiths.

Challenges

In broad terms there are a number of challenges faced by individuals from BME communities and their families who require mental health provision in Northern Ireland. These challenges can create an additional sense of stress and isolation for BME individuals struggling with existing or emerging mental health problems. This particular review will explore six key issues that emphasize this sense of isolation: 1) language, 2) access to and quality service, 3) discrimination, 4) tradition and cultural practices, 5) stigma and 6) local knowledge.

1. Language

One of the most significant and recurring barriers that BME community members perceive in trying to access mental health services, is language (Watt and McGaughey, 2006). For instance, research in Ballymena, Northern Ireland, found that over a third of BME respondents indicated that they would likely have problems accessing mental health care in the region as they expected to have 'language difficulties' (Rooney, 2013). In their research with Polish migrants in Northern Ireland, Kouvonen et al (2014) state that many participants with mental health problems felt 'voiceless' – this communication deficit and related inability to get help led some of them to return to Poland or to visit Polish internet sites for help with mental health issues. Research elsewhere also confirms the challenges associated with language in the mental health care environment – Carnvale et al (2009) note that effective communication in mental health care settings, between clinicians and service users, is a basic requirement for providing quality care and trust building (poor communication undermines the relationship between a patient and clinician and can create tension in the sessions between the two). Kaplan (2004) also observes that it is natural for service users to be more comfortable speaking in their first language – using a second language in interviewing or counselling may result in emotional

repression for the patient and could risk the clinician making an inaccurate assessment (The Centre for Social Justice, 2011). As one consultant describes in Radford (2010): “Your diagnosis is in the history 90% of the times, and if you can’t take a good history, then it’s like trying to do a jigsaw with a third of the pieces.”

After the significant rise in migration to Northern Ireland in 2004, many migrants chose to reside in Dungannon, Newry and Mourne, Craigavon and Belfast – which placed extra pressure and responsibility on the statutory services in these areas (Russell, 2012). The relevant health care Trusts have attempted to engage with these groups and meet their needs in different ways – a mapping report, *In Other Words*, has provided details on the different languages used in the areas (Holder, 2003). In association with this mapping exercise, BHSCT has recruited 397 interpreters and offers support in 33 languages (Aware, 2014) – the most requested languages have been Polish (over 50%), Lithuanian, Chinese and Portuguese. There have been 350,000 requests for such services by patients (Aware, 2014), but studies that have evaluated the usefulness of interpreters in mental health care settings throughout the UK have found mixed results – some patients from a BME background have indicated that they have felt comforted and supported by the inclusion of an interpreter in their care, while others have suggested that they were uneasy explaining their problem to someone without a medical background (Kwong, 2011). Also, some individuals who have previously used interpreters were not totally confident that the interpreter had effectively relayed everything they had said, as the interpreter may have been embarrassed by a sensitive matter, or may not have been completely clear with what the patient or professional were attempting to discuss (Searlight and Searlight, 2009). Other studies (Mind, 2009) also reference the trans-generational impact on the mental health and well-being of young people that have been asked to translate on behalf of older family members who are suffering from mental ill-health – a process which the Belfast Trust and other Trusts have tried to avoid due to its inappropriateness, but can still occur where there is a lack of resources. There are also issues related to men interpreting on behalf of their partner, especially problematic in cases related to domestic abuse and sexual health (NICEM, 2011).

Increasing the general quality of options open to individuals who have language difficulties needs to be urgently addressed in Northern Ireland, as the failure to do so could constitute indirect racial discrimination under the Race Relation Order (1997) (Belfast Health Development Unit, 2010).

2. Access to and Quality Service

A number of studies have found that service users elsewhere have also reported problems with the quality of mental health services they experienced, which are not limited to language. Knifton (2014) notes that despite the range of UK wide programmes and initiatives directed at increasing the quality of service delivered to BME community members, there have been few improvements in the quality of care experienced by these groups. Knifton explains that this lack of improvement can be attributed to the inconsistent approach taken by health care providers, as there is often a sporadic focus on trying to improve services delivered to BME communities before a new priority emerges.

Most initiatives that have been fully developed have focused on achieving greater diversity throughout the health care workforce (to try and create a deeper understanding of key cultural

issues within the service). However Palinksi et al (2012) contend that this has yet to translate into significant representation of people from BME communities in management positions – the *Migrant Voice* (2010) newsletter indicates that there is only one Polish speaking psychologist in the whole of Northern Ireland, for a community estimated to include 25-30,000 people. Other research warns that the desire to increase diversity should not be reduced to mere tokenism as this could, theoretically, reinforce or even exacerbate the negative experiences that some BME users have encountered (Fernando, 2012).

Currently DHSSPS does not hold statistics in relation to how many people from a BME background work or in their mental health services or access said services, though some health care Trusts collect voluntary Equal Opportunities information, which includes ethnicity. DHSSPS does not have direct access to this data, but information can be provided by individual Trusts – in January 2015, BHSCT indicated that 4% of their staff were from a BME background, 80% were ‘white’ and the ethnicity of 16% of the staff was ‘unknown’ (BHSCT, 2015). Also, the Western Trust (2015) show that 64% of their staff are ‘white’, 0.6% are from an Indian background, 0.3% are Filipino and 0.1% are Pakistani. The Western Trust states that the ethnicity of 35% of their staff is ‘unknown’, though this is not completely uncommon as research elsewhere suggests that many people from BME communities tend not to share much information about their background (WHSCCT, 2015) – frequently due to a distrust of statutory services and general fear it could lead to intimidation (Betts and Hamilton, 2006).

The challenge for creating better quality care and clearer pathways to care seems crucial in Northern Ireland, as several studies (O’Reilly and Stevenson, 2003; O’Rawe, 2003) indicate that, in general, people in Northern Ireland may be at greater risk of developing mental health problems than those in other parts of the UK. O’Reilly and Stevenson suggest the higher risk of mental ill-health can be largely attributed to the ‘Troubles’ – though more research is needed in this field to confirm whether the increased risk is associated with the violence that existed in this period, or other aspects of the era (e.g. segregation, tension, deprivation, and increased security presence). Additional research might explore what impact the post-conflict environment of the country (where tensions and segregation remain) has had on the mental health of migrants, who in some circumstances (and particularly in the case of some seeking asylum and refugee status) are seeking to escape from a country currently in conflict.

Kouvonen et al (2014) point out that further research assessing ‘quality of service’ needs to recognise the health system in Northern Ireland is significantly underpinned by the role of GPs who act as ‘gatekeepers’ to additional services. They indicate that this may be confusing for some migrants and frequently causes them to look elsewhere for support (e.g. on-line medical advice, services in their home country). Other research (O’Rawe, 2004) indicated that a small number of migrants have been refused treatment by GPs, as they explained that they had reached their perceived ‘quota’ – such an outcome may well explain why Bell et al (2009) state that 20% of migrants felt that they did not receive the same type of treatment as NI nationals. In addition, a number of migrants have been unable to register with a GP, as they did not have a National Insurance Number (Animate, 2005). Furthermore, some individuals from BME backgrounds have stated that they were ‘caught out’ by GPs de-registering them after two years, even if their visas had been renewed (Watt and McGaughey, 2006).

