Oasis-Talk
Emotional health & well-being

Elders Project Report

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Author: Shazia Riaz
Oasis-Talk Elders Community Worker

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BRISTOL AGEING BETTER

LOTTERY FUNDED

Contents

All quotes provided are from taster session participants.

1) Executive Summary

The Elders Project was a seven month project based in Easton, funded by Bristol Ageing Better, with the aim of liaising with Black and Minority Ethnic (BME) adults over 50 to help them identify barriers to accessing mental health services. The project also aimed to help them design the mental health services to support the emotional needs in their respective communities.

The population of Bristol has become increasingly diverse and there are now at least 45 religions, at least 180 countries of birth represented and at least 91 main languages spoken by people living in Bristol. The proportion of the population who are not 'White British' has increased from 12% to 22% of the total population (Bristol City Council – Key Facts). Lawrence Hill and Easton in Bristol have the highest number of Black and Minority Ethnic residents in their wards; 59.6% and 37.9% respectively. This rich diversity means that a substantial number of community organisations, ethnic food stores and places of worship are based here and hence this area was a natural base for the project.

This outreach and development project involved consulting with community leaders and BME organisations to design mental health services appropriate to their needs. I did this through publicising the Elders Project in community, shopping and health venues as well as working with community groups to publicise and support the project. Also, the project aimed to encourage BME elders to take up counselling through the special pathway to NHS Talking Therapies set up by Oasis Talk, in collaboration with Nilaari an organisation providing multi-lingual counsellors.

It became clear early on in the project that mental health, by and large, is still stigmatised and viewed negatively in older minority communities. To overcome this I switched the emphasis from clinical mental health to symptoms of emotional distress which community groups could better relate to, i.e. low mood, anxiety, stress etc and

thereby encourage discussions. Oasis-Talk already delivers psychoeducational groups on many of these topics, and community organisations were able to select their topic of interest and we developed psychoeducational taster sessions according to individual group needs. This also gave me a valuable opportunity to discuss barriers to mental health and how to improve services to reflect the needs of older communities. This co-production approach worked very well and over 110 over 50's from BME communities participated and gave us their valuable views and experiences which informed both the outcomes from the psychoeducational taster sessions as well as feedback from community leaders and organisations.

Highlights of the feedback are as follows:

Taster sessions with older BME communities

- Most of the participants found the taster sessions very helpful and practical especially the Cognitive Behaviour Therapy-based interventions which highlighted the interrelations between thoughts, feelings and behaviours - especially how to overcome unhelpful behaviours. There is a desire within all the BME communities visited for more psychoeducational courses tailored to their individual cultural needs
- Taking a symptom-based approach to mental health was helpful allowing more people to engage in the discussion. Flexible and proactive engagement methods were important
- Participants that had undertaken counselling in the past had mostly found it helpful

Consultation with community leaders

- The need for talking therapies to be based in community venues not only for accessibility reasons but for supporting people and reducing stigma around mental ill health. This could be done through community volunteers trained in listening skills to signpost older people to find appropriate services and support which they

are currently not accessing.

- Public health messages need to raise awareness around mental health through campaigns targeted at older BME communities, as they already do for physical ill health for example diabetes and heart disease. Surprisingly, none of the participants were aware that they could self-refer to counselling services.
- GP's need to make people more aware of the different treatment options available for mental ill-health in order to overcome perceptions that prescribing anti-depressants is the only option.
- Diversity of staff - more bilingual counsellors are needed who speak the languages and understand the culture of minority communities.

This project has worked with older community groups to identify barriers to accessing mental health support. It is hoped that their concerns will help service providers, commissioners and the public to understand their needs and look to provide appropriate support.

Finally, I would like to thank all the staff and counsellors at Oasis-Talk who supported the Project; the members who participated in the psychoeducational taster sessions and shared their personal experiences; staff in Nilaari for their support and Mohammed El Sharif, Health Improvement Manager at Bristol NHS. Other contributors are listed in the Acknowledgements.

"I want a service which which will give time to me and my needs, and will understand my culture."

2) Background to the Study

One in five older people are affected by depression, and this number increases among BME communities. NHS studies have shown that older people who access psychological therapies are not only more likely to complete their treatment but have higher rates of recovery from depression than individuals of working age. Despite this, the take up of free counselling and cognitive behavioural therapy (CBT) available through the NHS is much lower for older people compared to those of working age.[1]

Different ethnic groups have different rates and experiences of mental health problems, reflecting their different cultural and socio-economic contexts and access to culturally appropriate treatments. In general, people from Black and Minority Ethnic groups living in the UK are:

- more likely to be diagnosed with mental health problems
- more likely to be diagnosed and admitted to hospital
- more likely to experience a poor outcome from treatment
- more likely to disengage from mainstream mental health services, leading to social exclusion and a deterioration in their mental health.[2]

These differences may be explained by a number of factors, including poverty and racism. They may also be because mainstream mental health services often fail to understand or provide services that are appropriate and accessible to BME communities and meet their particular cultural, religious and other needs. It is important to note here that people from minority ethnic communities are not a homogenous group but rather have marked differences in their experience of mental health services.