Some research has found that staff members elsewhere in the UK have conceded they have experienced challenges in meeting the needs of individuals from BME groups – Palinski et al (2012) indicate that some staff often felt powerless; overworked and inadequately trained to deal with the sensitive issues they felt they would face from different individuals of BME backgrounds. Dumper et al (2007) also state that some mental health professionals have indicated a sense of anxiety about working with refugees and asylum seekers, as they do not feel equipped with the necessary skills and experience to deal with the particularly sensitive issues related to the impact of torture, forced marriages and female genital mutilation. Moreover, the Joint Commissioning Panel for Mental Health (2014) suggested there is a concern that the health care service continues to view BME service users as ‘hard to reach’ – which might theoretically risk a sense of ‘blame’ being placed on BME groups for not taking ownership of their own health care. The Department of Health UK (2011) conceded that BME groups may be ‘hard to reach’, but the blame is largely on the system, rather than service users – as the pathways to service provision are often challenging for the groups to navigate. The department referenced an important distinction in regard the perceived ‘fear’ individuals from a BME background have of mental health care services in the UK – they note that although individuals from a BME background often have a ‘fear’ of discussing their mental ill-health with clinicians, they are also significantly concerned about the different barriers they feel they would have to deal with to access such services. They also point out that BME service users often express a lack of confidence in their ability to understand the associated bureaucracy, which they felt could be frequently intimidating and overly complicated. In addition, the pathways for people to come forward are often further undermined by additional health problems – 20-25% of people in Northern Ireland who have a mental health problem also report having a learning disability (DHSSPS, 2006).²

The mental care needs of migrants in the prison system in Northern Ireland is another matter that needs careful consideration, as they can frequently suffer depression and express thoughts about suicide (Embrace NI, 2014). As a consequence of the increased number of foreign nationals living in Northern Ireland the rate of those being convicted has proportionally increased – in 2012 there were 113 foreign nationals in custody in Northern Ireland. The situation for these individuals can be complex, as they often have little knowledge of their rights, while there can also be significant delays in deportation (that can create lengthy waits in detention services). In 2010, Justice Minister, David Ford expressed regret regarding the suicide of an unnamed man who had been a ‘vulnerable prisoner’, with the added challenge of having little or no English (Embrace NI, 2014).

3. Discrimination

One of the most serious concerns expressed by many BME community members when reflecting on their experiences of mental health care is in relation to the perceived sense of discrimination they feel resides within the greater community and the health system itself. Mckee (2015) has found in a recent analysis that there has been an intense increase of radically motivated incidents and crimes of a racist nature towards ethnic minorities in Northern Ireland. A range of

studies has also confirmed that discrimination does exist throughout mental health care services in the UK in a number of different ways. For instance, in basic terms related to outcomes, the NHS *Inside Outside* (2003) document indicated that there does not appear to be any area of mental health care in the UK where BME groups fare as well as, or better than, the majority White community. The *Inside Outside* document found that in terms of service experience and the outcome of interventions, BME service users fare much worse than people from the ethnic majority.

Several studies have also confirmed that BME communities generally tend to experience less favourable outcomes in their mental health care experiences than the majority culture. Corrigan et al (2003) conducted a multistate study in the United States of 1,824 individuals with serious mental health problems – 53% reported problems with discrimination (the most frequent sources of reported discrimination being mental disability and race, with 65.6% of the Black participants, 52.5% of the Latino participants and 60% of the Asian participants reporting problems with racial discrimination). In the UK, Bhui and McKenzie (2008) state that suicide rates in England and Wales were higher among Black African (2.5 times) and Black Caribbean (2.9 times) men aged 13–24, and among Black African (3.2), Black Caribbean (2.7) and South Asian (2.8) women aged 25–39 than among their White British counterparts. Also, Kirkbride and Jones (2008) indicate that the risk of psychosis in Black Caribbean groups is nearly seven times higher than in the White population. Basnal et al. (2014) found that ethnic minority groups living in Scotland have the highest number of hospitalisations for psychosis and compulsory treatment. In the UK Department for Health's statistics from 2008-09 the Black and Black British group accessed mental health care more than any other grouping – they had an average access rate of 3,454 per 100,000 population (these figures were 17.1% higher than the rate for all ethnic groups) (Department of Health, 2011). McKenzie (2006) states that in both the UK and USA there are clear and 'unequivocal differences in the receipt of mental health care on the grounds of race. These differences lead to poorer outcomes than could be expected in some ethnic groups, with higher rates of re-hospitalization and use of coercion.'

A number of studies have found that in addition to the trend of poor outcomes for BME users, there have been two high profile and seemingly consistent occurrences of institutional racism within mental health services in the UK (Department of Health, 2011; Fernando, 2012): first, the elevated rate at which 'schizophrenia' is identified in black people and second, the significant number of black people who are compulsory detained and medicated. Between 2005 and 2008, the *UK Count Me In Census* found that inpatients from the Black Caribbean, Black African and Other Black groups were more likely to be detained under the Mental Health Act than inpatients from any other grouping. Data from the 2008 Census indicated that 53.9% of the Black and Black British group who were inpatients during the year had spent a compulsory detained period in hospital, compared to 31.8% overall. Furthermore, despite a decrease (3%) in the general number of people spending time as inpatients, the rate of the Black and Black British group increased by 5.3% (Health Care Commission, 2008).

The range of poor outcomes experienced by individuals from BME backgrounds will likely have ramifications on the way in which different migrant groups throughout the UK view mental health services. Lee and Turney (2012) state that perceived discrimination can be as harmful as actual discrimination – given that it is 'consistently and positively associated with mental health

across a vast array of cross-sectional and longitudinal data, that has been linked to multiple mental health outcomes' (including depressive symptoms, psychological distress, anxiety and psychiatric disorders). Furthermore, the Joint Commissioning Panel for Mental Health (2014) suggests even the experience of a small number of individuals feeling discriminated against in the health care system can have a sizeable impact, as other people hearing about such negative experiences may be less likely to come forward with future concerns – this is particularly significant when the service fails to advertise the fact that they have made internal efforts to resolve complaints and concerns.

A number of studies have demonstrated that experience of discrimination exists in other parts of society might also have an impact on the way in which individuals from a BME background are willing to access statutory services (Bell et al, 2004). Palinski et al (2012) show that several participants from a BME background in their research explained that previous coercive experiences, relating to police arrests and other forms of institutional violence would reduce their willingness to use mental health care services. Moreover, the Joint Commissioning Panel for Mental Health (2014) acknowledged that 'societal experiences of racism and discrimination' faced by many individuals from BME communities led to emotional and psychological problems. The impact for individuals from BME backgrounds might be even more severe in rural areas of Northern Ireland – where there is generally limited multiculturalism and less obvious access to support services (McAreavey, 2012). Furthermore, some BME groups have reported a greater sense of social discrimination than others in the region – the Traveller community frequently report problems in accessing social accommodation (3 out of 4 people from a Traveller background reported this), being served in shops and bars (7 out of 10 noted this) and finding work (6 out of 10 reported this) (All Ireland Traveller Health Study, 2010).

Individuals from a BME background working in the health service in Northern Ireland have also reported problems with discrimination and racism (Betts and Hamilton, 2006) – with some research (Hainsworth, 1998) indicating that it is a long-term, widespread problem. Betts and Hamilton found that 46% of their participants had experienced racism in the workplace (though not necessarily in the previous 12 months). Most staff (70%) had lived in Northern Ireland for 1 to 5 years and those from Arabic descent were the most likely to experience problems (70%). A similar study by Lemos and Crane (2001) explored the nature and extent of racism within the NHS throughout England in 2000 – they found that racial harassment of both staff and patients was a significant problem (46% of respondents working in all areas of health care had experienced racism in the workplace in the previous 12 months, 38% had witnessed racism, front line staff were 1.5 times more likely to have suffered harassment and Chinese staff members were the group that experienced the highest levels of harassment). In both studies (Lemos and Crane; Betts and Hamilton), participants stated that they were most likely to face harassment from other colleagues (50% in Northern Ireland and 33% in England), followed by patients (47% in Northern Ireland and 29% in England). Betts and Hamilton found that common to both studies was the under-reporting of incidents (the main reason for this was the fear of provoking reprisals).

4. Tradition and Cultural Practices

Clearly some service users and providers have experienced different forms of discrimination during their use of mental health care provision. As the users suffer different forms of discrimination it is natural to assume that there are different reasons for such experiences. Some studies have suggested that discrimination can be attributed to a lack of staff training on key issues that impact on BME communities, which is often manifested in a lack of knowledge of BME traditions and cultural practices. Fernando (2012) indicates that this is in-effect, an indirect form of discrimination largely caused by how different the approaches to mental health are in western and eastern traditions: 'there is a more significant focus on individualism within western cultures, while other traditions often emphasize balance, harmony and stability, as opposed to individual autonomy, efficiency and self-esteem.' Knifton (2014) more broadly found it important to acknowledge that some mental health illness categories are western constructs – for instance, some minority cultures may not define distress as an illness. The cultural variances can be difficult to distinguish for practitioners, leading to BME users often feeling as though western health care is inaccessible or insensitive.

Other studies have also suggested that service providers have often struggled to understand the cultural challenges of individuals choosing to acknowledge a mental health problem (Cauce, 2002). For instance, individuals from some BME backgrounds may prefer to seek the help of their family for issues related to mental health, rather than getting professional care – previous research in Ballymena, Northern Ireland, found that 13% of BME respondents would be prevented from getting professional help for a drug or alcohol problem because they stated that their culture would encourage them to get help from a family member (Rooney, 2013). Also, some individuals from a BME background have often indicated that their culture would not find it acceptable for an individual to talk with someone from the opposite sex about a sensitive personal matter (Palinski et al, 2012).

A number of research studies have stated that it is important for practitioners to understand that many people within BME communities have different coping methods for mental health illnesses, and illness in general, via their distinct cultural backgrounds. Loewenthal and Taylor (2001) state that BME groups tend to show much more reliance on religious coping when experiencing emotional problems. The authors suggest that health care practitioners need to more thoughtfully consider whether supporting these coping strategies may 'improve resilience and promote recovery, especially if conventional psychiatric interventions are perceived to be unattractive or culturally unacceptable.' Hofmann et al (2010) also indicate that it is important for clinicians to understand that spiritual interpretations of mental health problems can play an important role in successful treatment outcomes.

There are obvious variations in how different individuals from BME backgrounds use spirituality as a means of coping with mental health problems, but some research has also indicated that when individuals from BME communities are unable to maintain their regular religious routines this can create feelings of 'anger, aggression and loss of control' (Bhui et al, 2008). In addition, migrant groups frequently accept mental health problems in different ways, Bhui et al demonstrate that Bangladeshi Muslims tend to accept moments of distress and are clear in their belief that religious practice is their most effective source of support. While Bhui et al also

indicate that African Caribbean subjects were likely to use religious coping more flexibly in a manner that assisted them in making important decisions. Furthermore, the study suggests that Indian and Pakistani participants were 'practiced at not making their distress into a problem.'

Other studies have also revealed a close correlation between mental health and religious beliefs – the World Health Organization (WHO) (2006) suggest that spirituality, religion and personal beliefs were highly correlated with psychological and social domains and overall quality of life (in a study of 5087 individuals from 18 countries). Some research (Koenig et al, 2001) has also indicated that many people with mental illness have emphasized the support they found in their spirituality in dealing with the issue in recovery. However, a 2007 online debate in the British Medical Journal highlights that no medical school in the UK or Ireland teaches spiritual history (Stammers 2007). Furthermore, to date, there have not been any studies that have considered the value placed on the Orthodox or other Christian churches as a coping strategy for those from Eastern Europe and in particularly post-Soviet states, where the overt faith based practice has increased.

5. Stigma

In addition to the significance of understanding the various cultural approaches to mental health issues, it is also important for practitioners to understand the stigma that some service users could face in their culture for coming forward with a mental health issue. Corrigan and Penn (1999) explain that seeking mental health care support is often a 'clandestine, shameful or secret activity.' Research in Ballymena, Northern Ireland, indicated that 53% of BME community members living in the area felt there was 'a lot' of stigma attached to mental health issues (Rooney, 2013). Kouvonen et al (2014) also state that several Polish migrants in Northern Ireland would be unlikely to come forward with a mental health problem, as they felt it could become a source of gossip (due to the small size of their community). As a consequence of such perceived pressure, Schomerus and Angermeyer (2008) explain that people with mental health problems frequently delay seeking help for fear of social consequences. Knifton (2014) suggests that while people from BME communities with mental health problems feel significant individual pressure regarding their illness, the wider sense of shame on their family can also be influential. Furthermore, Stickney et al (2015) note that such stigma is also often connected to the gender of the individual seeking mental health support – with the individuals they surveyed indicating that they would be more sympathetic of a female experiencing problems with mental health seeking help, than a male.

6. Local Knowledge

Over half (51%) of the BME community members surveyed in Ballymena, Northern Ireland, stated they did not know 'who to go to or what kind of help is on offer' (Rooney, 2013), if they had a mental health problem. Knifton (2014) suggests that this sense of disconnect could be caused by the failure of previous UK wide initiatives to connect with 'hard to reach' communities – largely due to the use of unsuitable language, imagery and media.

Watt and McGaughey (2006) also reveal that health care staff were often unaware of the support structures available to them for dealing with individuals from a BME background – they indicate that many staff members were not aware of the Regional Interpreting Service.

Future

A wide range of academic literature and policy reports have indicated that there are a number of measures which health care providers could consider implementing in order to better meet the needs of BME community members who interact with mental health services – this review will consider six possible key interventions: a) cultural awareness training, b) clearer understanding of the current context of migration, c) sensitive consideration of the pressures of migration, d) greater representation of BME communities in the health care system, e) better use of statistics and f) perceptive use of advertising.

1. Cultural awareness training

A number of studies demonstrate the importance of high quality, mandatory and robust cultural awareness training (Aware, 2014). Kwong (2011) suggests that while several training initiatives have been set up in the past to try and combat examples of racism within the health care environment, they often tend to cover broader inequality training. Moreover, Kwong stresses that race equality training cannot be restricted to a one off training event, delivered within a generic framework. In addition, within the cultural awareness training sessions it must be stressed to participants that migrant communities are not homogenous (McAreevey, 2012) – different ethnic groups have different needs and it is important that service providers appreciate these variances and avoid treating all migrants as a single group. It should also be recognised that there are differences in relation to the economic and professional characteristics of migrants within their own groupings and further divergences in the way in which family members adjust to a new country (with young people often adapting most easily).

Aware (2014) stress the need for the health system to more effectively understand the needs of BME communities, as it is important to appreciate the cultural background of a patient before that respective individual can be appropriately treated. Aware note that it is important for staff to develop an understanding of a patient’s cultural perspectives – including their ethnicity, place of origin, education, religion, values and social status. In this regard, Palinkski et al (2012) suggest that public health and wellbeing agencies could consider working together with religious institutions to identify where and how religion and spirituality could provide support in patient care. Also, a wide body of research has stressed the need for health care professionals to try and better coordinate their services with community groups in BME areas – to expand the awareness of available services in these communities and increase their general sense of accessibility (Lee and Turney, 2012). This patient-centred approach could be guided by the work of Kleinman (1988) who suggested that it was important to understand the differences in the domains of professional care and informal networks within which patients often participate.

2. Clearer understanding of the current context of migration

Through training and wider interaction with BME communities, it is important that service providers and clinicians develop a clearer understating of the current context of migration. In the past, migrant communities were simplistically considered as either ‘permanent’ or ‘temporary’, now modern migration would be more accurately defined as ‘fluid’. Circular migration and the existence of transnational communities are now a feature of modern society

(McAreavey, 2012). Watt and McGaughey (2006) also note that the current form of migration appears different for two reasons – first, the speed of immigration is much more rapid than ever before; second, most migrants over the last 10 years are coming from countries where there has been little previous migration to the UK and Ireland. It is important that clinicians understand these current forms of migration, as it could theoretically be relevant to an individual's treatment – with many migrants maintaining regular contact with their families in their country of origin via rapidly improving telecommunication links, which could be utilised as a possible support network.