1 NHS England
2 Mental Health Foundation

3) Aims of the Project

This was an outreach and development project working with community leaders and organisations of BME communities in Easton to design mental health services appropriate to their needs taking into account factors such as language, religion and culture. This was done by publicising the Elders Project in Easton community and health venues as well as working with community organisations to publicise and support the project.

The project also aimed to encourage BME older people (over 50) in the inner city to take up counselling or CBT through the special pathway to NHS Talking Therapies set up by Oasis-Talk, in collaboration with Nilaari (an organisation providing multi-lingual therapists).

To fulfil the aims the project set out to:

- publicise the Elders Project in Easton community and health venues
- contact community leaders to publicise and support the pilot.
- establish referral pathways, referral tracking and data reporting systems for older adults receiving interventions through the project
- identify BME communities for the pilot to focus on
- identify barriers to older BME adults accessing psychological support
- identify possible solutions to barriers identified by communities.

Due to the time limited nature of the project, it was critical from the outset to build community trust and confidence in working with me on the project.

4) Community Consultation

In my initial visits to community groups I spent some time raising awareness of and publicising the special NHS Pathway to Talking Therapies developed by Oasis-Talk. This was to encourage BME elders over 50 to utilise the NHS-funded face to face or group therapy services available.

However, it became obvious early in the project that mental health amongst minority communities of this age group, is still considered taboo and is by and large stigmatised. Compounding this were difficulties around language in that terminology such as "depression" and "talking therapies" has no equivalence in some minority languages spoken by the community groups that I visited. Also, ideas around mental health varied between and across groups especially as minority communities tend to view health more holistically rather than the western medical model.

In order to overcome some of the negativity and stigma around mental health and the reluctance of some elders in the community to engage on this issue, some community leaders felt that their members would be more comfortable talking about mental health collectively. It was also felt that switching the focus of discussions from mental health to symptoms of emotional distress would be more productive - for example, talking about low mood, anxiety, stress, panic attacks - which the elders could relate to as having had experienced and therefore felt more comfortable discussing.

5) Developing the Psychoeducational Taster Sessions

As Oasis-Talk already delivers Cognitive Behaviour Therapy-based group sessions around many of these topics (see Appendix 1), community groups were given a list of these topics to discuss amongst themselves. These discussions culminated in community members deciding to undertake a short one hour taster session on the topic of their choice. Discussions also focused on the content of these sessions,

and it was felt that the taster sessions should be centred around providing practical exercises and understanding around the symptoms of stress and anxiety rather than focusing on the theoretic and often Western culture-specific concepts which would be extremely difficult to translate. This co-production approach empowered and enabled community groups to direct and plan the taster sessions which in turn resulted in excellent engagement and attendance – more than 115 participants over 50 during the project's duration.

Following on from the detailed discussions with community groups, I had one to one meetings with the experienced group therapists from Oasis-Talk – many of whom had designed and written the programmes around the topics requested by groups - to ensure that the taster sessions met the needs and requirements highlighted by community elders.

As community elders had preferred taster sessions on the symptoms of emotional ill-health rather than focus groups discussing mental health services, it was still important for the project to understand what barriers BME communities were facing in relation to accessing mainstream mental health services. The project therefore then developed 5 generic simple questions to be discussed with community groups before the psychoeducational taster sessions in order to understand better: who they would turn to if they were stressed/worried; what barriers there were to accessing support; what services and support they would like to see as well as their experiences of using talking therapies.

Other considerations for setting up taster sessions were access arrangements such as transport and interpreters. Transport issues were by and large resolved by running the taster sessions on days that community groups met so transport was already provided by their respective community organisations. However where this was not provided by the groups then the project paid for taxis especially for the disabled and less mobile members of groups to enable them to participate in the taster sessions and share their experiences.

Interpreters' were provided by community organisations themselves and as most were known to the older group members, they felt comfortable and at ease discussing their emotional health with them present. In using interpreters in the taster sessions, I also had to factor in the time taken for interpretation as well as the discussions and responses from 5 pilot pre-determined questions around mental health which were critical themes for my project. Hence a structure was developed around the group taster sessions that met both the community group and the Elder project's needs. Therefore, by delivering taster sessions on symptoms of emotional ill health chosen by community members, this allowed me to open up the dialogue and explore issues around mental health that was acceptable and accessible to the BME elder groups.

6) Structure of the Psychoeducational Taster Sessions

After consultation with community leaders and Oasis-Talk therapists the following structure was agreed to maximise the time available for the taster sessions and encourage participant input:

1. Meeting with interpreters 15 minutes prior to session to brief them on the format of the taster session and reviewing if there were any difficult terms that needed explanation. Clarifying the pace of the interpretation and pauses to allow time for both interpreters and participants to engage and ask questions throughout the taster session.

2. Introductions – myself, counsellor and interpreters.

- Briefing each group again on Oasis Talk, my project and encouraging people to use the special pathway to Talking Therapies developed specifically for this project.
- Recapping on the decisions they had taken on previous meetings regarding the topics selected and length of taster session.
- Reminding the group that due to the informal and engaging nature of the session, they were welcome to stop the session at any point to raise questions and seek clarity etc.