It is also vital that clinicians understand the community environment within which individuals from a BME background currently reside, as research (Pickett and Wilkinson, 2008) suggests that when individuals from a BME community live in a high concentration of people from a similar background they tend to be healthier. Living in a higher density of people from the same culture could offer individuals with mental health problems a strong support network (however research in Belfast suggests that there are no distinct ethnic residential areas in the city – Jarman and Byrne, 2007). Other research (McAreavey, 2012) indicates that it must be accepted that some individuals from a BME background will go back to their home country for treatment. However, Kouvonen et al (2014) highlight the problems when migrants do decide to go back to their home country for health care, as they can receive conflicting advice between the regions and neither health care system is likely to share patient records.³

Mind (2009) point out service providers need to understand that the social context of the UK in general terms can be unwelcoming for refugees and asylum-seekers, largely due to the often negative media coverage associated with these individuals. Moreover, Mind indicate that the way in which immigration has been discussed in recent election campaigns in the UK is also unhelpful, as the numerous positive contributions made by migrants to civic society are rarely referenced – with the political far right, instead, emphasising the increased pressures placed on services by the UK's increasing population. Some politicians, as well as lobby groups like Migration Watch UK, contest the notion that Britain is a 'global traffic station for migrant workers', with some political parties (UK Independence Party, UKIP, and British National Party, BNP) supporting the need for 'zero net migration' and 'voluntary repatriation' (McVeigh, 2008). Mind note that this type of political and social pressure can make individuals from a BME anxious about approaching service providers in the UK for personal matters. Again, refugee community groups might find this issue particularly challenging – for instance, some refugees have reported that the asylum process often appears arbitrary, with people living in high levels of fear and stress that they could be detained and deported at any time.

Understanding the current context of migration appears particularly significant in Northern Ireland, as it is a society that has traditionally been defined by two distinct blocs of Protestant and Catholic communities. Ream (2003) states that increasing diversity can create tension, particularly in areas where there is already on-going conflict over territory and in rural areas that have been traditionally homogenous. While Mind (2009) confirm that the social environment that new migrants find themselves in has a considerable impact on their mental health – the organisation suggested that the fact that migrants are often placed in deprived

housing estates can be very damaging. These areas tend to be traditionally homogenous with significant social problems and little previous diversity – meaning that integration can be complicated. Mind note that although more care is generally taken in housing migrants with physical disabilities, little care is taken in deciding where individuals with mental health problems are located.

3. Sensitive consideration of the pressures of migration

Equally as significant as understanding the context of migration in broad terms, is the need for sensitive consideration of the pressures of migration for individuals. The Joint Commissioning Panel for Mental Health (2014) felt that there were several factors that likely led to members of the BME community having high rates of poor mental health and wellbeing throughout the UK – this included the increased likelihood that they would be in poverty, suffer higher levels of unemployment and obtain poorer educational outcomes (in comparison with the general population). Furthermore, Fenta et al (2004) indicate that a wide number of BME patients have found that their disorders have been closely correlated to ‘exposure and proximity to pre-migration and post-migration traumatising events.’ Myers et al (2005) also found that ‘migration trauma, along with life events, such as family absence and acculturation’, can have a significant impact on an individual’s mental health. In the particular case of Northern Ireland, McAreavey (2012) indicates that society has struggled to create conditions that would be ‘conducive to migrants’ positive adjustment’. A number of government reports and policy documents frequently reference the need for ‘integration’, but there is a practical problem in establishing what integration is in real terms, as there are a range of models – some of which cannot easily be transposed (Canoy et al, 2006). Several studies have attempted to explain how the process of integration can be made more safe and reassuring (Amin, 2008; Rogers and Muir, 2007) – Martynowicz and Jarman (2008) suggest there is a general consensus that new migrants should feel part of the country they live in, rather than simply being regarded as migrant workers.

Rolston and Shannon (2002) note that determining how best to deal with immigration has been a significant long-term problem in both the North and South of Ireland: poorly conceived relevant policies, such as dispersing asylum seekers that arrived in Dublin to Kerry and Donegal, have demonstrated the inability of the region to effectively create the environment for positive assimilation. Some migrant groups in the North and South of the island have also endured significant and consistent aspects of racism – despite an internal sense that racism is not a substantial problem in the country (Farrell and Watt, 2001). In 2011, 20 Romanian families left their homes in Belfast after a prolonged sequence of abuse (Belfast Health Development Unit, 2010). There are also examples of long-term settled BME groups struggling with aspects of racism – Rolston and Shannon point out that the Chinese community in Belfast are often sporadically targeted for abuse and harassment, despite their recognised status in the area. In total, there were nearly 1000 incidents of racist abuse in 2008 alone; when the figures for such incidents were first recorded in 1996 there were only 41 reports (PSNI, 2008). The PSNI found in the 12 months up to June 2014, racist incidents rose by 36%, from 830 to 1,132. In the same period, racist crimes increased by 51%, from 525 to 796. In May 2014, the PSNI introduced a

dedicated phone line for racist hate crime, due to increased concerns about such incidents – two months later a Ku Klux Klan flag was seen flying in Belfast (PSNI, 2014). Northern Ireland has struggled so much with issues of racism that it led to the country being branded the ‘race-hate capital’ of Europe in 2006 (Knox, 2011). Hainsworth (1998) points out that while most people in the country may prefer to blame racist incidents on the mindless minority, he suggests that there has often been a concerning range of language used by local political representatives in Northern Ireland, who credited migrant groups for ‘keeping their heads down’ and ‘not bothering anyone’. Hainsworth states that the irony and mistake of such thinking should be considered in equal measure – as Northern Ireland has always had a sizeable range of minorities who have effectively contributed to the development of the country in many ways that lie outside the broad vision of the two-tradition society.

Currently the largest ethnic minority group in Northern Ireland is the Polish community, with 19,000 Census 2011 respondents stating that Poland was their country of birth (NISRA, 2013) – indications of the growing Polish population in Northern Ireland are demonstrated by the range of support groups, social networks, and shops and bars selling Polish products. The Belfast Health and Social Care Trust (2011) state that mental health is one of the key health issues affecting the group – the Trust indicate that Polish migrants may be at higher risk of depression, substance abuse and suicide than other migrant groups. A number of studies have also suggested the Polish community could be at increased risk of depression, due to a heavy intake of alcohol (Lakasing and Mirza, 2009; *Migrant Voice*, 2010). Gapapich (2010) states that the Polish community was likely to consume alcohol in a significantly more ‘aggressive’ and ‘destructive’ manner than other migrant groups. Further research (Kouvonen et al, 2014) has stated that although most Polish migrants in Northern Ireland have now lived in the country for five to ten years they are still trying to put down roots in Northern Ireland, and yet at the same time, there is a realization that they are unlikely to return to Poland – in this sense they face a double form of separation, as they are physically separated from their family in their home country and do not yet have strong social networks in Northern Ireland to rely on for emotional support. Kouvonen et al suggest that this often leads to feelings of social isolation and ‘non-belonging’, which can create unusually high levels of self-reliance (that may place a large strain on the relationships of migrant couples, as they frequently struggle to combine irregular working patterns with parental duties). They also explain that the Polish participants in their research indicated that working well below one’s occupational and professional qualifications was a key source of frustration, particularly when their current work involved working in dirty and unpleasant environments. Furthermore, the Polish community are over-represented in the industries most significantly impacted by the economic downturn, with many men affected by the shortage of work in the construction sector. Kouvonen et al indicate that as a consequence of the economic climate and general quality of jobs, the Polish community experience a substantial level of ‘job insecurity’. Research in 2009 indicated that 20% of Polish people in Northern Ireland were unemployed (three times the national average) – despite this, the uptake of Job Seekers Allowance was low (with many individuals suggesting that the welfare system is too complicated to navigate) (Belfast Health Development Unit, 2010). McVeigh and McAfee (2009) state that about 50% of respondents to his research indicated that they were concerned about their job security, due to the increased number of temporary contracts in Northern Ireland. Furthermore, national wage regulations do not apply to agency workers whose

contracts were created by agencies outside UK jurisdictions and for some migrants their employment conditions are below UK standard, which breaches equality and employment law, health and safety legislation (NICEM, 2011). However, most of the Polish research participants involved in the various studies in Northern Ireland (Kouvonen et al, 2014; McVeigh, 2009) have explained that the lack of work prospects in Poland and their family situation in Northern Ireland (children settled in schools) means they are unlikely to leave the country. In an effort to deal with the significant challenges Polish people appear to face in the region, the Polish Association has provided counselling services to support those struggling with different personal and social challenges (Belfast Health Development Unit, 2010).

Irish Travellers are another key migrant group in Northern Ireland, having been part of Irish society for centuries. The community has its own traditions and values, which have made them an identifiable group, both to themselves and others (including service providers) (All Ireland Traveller Health Study, 2010). Public Health Agency (2012) research indicates that the largest proportion of Travellers in Northern Ireland reside in Belfast (22%), followed by Dungannon (17%), Craigavon (12%), and Derry (11%). Just over half of the Traveller families live in a house or flat, nearly one quarter (24%) live in a trailer/mobile home or caravan, with a further 21% living in serviced sites. Most of the community who live in houses or flats are generally living in social accommodation provided by the Northern Ireland Housing Executive (NIHE) and other associations – the Public Health Agency note that the impact of living in settled accommodation/standard housing can be a complicated experience, as it isolates individuals from other family members and friends. Moreover, the general sense of separateness associated with the group can also have mental health implications, as they frequently feel their distinctive culture and nomadic tradition is being threatened (Ni Shuinear, 1994). In addition, the group experience of low social status and exclusion can have a significant mental health impact, as they frequently face hostility from the main population (Helleiner, 2000).

The All Ireland Traveller Health Study (2010) raised concern about the high rate of premature mortality in young male travellers – indicating the significant rate of suicides and accident related deaths in the community. The study pointed to a number of potential risk factors that exist in the community – which include the disintegration of family ties (in a community where family is traditionally significant), problems with finding work (NIHE, 2008, found 85% of the community to be ‘economically inactive’) and the decline of religious certainty and belief. Also, where the close-knit community environment does exist it can be restricting (despite obvious advantages) – there can be little personal space for people to consider their emotions and a general level of pressure to take part in group activities. Moreover, significant alcohol use and low self-esteem are considerable problems in the Traveller community (and recognised triggers for mental health illness). The potential impact of these different issues on the mental health of those within the Traveller community is complicated by over one quarter (26.3%) of the group feeling they have less opportunities for accessing mental health care than any other BME group in Northern Ireland (All Ireland Traveller Health Study, 2010).

Several studies have noted the importance of developing a well-informed and flexible health system to best meet the needs of different BME groups (especially as many new migrants in Northern Ireland do not plan on staying permanently – Jarman and Byrne, 2007). As mentioned elsewhere in this review, Palinkski et al (2012) explain that a key aspect of moving toward a

more comprehensive service is for the need by health care providers to understand that not all migrant groups are homogenous. It is also crucial that unique mental health care challenges facing different age groups within these communities are better considered: specifically young people and older people, whose needs are often overlooked in mental health care generally.

The Children and Young People's Mental Health Coalition (2014) found that there is an absence of successful early interventions for young people with mental health problems from BME backgrounds throughout the UK, and several studies (Malek, 2011; Olivia and Lavis, 2013) indicate there is a basic lack of data to supervise the development of future interventions – even though the National Children's Bureau (NI) (2010) state a significant proportion of young people from a BME background have encountered racism at school, on public transport and in public spaces. The Children's Bureau also reveal that migrant children often explained that they were dealing with some type of loss and general sense of isolation (this was most prevalent amongst asylum seekers – who were regularly affected by their parent's physiological problems).

A number of studies have found that young people from a range of BME backgrounds have demonstrated a high incidence of mental health problems – including mental illness (such as depression) and behavioural problems (such as bed wetting and nightmares) (Geraghty et al, 2010). Furthermore, experience of trauma in asylum seeker and refugee children appears to increase the risk of mental illness in later life (such as depression and post-traumatic stress disorders). Morley and Street (2014) point to the urgent need for additional research in this area, given the increasingly complex and demanding society within which young migrants live – which can lead to identity issues, poor self-esteem, feelings of isolation and experiences of racism. The significant need for Northern Ireland to better consider the need of young people from BME backgrounds is emphasized by the high rates of mental health problems found in general amongst young people in the country – the Northern Ireland Health and Social Well-Being Survey (2001) reveals that 21% of all those aged 16 and over in Northern Ireland demonstrated aspects of potential mental health problems. Furthermore, two thirds of children in care in Craigavon and Banbridge, between the ages of 11-16, had diagnosable mental illnesses (Teggart and Menary, 2005).

Research (McCracken et al, 1997) has also suggested that older people from BME backgrounds with mental health problems living in the UK have faced challenges during their experiences of interacting with key services – as many individuals felt as though they could be discriminated against on the basis of age, gender and language. Rait et al (1996) indicate that older people from BME backgrounds are at increased risk of mental illness and other poor health outcomes, as they frequently face a 'triple whammy' of disadvantage – age, ethnicity and socio-economic deprivation.

Other studies have suggested that mental health care services should also be more aware of some of the difficult challenges facing women from a BME background who are experiencing mental health problems. Whilst migration can create challenges for everyone, women are frequently more seriously affected – they often have a lower cultural status than men (in particular women from the Indian subcontinent, of Chinese origin and Roma Romanians), they are more likely to let males in their family make decisions, suffer domestic abuse and they are less likely than males to be in employment (Belfast Health Development Unit, 2010). Latif (2014)

indicates that migrant women could face multiple challenges in integrating into their host society – as women, as workers and as foreigners. The study notes that these pressures can be further emphasized by many women arriving in a new country alone, having been separated from their family. Latif also reflects on the significant need to ensure that female refugees and asylum seekers are aware of the mental health care facilities that exist in the UK, given that these women likely fled from gender specific forms of persecution, such as: sexual violence, marital rape, domestic violence, female genital mutilation, forced abortion or sterilisation. In addition, the British Medical Association (2002) have stressed the need for greater consideration of the needs of pregnant women from a BME background in Northern Ireland, as they tend to have a lower uptake of antenatal care in the Belfast Trust and are often unfamiliar with relevant services that are available. The Community Child Health Service (2008) also indicate that postnatal depression is a significant problem amongst women from a BME background in the Belfast Trust. Furthermore, while Latif acknowledges the fact that a limited, but valuable evidence base related to African women with maternal mental related illnesses has been established in the UK (Edge et al, 2004; Edge and Rogers, 2005; Edge, 2007), much more work is needed to consider the needs and experiences of women who have arrived from Eastern Europe.

Mind (2009) rightly note that it should be stressed that not all refugees will develop mental health problems, nor should they be viewed as helpless victims (the turbulent way in which many have arrived in the UK is an indication of their strength and resilience), but where people from a BME background do need mental health support there should be clear pathways for them to follow and more sensitive consideration of their experiences and needs.

4. Greater representation of BME communities in the health care system

As mentioned elsewhere in this review, one of the most effective ways to increase the level of understanding of mental health issues that exist within BME communities is to create an ethnically diverse health care service. Other research (NHS, *Inside Outside*, 2003) has indicated that in addition to trying to achieve greater equality in the workforce, it should also be considered how BME service users can better contribute to the design and delivery of mental health interventions.

However, it is also pertinent to note that the way in which medical workers can be perceived by patients may also depend on cultural specificities. George (2005) argues that in Kerala and amongst Hindu communities, discourses of caste and gender impact on how nurses are stigmatised.

5. Better use of statistics

Some studies have also indicated that the better use of statistics connected to mental health related deaths in BME communities is important, as it may encourage those not already receiving care to come forward (Rooney, 2013). The disturbing number of suicides in some parts

of Northern Ireland needs to be sensitively highlighted – in the Craigavon/Portadown area there were two suicides in quick succession within the town’s migrant community (a Lithuanian man died near Seagoe and a Portugese resident returned to his home country, where he jumped to his death from a train). Also, Jerome Mullen, Polish Honorary Consul, stressed his concern that there had been five suicides in the Polish community in the area in the year up to April 2013 (Embrace NI).

The UK Department of Health (2011) acknowledge that better record-keeping of care experiences is required, to demonstrate the level of positive outcomes that people from a BME background have had (they note that the Health Care Commission has found increasing levels of satisfaction among BME communities in relation to mental health care experiences). Bhui et al (2008) also explain that further research is required to assess if ethnic groups access mental health care services differently. They note future evaluations should not just simply assign all differences to ethnic origin: greater attention needs to be put on place of birth, religion, duration of residence in the UK, place and level of education and cultural identity.