3. Each group were asked the same 5 questions below at the start of each session. All the groups were very engaging and the questions were designed to be open and accessible (and easily translatable) to give me as much feedback as possible on the types of services that BME elders would like to see in the future. Responses to these questions were noted on a flip chart.

- *Who would you talk to if you were stressed or low?*
- *What would stop you from talking to anyone?*
- *If you wanted help where would you like to go?*
- *What kind of help would you like?*
- *Have you, or someone you know, tried to access services in the past and what has been your experience?*

4. The group psychoeducational session followed after the responses to these questions were completed on the topic chosen by the group e.g. anxiety, stress, sleeplessness (see below for a full list of topics by group).

5. Monitoring forms were then completed with individual group members after each session for our funders Bristol Ageing Better. The draw backs of using the monitoring form was that it was time consuming to explain and complete especially when some members could not read or write English; some questions were felt not to be relevant and some intrusive i.e. asking for age, postcode and sexuality.

7) Community Groups Involved with the Project

The following is a list of groups who agreed to be part of the project from the groups who were contacted and given information about the Elders Project (see Appendix 2):

1. Dhek Bhal - Asian community elders and carers from the Indian sub-continent – Pakistani, Indian, Bangladeshi
2. Bristol and Avon Chinese Women's Group

3. The Golden Agers - African-Caribbean elders
4. Bristol Somali group
5. Bristol Sudanese men

The table shows the groups; the topic of their choice for the counselling taster sessions; name of the therapist delivering the sessions as well as the number of attendess at each session.

Group	**Psychoeducational Group Topic**	**Therapist**	**Attendees**
Dhek Bhal Women	Anxiety Management	Chris Bowles	14
Sudanese Men	Stress Management	Ann Barham	12
Dhek Bhal Carers (Men & Women)	Anxiety Management	Ann Martin	6
Somali Women	Stress Management	Bernadette Bailey	6
Chinese Men & Women	Managing Anxiety	Kate Hannay	20
Dhek Bhal Women	Relaxation	Chris Bowles	20
The Golden Agers	Sleep Management	Sue Jackson	22
Dhek Bhal Men	Stress Management	Stephen Wolff	13

"Culturally appropriate counselling services are desperately needed."

8) Findings from the Taster Session Consultation

The following is the collective feedback and responses from groups above to the 5 pilot questions. Individual group responses are shown in Appendix 3.

1. Acknowledging mental health problems.

Question: Who would you talk to if you were stressed or low?

This question yielded fairly similar responses across all groups with the majority stating immediate family, close friends and GPs. More men said it was better to forget about their problems and carry on. More women said family support was important in seeking help.

A significant number said they were ashamed of their feelings and would tell no-one for fear that people in the community would think they were "crazy" or "mad". Hence confidentiality and understanding the cultural context of health beliefs especially emotional ill-health is fundamental when working with BME communities.

Some would seek support from leaders of their faith, this was especially true of a significant number of the church going members of the African-Caribbean community as well as some of the Muslim participants. Many of the African-Caribbean elders were 70+ years old and their faith had provided considerable emotional support in the past. Hence they did not feel the need to undertake talking therapies. Similarly, for some of the Asian elders "talking therapies" was a Western concept that they were not really familiar with so didn't know what was involved or what choices were available.

" We have a definite culture of not seeking help in our community until it is too late - both for physical and mental health issues."

2. Identifying barriers to seeking help for mental health problems
Question: What would stop you from talking to anyone?

Although some group members said that they would speak to their GP if they were stressed or low, a large proportion said they suffered in silence as there was no honour in revealing your problems. This reluctance to seek help early and use preventative primary care services such as talking therapies obviously has an impact on the take-up of services from minority communities. This was clear from the low attendance at the Talking Therapies set up by Oasis Talk for this project (to date 2 participants have come forward and engaged with talking therapies).

Stigma, shame, worries about gossip, negative stereotypes, lack of understanding of their symptoms, social rejection, language problems and short consultation time with GP were some of the obstacles cited. Cultural expectations also prevented people from seeking help, especially carers (the is no word for "Carer" in Urdu and Punjabi as it is a duty look after your parents, for example) which compounds feelings of guilt and shame if Carers show that they are not coping well. Group members were also not aware of positive media portrayals of people living well with their mental health conditions.

It was clear from these answers that significant awareness raising and public health engagement needs to be done not only around symptoms of mental ill-health and the range of services available but also promoting positive images of mental health. It was obvious from participant's responses that public health messages need to target the older BME communities just as they do with physical conditions like diabetes.

"I don't know what mental health services are available and need someone to signpost me."

3. Knowledge of support and services available

Question: If you needed help where would you go?

Here again older participants cited the importance of family and close friendship support in seeking help with mental health problems.

GP support was also raised, along with the problems of long waiting times for accessing GPs, when their emotional health would have deteriorated even further.

Community organisations were seen as very helpful in supporting older BME people and there was a strong desire for community groups to meet more often as those that lived on their own had little other social interaction apart from the group which met twice a week. African-Caribbean and Asian Elders including Carers expressed this need for more social interaction. However, funding issues and availability of the church hall during other days did not allow socially isolated members to meet more frequently, although there clearly was a need.

"I want GPs to give us alternatives to medications for treating mental health. They give out anti-depressants too quickly."

4. Service Preferences

Question: What kind of help would you like?