6. Perceptive use of advertising

Some research has suggested that the perceptive use of advertising could better inform individuals from a BME background of the services that are available to them (Rooney, 2013). This seems crucial, as service users have long requested ‘a new model for national campaigns that placed greater emphasis on community development, cultural events, positive contact and dialogue with families, faith leaders and youth groups’ (Knifton, 2014).

More effective advertising, underpinned by the better use of statistics, could also seek to overcome a number of the fears and stigmas mentioned elsewhere in this review – the Department of Health UK (2011) state that a wide number of people from BME backgrounds struggling with mental health often failed to contact relevant services, as they had pre-conceived fears that they would be over-medicated, there would be breaches in confidentiality and they be at risk of developing further symptoms and illnesses through contact with other service users.

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Case Studies from BME Communities

The authors find it useful to include sample case studies lifted from interviews and focus groups conducted in October 2015 with individuals and groups stemming from black and minority ethnic backgrounds. Their stories and reflections aid in further frame experiences of BME individuals to accessing mental health and well-being services in Northern Ireland.

Participant No.1

Angolan-Portuguese Woman, 41

Participant No.1 left her home country of Angola after being shot amidst the civil war, in search of medical assistance in Portugal. There alone, she had one of her two daughters before enrolling in a recruitment agency and coming to Northern Ireland, where she works still in a poultry factory. In Northern Ireland, she had her second daughter with her then husband. *'After separating from my husband I had depression for about three years. My husband left home and got another lady, had another child and [was not] too far away.'* She suffered from depression and other byproducts of mental distress, *'I didn't seek any help at the time even though I did have suicidal thoughts.'* It was *'a hard time because I needed treatment and social services got involved.'* Isolation of being in a foreign country only increased when *'friends separated from me after we broke up...I have lost faith in a lot of people and have kept to myself.'*

The participant shows signs of inter-generational trauma, post-migration stresses, post-conflict trauma, loss, and distress from poverty. After social workers became involved she chose to *'sort out my problems for myself.'* She feels that the systems- migrant, health, labor and community- have been unfair, *'because depression is a serious illness, people who don't have it don't understand, they think you're putting something on.'* She has a general practitioner who *'has been very helpful and he understood the gravity of what I was feeling and was able to help me'* but *'at the moment I have stopped my medication.'* Being isolated from the community and choosing not to access alternative aid has left her *'hold[ing] my sadness for my own.'* The level of isolation, emotional insecurity and fear expressed by the participant alludes to a need for better outreach, *'we need someone who could offer emotional support, help to be there with us through the process.'*

Participant No.2

Polish, Woman, 50s

Participant No.2 is a long time sufferer of depression, anxiety and panic attacks, and has also been diagnosed with systemic lupus erythematosus. *'I have had some suicidal attempts. There is an extremely thin line between life and death for me. I am walking a narrow road, and I never really know when I could be on the other side.'* She came to Northern Ireland over a decade ago with her family but, *'my husband was burned at work and hasn't been able to go back. I have two children so life has been really hard.'* Being unable to speak English, she struggled to find resources that catered to her needs, which left her with a mixed perception of health services. *'It helped to go to [the facility] to have a place and just be there, to cry, even if I am unable to talk to anyone.'*

Situations being hindered by language barrier, racism and inconsistency are prevalent. It was a challenge to receive basic help, even though she had been diagnosed with these illnesses in Poland, prior to arriving in Northern Ireland.

'On many occasions I would go to the doctor because my voice wasn't being heard. It was many years of hard work just to be diagnosed and to make them understand that something was wrong and I needed help...when I first went to the doctor six years ago they dismissed my Polish medical records.'

Inconsistency is prevalent as, *'I don't have the same psychiatrist, it keeps changing so often.'* The participant also suffers from poverty despite working so long as her health permits it, and this hinders not only the ability to access services but also exacerbates the condition of anxiety. Outreach services have been helpful so far for this participant however, further outreach like a welfare advocate would aid in economic and mental stability, aiding in the participant's healing process. The hurdles that she must overcome just to access basic services, even from her general practitioner, is a challenge but, *'I have some hope and I am constantly looking for help because of walking this thin line.'*

Participant No.3

Polish, Woman, 50s

Participant No.3 has been in Northern Ireland for eleven years but *'the start of [a] new life in Ireland was traumatic and hurtful.'* When she and her husband *'got to Ireland there was nothing for us here, we were sleeping in a park, had no work and were starving.'* A community based organization helped her and her husband find jobs *'in August and in December my husband died of a heart attack. This is when my depression and anxiety started. In the circumstances of loss, I didn't know what was happening to me.'*

She began to have regular panic attacks but continued to work out of necessity. When a panic attack would occur at work *'a lot of people were racist towards me and would make fun of me for what was happening...I was just hoping for some sympathy.'* Her place of work was unhelpful and because of a language barrier, *'it took a very long time for the depression to be diagnosed.'* She has sought various mental health and wellbeing services and has a mixed response of their helpfulness.

'It would help to have a regular contact with a psychiatrist. There was a psychiatrist nurse that was coming to my house and it wasn't helpful because there was very little empathy from her and the nurse was constantly asking about my past and re-traumatizing me. She would sometimes show up for only 15 minutes and other times not at all. I didn't report her, because I didn't understand the system.'

Participant No.4

Lithuanian, Male, 50

Participant No.4 is an economic migrant who suffers from depression, shows signs of post conflict trauma as a veteran and *'I am an alcoholic and I have been sober now for eight*

years.' He was involved in a human trafficking like scheme which constituted an 'employment agency' where the seeker would pay upwards of 200 pounds for a job recommendation;

'I came to Northern Ireland in 2007 because a friend promised me an easy job. I started looking on my own and there were Lithuanian people that had relations with employers and will pay for someone to find a job.'

'In Lithuania I was working in security, had a gun and there were revolutions and problems, so I was drinking for the stress.' Eventually, 'I got treatment in Lithuania and was sober for a year in Northern Ireland and then started again from the stress' of post migration. The participant actively sought out services, 'I went to the GP and told him everything about the alcoholism. The doctor promised to get me help and medication.' He has had only positive experiences with the services he has sought out 'because now I am not drunk all the time and am able to function. Sometimes there is depression or I am in a bad mood, but it's not too bad'.

The participant has other health ailments, *'some of the things are related [to the alcoholism], including heat problems, including depression. Many physical things come from being in the army and security'.* For depression, *'I have gotten medication but I have never been able to make an appointment for a psychiatrist. I haven't sought one out because I want to handle it myself. I seek self-help through books'.* Many people have a hard time in admitting their need for services, or choose to self-help for a wide variety of reasons, *'first I want to know the problem with myself, and after reading [about] how to help it, I figure out what I can do for myself and then I get help from others'.* Language barrier is a major part of this, including the need for more information regarding access to such services so that people from vulnerable backgrounds have the ability to access someone to talk to. The participant has expressed a certain amount of isolation because of the lack of a cohesive Lithuanian community, including any cultural programs or groups that offer activities.

Participant No.11

Somali, Woman, 45

This participant is an asylum seeker who sought refuge in the European Union from the Somali civil war about 15 years ago. She is at high risk for poor mental health as she left one conflict, only to seek asylum in another conflict. Areas of this include, detainment and an unsettling asylum seeking process, *'a solicitor sent me to a psychiatrist because I had stopped eating, so that they wouldn't detain me or send me back. The first time I stopped eating was for twelve days.'* Her experience of undergoing the asylum process has left her with post-conflict trauma, post-migration stress, and in a contractual state of poverty, which has only been aggravated by state processes.

The stresses of the asylum process have contributed to this participant's lack of trust in state services and have aided in not only hindering the healing process from current mental health issues but have in fact made them worse.

'For more than three years I was taking sleeping tablets and depression tablets but I didn't get help otherwise. My story is in front of me everyday and everything is my story so I said no, I didn't want any other help. It didn't solve any of my problems so I just stopped.'

This is due to cultural boundaries of what health services entail and fear of diagnosis inhibiting asylum status.

Post migration stress also includes being placed in contested housing areas where she has faced racist natured hate crimes and Islamophobia. *'I was two nights in the hostel. There were two bums near Sandy Row and I was saying why and then there were police and they caught a man with a gun. It was December 2011 and Christmas and I was scared because I didn't know if I was safe or not.'*

Participant No.6

Somali, Woman, 20s

Participant No.6 is a refugee from Somalia who lost her family and her husband, *'I went to the doctor for stress and that's why I went to the doctor. I never knew anybody when I come here and it's very difficult with talking and understanding. I am very scared being alone'*. She suffers from depression and the intense symptoms of the illness, including sleep deprivation, severe headaches, fear and isolation. *'When I feel and I'm thinking, I can't sleep. I've gotten a tablet from the doctor for headache and sleep.'* It has either stemmed or been further aggravated by the trauma of conflict and loss. This trauma continues on a daily basis for this participant, as she has been unable to keep in touch with the people she is close with back in Somalia, *'I want to go back, but I can't now...I met my friends at Mosque but, I haven't been in touch with anyone in Somalia since [I left]'*.

She has expressed only gratitude and positive remarks of her general practitioner however, she has expressed the level of difficulty that has come with living in Belfast due to post migration stress, *'it's better, but life is still very hard'*. Part of her comfort is sought through her faith, she does express the need for a Muslim women's support group, especially for those living with post conflict trauma. This participant's experience alludes to post-conflict trauma, post migration stress, loss, poverty and isolation. These various experiences have furthered her current mental health issues from when she arrived but overall, *'my doctor is helpful and we have become very close. I'm not sure if everyone is having a good of a time [with the GP], other's might be having issues.'*

Asylum Seekers and Refugees- Somali Women Case Study

A consultation was conducted with seven Somali women who are refugees and asylum seekers regarding their experiences with accessing mental health and well-being services. The Somali community has grown significantly over the past 5-10 years which will both aid in some of the gaps in support and services, but at the same time points to the need for more substantial services due to increase in demand. Refugees and asylum seekers require different levels and types of attention, as their experiences are nuanced and of course, individualized. There are however strong parallels including post-conflict trauma, loss, post-migration stress, poverty, racism and isolation which is all supported by similar cultural, religious practices that define frame of mind regarding mental health and well-being. Commonalities in approaching mental health and well-being amongst this community is useful to refining service provision.

'Sometimes you question where you belong. It's not safe back home and then you come here, and there is conflict here. I really liked a place near city centre and they printed out a piece of paper that said 'for locals only.' I ended up not taking the house because I didn't know what was going to happen to me. It wasn't safe. That was a council house that was offered to me. I thought, 'if I am the only [African-Muslim] person here, then they are sending me a message.' The ability to access a Mosque is essential to the self-care regimen amongst this community because it provides a space for prayer, where in many people utilize the space for 'comfort through faith' and relief from their impending mental stresses. *'When I feel really tired or sad, I try to go to the Mosque and pray or read the Qur'an for an hour or two hours and then I feel better.'* The Mosque also acts as an epicenter for social life, as all of the women in this consultation met and developed friendships with one another exclusively through the Mosque. *'We are all friends. We met each other through the Mosque, that's the first place where we met.'* Therefore, this institution aids in creating support networks, connecting individuals with others and a community and is a religious space where someone is able to act on their faith to feel comfort, to focus and to feel relief, in other words, being able to practice their religion in a safe, familiar space is an act of self-care.

The nature of this community, in its culture, religion and status as a minority refugee or asylum seeker is apparent to services that have been accessed and the feedback on the experiences. For one, Somali women seek help for mental health issues almost exclusively through their general practitioner only. Accessing the current Northern Irish standard types of therapies, psychiatrists or otherwise is not compatible with Somali culture in dealing with mental health alignments. *'In Somali culture it is forbidden to talk about your secrets and some things it's a shame to say such a thing. To say something happened to you is difficult.'* This is problematic when it comes to such cases of sexual violence, domestic violence, clinical depression and suicidal tendencies when the roots of such actions are mental health problems or trauma related.




Other problems arise when people in such a situation review their experiences of services. This includes that many people who come to Northern Ireland as asylum seekers are alone, if they are refugees or single mothers. If a single asylum seeker or single mother to young children is to be hospitalized, there is no next of kin in the country.

'We didn't want to ask questions because we wanted her to heal. She doesn't have any family here so we would go to hospital to ask about her health and help her but, we aren't family. So, we are not able to help her [medically] because none of us are next of kin. We had no idea what was wrong with her or how to help her.'

This aggravates stress and reconstitutes loneliness and isolation, all of which are major factors of clinical depression and PTSD. Refugees who are single mothers are left in a dire situation where they are struggling to get by, as most refugees live in poverty in Northern Ireland, and must choose between their mental well-being or taking care of their children. *'There is a barrier with the language, people are so eager to learn the language because it is so important. But being a mother, it is so difficult with having a babysitter while you're studying. We want to study but it's very hard for us to pay for childcare.'* Most choose to push their mental health issues aside and care for their children, these choices may arise alternatively in the future.

Core Recommendations

-Symbols-

Cost	{£}- {£ £ £ £}
Policy	
Community	
Health Services	

Introduction

Effective care which aims to promote resilience, good self-care and well-being is the beacon of the recommendations listed below. Together, they encompass a set of ideas that shift mental health care services for individuals of black and minority ethnic backgrounds into a system that promotes person centred care. In order to achieve this substantial goal, the attitude towards mental health and well-being must move from being ‘reactive to crises’ to being ‘proactive’ in the form of accommodation, education and prevention. A proactive approach to mental health and well-being entails developing a wider capacity for recognition of the symptoms of poor mental health, clear and convenient pathways to services and earlier intervention when someone has poor mental health. Proactive care eliminates the notion of ‘one standard service for all’ and focuses on person centered care by insuring that services are flexible and approach service users as unique, complex and autonomous individuals that deserve care specified to their respective needs and wants. The optimum method to achieve this shift is by developing education programmes and services through co-production between services providers, professionals, the community and voluntary sector and black and minority ethnic individuals. Everyone has a significant contribution to make, co-production will enable all parties to plan and deliver support services together, for the betterment of Northern Ireland’s communal mental health and well-being. The recommendations developed after an in-depth literature review and numerous consultations and interviews address *improving service delivery, culturally appropriate services, attentive and inclusive care, alternative and complementary therapies, education, communication and empowering the front line- the community and voluntary sector.*

Improving Service Delivery

1. Accountability of Racial Equality: {£ £}



The Race Equality Strategy needs to include indicators of accountability in Health which ensures individuals from BME backgrounds are prioritized in both mainstream and specialist health care and wellbeing strategies to provide, flexible, optimal care. Rigorous monitoring of discrimination of any nature- race, ethnicity, and religion- should be embedded for the protection of both service users and providers. There must also be clearer, more easily accessible protocols for reporting instances of discrimination.

2. Long-term funding initiatives & Continuous Research: {£ £ £ £}



There must be a real commitment to improve service delivery that roots itself in equality of opportunity by the government. Secure, long-term funding of service and research initiatives in the mainstream health and social services system must be prioritized to analyze services and acquire the gaps, missing links and needs of BME communities, as well as then following up funding to support changes in the system. Projects should be developed within and through community based organisations that focus on policy development appropriate to the changing needs of such a diverse population.

3. Ethnic Monitoring: {£ £}



Health service policy must shift into promoting a dynamic approach to care that considers the strain on the mental health and well-being of individuals of BME background, including critical factors of being a new migrant, refugee or asylum seeker. There is a need for a more robust system of mandatory ethnic monitoring that records any multiplicity in ethnicity, faith, gender, sexual orientation, age, and country of origin, of patients and services providers. This might include GPs, nurses, therapists, psychologists and community workers in the health system to ensure ongoing integration of individuals of BME backgrounds into health services. Monitoring the use of services on such a basis could identify low levels of service use and what areas to target, as well as gaining better understanding of people's pathways to mental health services.