Participants advocated a range of services depending on their emotional health needs:

- Overall, participants stated the need for a confidential, non-judgemental talking therapy and/or lower-level listening service that was culturally appropriate and with language provisions.
- Help with making repeat appointments and transport problems could be overcome if the therapists undertook their sessions when community groups were meeting.
- Participants highlighted how important the voluntary and community sector is in providing support and wanted their role strengthened by having therapists based in community centres as transport and language support would be provided by community organisations.
- If talking therapies were based or delivered from community settings it would have the added benefit of normalising mental health support and overcome some of the stigma surrounding it.
- However, a minority felt that due to the stigma around mental health they would not like services in the community at all, rather somewhere sufferers could go for treatment anonymously.
- Talking therapies both group and 1-2-1 that understood the language and cultural context of participants' emotional ill health was advocated with bilingual counsellors being preferred.
- More social activities delivered by community organisations more regularly to overcome the isolation and loneliness felt by some elders.
- More education and awareness around the signs/symptoms of mental ill health and preventative strategies for people to use.
- More sessions and awareness raising around mental health so that talking about it does not feel wrong.
- Awareness around medication/treatments therefore demystifying and debunking some of the myths that anti-depressants are prescribed too readily as a treatment for anxiety.

- More information around pathways to accessing services – none of the group members knew that they could self-refer to talking therapies.
- Therapy services delivered at home was a preference for those with a disability, those that were isolated and older carers.
- Some elders wanted services to be delivered more holistically between health and social care. For example one member had to wait a whole year to be referred to this organisation, after previously been referred to a community centre in Withywood where there no BME members, no language provision or halal food – so better social prescribing

" I want mental health services in the community where I feel safe and comfortable."

"My job as a taxi driver is very stressful but I won't ever go to the GP as I don't want to lose my taxi licence and my livelihood."

5. Prior experience of using mental health services
Question: Have you, or someone you know, tried to access services in the past and what has been your experience?

Some members had been offered counselling in the past and had mixed experiences of these services. One had had bereavement counselling on the recommendation of his GP who could see that he would benefit after the death of his spouse. Neither he himself nor his family recognised his emotional distress as culturally, the expectations were that he should have coped.

One older lady had had several counselling sessions but, due to the expense of transport to the other side of the city, she could not afford to go and gave up after two sessions, although she found them beneficial. Other elders had gone to Birmingham and London to access bi-lingual counsellors who they thought would understand the cultural context of their emotional distress, but had found them unprofessional and interested only in payment.

One participant had counselling which she had reported to be good, but because the counsellor was not from her cultural or linguistic background, she felt that she had to spend a considerable amount of time explaining the context of her thoughts, feelings and behaviours to the counsellor which took up quite a lot more time than the session allowed. Another woman reported that counselling had benefitted not only her emotional health but her physical health also.

One had had telephone counselling which was good, but was quite frustrating as it was not face to face, hence she felt that the counsellor could not pick up on the physical cues or understand her through her body language.

One woman had had positive experiences of CBT as it had helped her manage her symptoms of anxiety but now she relied on her religion to cope.

9) Therapist feedback from delivering taster sessions

Therapist A

Group Visited: Dhek Bhal (Asian Women)
Taster session topics: Managing Anxiety / Stress Management / Relaxation

What went well?
The group was very engaged and asked plenty of questions. They particularly enjoyed the relaxation exercises and found them helpful.

What would you do differently next time?
I used one or two visual aids but would probably use more to explain key ideas. The remit was a little broad so I would probably focus more specifically on one or two aspects of the topic.

Are there any other ways that the session could be improved in the future?
It would be helpful to have some basic notes for people to take away, translated into the relevant language, though obviously there would be a cost implication for this.

Therapist B

Group Visited: Bristol & Avon Chinese Women's Group
Taster session topics: Managing Anxiety / Stress Management

What went well?
The participants were all very engaged, seemed to enjoy it and it seemed to get them talking about anxiety a bit.

What would you do differently next time?
Keep it very simple, encourage small group work.

Are there any other ways that the session could be improved in the future?
I think it was really good to go to the community group that participants were already familiar with.

Therapist C

Group Visited: Sudanese Men
Taster session topics: Stress Management

What went well?
The men all participated and gave their views. They identified that their jobs and circumstances cause them stress. Some of them thought the relaxation exercise could be useful to them.

What would you do differently next time?
Spend more time finding out from them what signs of stress they suffer with. Use examples that are relevant to them of what can happen to people when they are stressed. If there was more time, give them exercises to do about how stress affects them and break them up into pairs or smaller groups to discuss it. I think it would be good to give them a bit more information to take away with them about the topic e.g. stress - what it is and how to manage it.

Are there any other ways that the session could be improved in the future?
A longer session. It might help if I had had a bit more knowledge of what kind of problems they might have in advance so that I could prepare relevant examples.

Therapist D

Group Visited: The Golden Agers (African-Caribbean Elders)
Taster session topics: Sleep Management

What went well?
Giving them information about what normal sleep looks like and how it changes across the lifespan. Listening to the issues and queries from the participants and being able to reassure them that what they are experiencing is normal age and/or health related changes to sleep.