4. Accessibility: {£ £}



Alternative and complementary services must be made more accessible in low socio-economic status communities, where the majority of BME individuals live. Complementary, alternative and holistic therapies such as, reflexology, activity based group work, massage, aromatherapies, family-focused psychoeducational programs, acupuncture, traditional Chinese medicine, yoga and meditation instead of just Western-oriented individual talking therapies must be incorporated in main stream health because they are more effective and will ensure that the recovery plans are more dynamic and flexible. Factors that must be included in making facilities and services more easily accessible is the expensive costs of self-care, and other structural barriers including the cost of transportation to facilities,

housing challenges of living in communities that do not have hospitals or other health services and child-care centres, especially for single mothers, to relief some of their struggles.

5. Addressing Stigma through Training: {£ £}



Service providers must shift into a practice that ensures that they are readily available, emotionally and mentally, to help someone with differing cultural beliefs and to aid them in finding the best care plan for their specific needs and concerns rather than utilizing a scheme of 'one standard service for all.' Service developers and providers should aim to incorporate the impact on BME individuals of both the stigma around mental health and highlight the challenges of help-seeking and cultural beliefs into training and education for service providers. New campaigns should include the images and experiences of those from a range of BME backgrounds. Some beliefs challenge mainstream western medicine and must be approached with flexibility when developing recovery plans and what an individual will be willing to pursue.

Culturally Appropriate Services

6. Flexibility in responding to people from a range of backgrounds: {£ £}



Services must incorporate an understanding that considers cultural and ethnic pluralism and important social and economic determinants contributing to an individual's mental health and wellbeing into strategies of approaching care. Service strategies must be flexible in responding to the needs of people from a range of backgrounds to be effective, with a particular emphasis on how post-conflict trauma, loss, post-migration stress, poverty, isolation and racism may effect someone.

Attentive and Inclusive Care

7. Autonomy {£}



Individuals must have better control over their recovery plan. With the assumption of capacity, autonomy respects a person's right to decide and act on his or her decisions regarding treatment, care and wellbeing. Being attentive to an individual's wants and needs including pursuing care past medication or choosing alternative therapies, must be included in the process. Autonomy is key for individuals to have confidence in the health service and to begin a path of recovery.

8. Individual Choice {£}



There must be greater assurance that patients have a more active role in developing either a prevention or recovery plan. If an individual finds relief and comfort in alternatives, especially to more traditional Western medical treatment, that individual should have the right to access said services.

Alternative and Complementary Therapies

9. Activity-based group work: {£}



Alternative therapies like activity-based group work in occupation must be better prioritized and easily accessible in care plans. It brings people together in a safe environment, develops skills and encourages social interaction through arts and crafts, exercise, dance, outdoor building and gardening. Activity-based group work improves self-perceptions of social interaction skills and provides greater symptom reduction in the long term, while giving a sense of accomplishment, relaxing, keeping one's mind off problems, increased skills and concentration.

10. Family-focused psychoeducational programs: {£ £}



Combining education and therapy is effective and worth mainstreaming into mental health care. Family-focused psychoeducational programs is an educational opportunity in a family setting that is chosen over that of a traditional individual talking-therapy. Families are simultaneously educated on how to best assist the patient while also attending to their own needs in order to prevent burnout. Family collectivism is important to the emotional well-being and symptom severity of patients from a minority ethnic background, especially for patients with psychosis or schizophrenia.

Communication

11. Accountability of interpreters: {£ £ £}



Many individuals of BME backgrounds require an interpreter or feel more comfortable using their native tongue when utilizing health services. There must be accountability of interpreters' qualifications in a medical situation and critical reviewing the work they have done to ensure the service provided is of the highest quality.

12. Accommodation of bilingual and bicultural service providers: {£}



Providing appropriate interpreters in a medical situation can be problematic. Many prefer a service provider that not only speaks the same language but who have the same ethnic background others want to avoid this due to the sensitivity

of their condition. Patients must be accommodated according to their specific needs, such as connecting a patient with a bilingual or bicultural service provider if requested. This should be a mainstream technique for providing services especially for those who are destitute or alone as a new migrant, refugee or asylum seeker.

13. Accessible information: {£}



Information in other languages on services, self-care and self-help must be easily accessible for anyone who might need it. Many services provide information for service access, self-care and self-help information in other languages but have not made them easily accessible, either on-line or in hard-copy. This means better distribution into community, voluntary and cultural groups, religious institutions and rearranging websites to be easy to navigate through to access information in another language. Adequate access and distribution of this material will help BME individuals to understand the health system, proper self-care and self-help.

14. Suicide Help-Lines: {£ £}



Easily accessible services for those who are destitute or contemplating suicide and do not speak English is strongly needed in Northern Ireland. Interpreters that are accredited in medical and psychological discourse must be incorporated into the system. Having bilingual suicide help-lines or having a service that is able to connect an individual with a doctor that speaks their language is crucial for handling critical situations.

Education

15. Education to Service Providers on Cultural Awareness: {£ £}



Service providers should be supported to pursue educational training programmes on cultural awareness. It will aid in building strong relationships with communities and will develop greater cultural capability. This includes education programmes for admissions workers, secretaries and nurses. There must be measures put in place in service protocol for greater cultural capability and accountability against scrutiny, discrimination and racism at first contact point.

16. Education to BME individuals on mental health and well-being: {£ £ £}



Practitioners and community developers should be engaged in an outreach educational programme into BME communities. An informative and well-rounded campaign with information-leaflet distribution on mental health and well-being should be developed to target BME communities for increasing awareness, breaking stigma and to make pathways to services clear. Education and targeted information distribution should prioritize higher awareness for recognizing more

critical illnesses like dementia, psychosis, and depression, as well as suicide prevention.

17. Targeted Advertisement: {£ £}



There should be a campaign of targeted advertisement in other languages to promote positive attitudes towards mental health services to increase a higher rate of service use by BME individuals. Campaigns include distribution of information leaflets with general health questionnaires, self-help tactics, leaflets with mental health services available, including alternative therapies, and simple ways to access them, like, 'asking your GP for alternative therapies.'

18. Education Community & Voluntary Sector, Mental Health Aid and Well-Being Training: {£ £}



The government should be supporting the efforts of the community and voluntary sector with Mental Health Aid and Well-Being Training programmes to increase their capacity to recognize poor mental health and people at risk quicker, aid them better in a crisis and ultimately, connect them with proper services. The training should also help workers develop tools and protocols needed in the community and voluntary sector to keep up with their own mental health and well-being.

Networking- Bridging Formal and Informal Networks

19. Directory of Service Points- Formal Connection: {£}



Service points need to be formally connected through a directory to make a more cohesive health sector. Networking between the different sectors should be promoted including, health care providers with informal networks for future creative partnerships between social organizations, religious institutions, community-voluntary organizations and health care providers. A directory must be well detailed and all-inclusive to strengthen the capacity for the health network to provide effective mental health problem identification and treatment.

20. Religious Institutions: {£}



Informal networks for mental health and well-being must be recognized, included in a directory and apart of the conversation on future care. Many people from BME backgrounds will choose to approach their religious institution for a mental health problem, like depression or suicide contemplation. Some offer counseling and guidance along spiritual lines in a non-stigmatizing way. Being able to connect an individual with these services may be the best option possible for relief from symptoms or for overcoming an illness. Empowering these connections will allow for better accommodation and for developing future strategies for tackling mental health in Northern Ireland.

Empowering the front line- Community and Voluntary Sectors

21. Funding: {£ £ £ £}



Departments should ring-fence a discrete pot to support preventative work in relation to mental health and wellbeing within BME communities, especially for well-being and community development projects because of their trust-worthy positions in BME communities. The community and voluntary sector of Northern Ireland is under great strain, due to a tense combination of capacity issues, funding cuts and greater demand from a growing population of BME communities. It is recommended to capitalize on their efforts and work within them because of their ability to break stigma. Most importantly, they act as the primary voice of BME communities and can aid in developing better policy and services to accommodate changing needs.

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