What would you do differently next time?
I wouldn't include the breathing and relaxation component.

Are there any other ways that the session could be improved in the future?
Getting the group to let us know beforehand what their concerns are so that we can better tailor the session.

Therapist E

Group Visited: Dhek Bhal (Asian Men)
Taster session topics: Stress Management

What went well?
Full group engagement, sharing of experiences between group members, active interest in the topic evident through questions and responses.

What would you do differently next time?
I wouldn't include the breathing and relaxation component.

Are there any other ways that the session could be improved in the future?
Through accessing a broader range of community venues in Bristol.

10) Demographic information from taster session participants

In total there were 106 completed monitoring forms from participants at the psychoeducational taster sessions across all community groups.

There were more females than males – 67% to 33% with almost half of the 106 living in Easton (48%).

Interestingly half of all participants were 70 years of age or over, with 4% being over 90 years of age which in turn was reflected in the high number of elders living with a disability (66%). A full breakdown of demographic information is in Appendix 4.

11) Demographic information from therapy participants

There were 2 participants who took up talking therapies offered by Oasis-Talk through the specially designed NHS pathway. Both were female and over 50 years of age. It is difficult to draw any real conclusions due to the small number of participants, and as both are still engaged in therapy we are awaiting the exit CMF outcomes forms.

12) Development of project focus groups

One of the original aims of the Elders Project was to recruit members of different community groups to participate in a focus group to design mental health services for their community. Despite concerted efforts most elders felt comfortable giving their feedback in their groups and felt that designing services was a huge undertaking and they did not have enough knowledge of current provision or the experience to tackle this successfully. What they were happy to do was to give their thoughts and personal experiences to me in feedback sessions on how they wanted services to look like in the future. This again meant that the project time which was already only 7 months would have to be extended.

13) Recommendations for future services

The below is a collation of feedback from Community Leaders and groups:

1. Older people from BME backgrounds require considerable awareness raising and practical engagement to overcome the stigma attached to mental health. There is a need to improve information about services, access pathways and treatments as there was a huge lack of knowledge around these for example many were unaware that they could self-refer to talking therapies or the process by which they could do this.

2. Healthcare providers need to develop effective communications strategies to improve engagement with older BME communities in the development and delivery of culturally appropriate services which would facilitate better understanding of mental health conditions and improve access to relevant services.

3. Health and social care agencies need to work closer together to meet community needs for example some communities prefer that therapists or mental health listeners are accessed at community venues. This is because older BME groups are more likely to use services that are BME led in the voluntary and community sector due to language and cultural needs. Most of the groups strongly advocated having therapists or mental health listeners at their community centres to enable ease of access and support from the community workers there. This will also normalise mental health and overcome the stigma and associated cultural taboos.

4. More practical group sessions were requested by Asian and Chinese community groups to enable practical self-help strategies to deal with anxiety and stress and well as having access to translated literature and short videos like there are on a host of other conditions such as dementia. This was especially important for those who were Carers as they could access this information whilst managing their caring responsibilities.

5. Many Carers suffer from poor mental health especially in minority communities where it is seen as their duty to care for family members (the word "Carer" does not exist in some cultures) so understanding the social pressures and cultural context is important for healthcare providers.

6. BME older people have generally been excluded from mainstream mental health strategies and receive poorer provision in comparison to those younger. It was felt that government policies have tended to focus on physical conditions such as diabetes, heart disease, stroke whilst largely ignoring mental health conditions such as depression in older people, despite its prevalence in later life.

7. High quality Public Health campaigns need to be aimed at BME communities in prominent community locations to dispel misconceptions about the nature of mental health services and raise positive awareness of available services and how to seek help and support as well as signs / symptoms of emotional ill health. This preventative work will, will in turn, help to overcome some of the cultural stigma and negativity attached to mental illness.

" I feel stressed like this all the time - we all worry, but how much is too much?"

List of Appendices:

APPENDIX 1 - Recruitment Material

Oasis-Talk
Emotional health & well-being

Older adults [50 years] in Bristol

NHS Talking Therapies for those with Emotional difficulties

As part of a project to reach adults 50 years and over from Black and Minority Ethnic communities, Oasis-Talk has developed a special NHS Pathway which will help you find the right support for emotional difficulties quickly without being put on a waiting list. We offer both group and face to face counselling.

Group Courses on topics of interest:

1. Managing stress
2. Managing low mood
3. Relaxation skills
4. Mindful Living
5. Course for Carers
6. Managing panic
7. Managing anxiety
8. Assertiveness skills
9. Improving self esteem
10. Anger management
11. Sleep programme

Talking therapy face to face:

Please ring Hayley Titmus on 0117 9277577 – and say "Elders Project" to book an initial assessment session which will be face to face, unless you want it on the phone. She will help you find the right treatment for you which will be free, based in Easton and delivered by counsellors from Nilaari who speak your language and understand your culture.

APPENDIX 2 - Groups Contacted During Elders Project

Asian Day Centre (aka Asian Health & Social Care Association)
African Voices Forum
Al Madina Community Welfare Foundation
Assertive Contact & Engagement Team (ACE)
Awaz Utaoh
Bangladesh Association (Bristol, Bath & West)
Bangladeshi Bristol Women's Group
Bristol & Avon Chinese Women's Group
Bristol Black Carers
Bristol Community Health
Bristol Golden Agers Club
Bristol Indian Association
Bristol Mental Health Leadership Team
Bristol Multi Faith Forum
Bristol Muslim Cultural Society
Bristol Somali Association
Bristol Somali Forum
Bristol Sudanese Mens Group
CASS
Dhek Bhal
Easton Evergreens
Elderly People's Club
Gurdwara Guru Nank Parkash Singh Sabha
Khaas
Knightstone Housing
Malcolm X Elders
Nilaari
Opoka
Overseas Chinese Association
PWO Learning Centre (prev. Bristol Pakistani Welfare Organisation)
Rethink Mental Illness
Sammy's Pop Up Club
Savannah Development Foundation
Ujima 98 FM

APPENDIX 3 - Individual Taster Session Feedback by Group

3.1
Group: Dhek Bhal (South Asian Men)
Date: 19 July 2017

Q1. Who would you talk to if you were stressed or low?

- Friends
- Wife
- GP although I know he doesn't have much time.
- Family

Q2. What would stop you from talking to anyone?

- Stigma in the community
- We have a definite culture of not seeking help in our community until it is far too late.
- Issues around confidentiality – because our communities are small I don't want what I say to be talked about in the community – open to shame and ridicule.
- Mental health taboos in the culture
- Don't want to be seen as weak / unable to cope in my community
- Social standing in my culture will be diminished
- Might not talk to my family as they will be affected by my mental health problems
- Phobia around mental health which prevents people from going out – they don't want to go out as they are aware that people will be talking about them /judging them and they get paranoid. So mental health then really suffers as they are afraid to go out and hide their condition when they would benefit from social interaction,
- Fear of non-acceptance

Q3. If you wanted help where would you like to go?

- In the community setting where we feel safe and comfortable. Somewhere we can talk and give time to ourselves and our needs as we don't really do anything for ourselves personally.
- Non-medicalised environment
- Somewhere where people won't know that I am seeking help

for mental health problems

Q4. What kind of help would you like?

- Anonymous, don't want anyone to know that I am suffering from stress
- Based in the community where we can access quickly without waiting and with language provision.
- We don't know what is available so need someone to signpost our people to supportive health services – so community based workers here would be helpful.
- We also need our culture to change to accept mental health problems as normal
- Need GPs to give us alternatives to medications, pin-point alternative services and sign-post and make referrals to other services that take into consideration our cultural and language needs.
- 1 member had to wait a whole year to be referred to Dhek Bhal and had been referred across the city into Withywood where there were no BME group members, no language provision or halal food provision etc – so social prescribing according to cultural need is vital for GPs to understand - which they don't at the moment.

Q5. Have you, or someone you know, tried to access services in the past and what has been your experience?

- Yes – I have counselling twice. Once was telephone counselling which was good but was quite frustrating as we were not face to face so the counsellor couldn't pick up on the physical cues or understand me through my body language etc.
- The second time it was much better as it was face to face. I didn't have an interpreter present but had to explain a lot about my culture, religion and expectations as the counsellor was not from my ethnic background and didn't understand the reasons /rationale of my worries and behaviour. But was a good counsellor who was sympathetic.

3.2
Group: Sudanese Men
Date: 10 July 2017

Q1. Who would you talk to if you were stressed or low?

- Friends
- Wife
- Myself – though I'm not sure if this is normal
- not GP as I don't have time to visit so wouldn't consult him unless I was very ill
- Have dependent families here and in the Sudan so can't afford to be ill so will carry on regardless of how stressed/low I am feeling because I have to earn a living and support my family.
- We play football together to relieve stress, anger and aggression that has built up – chance to let it out
- We come to this community centre to socialise – this is such an important outlet for our stress as we like to meet together and just talk, eat and play cards and unwind. Socialising is really important.
- I read the Koran whci gives me spiritual peace and fulfilment – my religion and prayers help me overcome stress
- Many people don't get that peace from religion so would use sports and socialising as a stress reliever

Q2. What would stop you from talking to anyone?

- My job as a taxi driver means that I won't ever go to my GP as I don't want it to show on my medical record as I don't want to lose my taxi licence as my livelihood is critical to me (single breadwinner). Every 5 years over 50s taxi drivers have to undertake a new health disclosure check
- How do I know I am stressed? We all worry but how much is too much?
- Women talk more than men and have more supportive networks. We only have this community centre to come together once a week. Pressures of work, family life, being newly arrived in this country and trying to support extended family means that we don't have time to talk

- Stigma in the community
- We have a definite culture of not seeking help in our community until it is far too late. This applies to both physical and mental health problems – not seeking help until things become critical.

Q3. If you wanted help where would you like to go?

- In the community where we feel safe and comfortable. We are all degree holders here – Masters and PhD but coming to England we are taxi drivers – which adds to our stress.
- We don't give enough time to ourselves so don't do anything for us personally
- We don't know what is available so need someone to signpost our people to supportive health services.
- We also need our culture to change to accept this as normal

Q4. What kind of help would you like?

- Anonymous, don't want anyone to know that I am suffering from stress
- Based in the community where we can access quickly without waiting and with language provision.

Q5. Have you, or someone you know, tried to access services in the past and what has been your experience?

No

3.3
Group: Somali Women
Date: 23 May 2017

Q1. Who would you talk to if you were stressed or anxious?

- Friends
- Family
- Doctor
- No-one outside the family
- No-one, I would be embarrassed and wouldn't trust that it would get out in the community and spread

Q2. What would stop you from talking to anyone?

- Shame as people wouldn't treat me normally
- Embarrassment of not being able to cope
- Confidentiality issues
- Don't want people knowing and talking about me as if I am crazy
- Don't want to burden others
- People are too busy in their own lives
- Don't want people to think I'm crazy but I'm really lonely

Q3. If you needed help where would you go?

- Daughters, brothers and family members
- Friend
- Doctor – although he has limited time to talk with me

Q4. What kind of help would you like?

- Range of options depending on how we are feeling from
- Counselling both group and 1-2-1 definitely needed
- Social activities
- Medicine
- Need more awareness around signs/symptoms of emotional ill-heath like depression
- Need more sessions like these to make everyone aware and talking about mental health so it doesn't feel wrong

5. Have you, or someone you know, tried to access services in the past and what has been your experience?

None – but after this workshop I would be willing to attend as long as confidentiality and language provision was available

3.4
Group: Dhek Bhal (South Asian Carers)
Date: 24 May 2017

Q1. Who would you talk to if you were stressed or anxious?

- Wife / husband
- Family – son or daughter
- Impartial friend
- Doctor
- No-one outside the family
- No-one, people would think I am mad
- Community is too judgemental on carers and cultural expectations are that carers will always cope so to raise our own emotional needs puts too much pressure on us as we are struggling to cope with our caring responsibilities

Q2. What would stop you from talking to anyone?

- Shame as people wouldn't treat me normally
- Embarrassment of not being able to cope
- Confidentiality issues
- Don't want people knowing and talking about me as if I am crazy
- Don't want to burden others
- Community too judgemental on mental health issues
- Stigma – Dhek Bhal group support has been great in overcoming some of this
- Culturally we don't recognise ourselves as carers as it is our "duty" in our culture
- Huge gap in understanding emotional wellbeing of carers from BME communities
- I would only share information with others in Dhek Bhal because I am safe and comfortable in this environment and won't be judged

Q3. If you needed help where would you go?

- Daughters, brothers and family members
- Friend
- Doctor – although he has limited time to talk with me
- Wouldn't speak to anyone as there is no honour in revealing your family situation / don't wash dirty linen in public
- Did go to the NHS who should have helped and supported carers but very let down. When wife / husband suffered a stroke there was no support when they were discharged from hospital; no information about difficulties we could face as the disease progressed so how to look after our spouses after illness was not explained and no support provided and in some cases made it more difficult for us for i.e had to fight to get the incontinence service and I was angry and frustrated as I had to prove and meet certain conditions/thresholds before receiving incontinence services etc

Q4. What kind of help would you like?

- Counselling - especially to build our confidence when we become carers – carers shouldn't lose hope which we all do at times.
- Counselling at home
- Social activities – currently our funding has been significantly cut so that we now only meet once a month before it was weekly and much needed support
- Outings and trips for us as carers with someone looking after our ill dependents
- Need more awareness around signs/symptoms of emotional ill-heath – it was only after losing my wife and going to counselling that I realised how much I was suffering
- Caring is a full-time demanding job 24-7 getting up constantly throughout the night so need emotional support
- Need more sessions like these to make everyone aware and talking about mental health so we don't feel guilty
- Change cultural expectations so when we do have a break from our caring responsibilities we don't feel guilty(will respite care understand her needs like I will) or when we as carers go out people ask who is looking after our dependents as if it was something shameful!

- Trips and respite care
- Funding cuts have meant that the welfare rights drop-in for carers has now gone which we really need in terms of what is happening to our benefits

5. Have you, or someone you know, tried to access services in the past and what has been your experience?

Yes had bereavement counselling which was excellent. My doctor recognised my need for counselling when family and friends didn't but it lasted only 6 weeks and I felt that it should have been longer.

Counselling services in our own language are much needed.

3.5
Group: Bristol & Avon Chinese Women's Group
Date: 21 June 2017

Q1. Who would you talk to if you were stressed or anxious?

- Friends
- Family – spouse and children
- Doctor
- Talk to myself
- Helpline

Q2. What would stop you from talking to anyone?

- Don't want people talking about me – sometimes it makes it worse talking to others so have to choose wisely
- Too much stigma around depression
- Don't want to burden others
- Trust issues
- People don't respect you if you talk about your problems
- People won't respect my privacy
- Culturally inappropriate to let others know your problems
- Time to overcome the stigma but where do we start?

Q3. If you needed help where would you go?

- Family members
- Search on-line
- Friend
- Doctor – although the language and cultural issues means that I can't really make him understand my problems

Q4. What kind of help would you like?

- Would like community based support through community workers who can help as they understand the issues
- Religious leaders to be involved as this helps

- Counselling services with bilingual counsellors who understand the culture and language
- Free NHS counselling services which we can see a counsellor quickly
- Not private counselling services as have had a bad experience

5. *Have you, or someone you know, tried to access services in the past and what has been your experience?*

- Yes I have had counselling services both privately and on the NHS.

When I privately paid for counselling sessions, I felt that he would understand the culture and be able to help me but I had a very bad experience. I had to go to London as there was no-one locally who could speak Mandarin. I paid a lot of money and received a poor service as the counsellor kept on watching the clock, yawning and showing me that he was bored of what I was saying. I stopped after 2 sessions. However, when I tried the NHS that was much better and helpful.

- My friend tried counselling services and an interpreter was used. However this did not work well as either the interpreter didn't explain our culture very well or the counsellor didn't understand the cultural basis of her problems so couldn't help her so she left as it wasn't benefitting her at all.

3.6
Group: Golden Agers (African-Caribbean Elders)
Date: 20 June 2017

Q1. Who would you talk to if you were stressed or anxious?

- Friends
- Family
- Doctor
- No-one outside the family
- Nurses

Q2. What would stop you from talking to anyone?

- Don't want people talking about me
- Don't want to burden others
- People are very busy

Q3. If you needed help where would you go?

- Family
- Friend
- Doctor – although he has limited time to talk with me

Q4. What kind of help would you like?

- Would like more social activities as isolated and lonely
- More groups like the Golden Agers where we can go everyday (this group can only meet twice a week due to the limited availability of the church hall during the week)
- Trips / outings

5. Have you, or someone you know, tried to access services in the past and what has been your experience?

No one had had cousenlling or knew of other people's experiences of counselling.

3.7
Group: Dhek Bhal (South Asian Women)
Date: 15 May 2017

Q1. Who would you talk to if you were stressed or anxious?

- No-one outside the family – only son/daughter/husband/sister

Q2. What would stop you from talking to anyone?

- My condition is my fault
- The feelings of shame and guilt in our culture.
- Embarrassment of feeling this way
- People will laugh at me
- My children are busy and don't have time to listen to me
- People won't listen as they think its not their business
- Cultural stigma – think I am mad
- I won't go to the doctor as I am frightened he will write in my notes that I am mentally ill.
- Language is a problem as I cant explain how I am feeling in English
- Doctors don't have time to listen properly
- Don't want to be a burden on anyone so will suffer quietly

Q3. If you needed help where would you go?

- Go to a friend / family
- Would go to the doctors but you don't get an appointment before 2 weeks by that time my health would be worse.
- Community organisations like this one helps me and gives me support

Q4. What kind of help would you like?

- Need support in making appointments and then reminders about attending
- Feel very alone – would like someone to come and talk to me in my own language and understand my culture
- Help me to go out as I am always in the house

- Support for when I feel panicked and can't cope and feel that something bad is going to happen. Someone to really listen to me.
- Community place where we can go and meet people who can help us.
- Counsellors here in Dhek Bal where we feel comfortable and is accessible to us so that there are no travel problems and staff can help with arranging appointments due to our language problems.
- Confidentiality is really important to us
- Someone to talk to who won't judge me and what I am thinking

5. *Have you, or someone you know, tried to access services in the past and what has been your experience?*

- 3 women had had experience of counselling services and responses highlighted the following barriers - the counsellor was located far away; the taxis were expensive and unaffordable hence stopping the sessions; one was a carer who couldn't afford to leave her children.
- 3 out of 14 had had experience of counselling and all 3 had positive experiences of it.
- 1 said the travel to the other side of Bristol where the counsellor was based, was a huge barrier both in terms of time taken and the financial cost. She had 3 sessions but couldn't afford any more as taxis cost £48 but would like to continue counselling sessions.
- For one the counselling had helped her understand and control her physical symptoms and her dependence on her faith had helped her significantly now.
- For the other counselling had helped her manage symptoms of anxiety and felt it had benefitted her health overall.

APPENDIX 4 - Demographic Data of Participants

4.1 Data from Group Participants

4.1.1 Gender

GENDER	No. of Participants	% of Participants
Male	35	33%
Female	71	67%

4.1.2 Gender the same as at birth

GENDER THE SAME AS AT BIRTH	No. of Participants	% of Participants
Yes	104	98%
Not answered	2	2%

4.1.3 Age

AGE RANGE	No. of Participants	% of Participants
50 - 59	17	16%
60 - 69	36	34%
70 - 79	36	34%
80 - 89	13	12%
90+	4	4%

4.1.3 Postcode

POSTCODE	No. of Participants	% of Participants
BS1	1	<1%
BS2	12	11%
BS3	12	11%
BS4	6	6%
BS5	51	48%
BS6	1	<1%
BS7	3	3%
BS15	1	<1%
BS16	11	10%
BS20	1	<1%
BS23	2	2%
BS34	2	2%
BS36	1	<1%
BS37	1	<1%
Not answered	1	<1%

4.1.4 Sexual Orientation

SEXUAL ORIENTATION	No. of Participants	% of Participants
Heterosexual	103	97%
Not answered	3	3%

4.1.5 Ethnicity

ETHNICITY	No. of Participants	% of Participants
Pakistani	32	30%
Other Black / African Caribbean	21	20%
Chinese	20	20%
African	13	12%
Indian	7	7%
Bangladeshi	6	6%
Any other ethnic group	3	3%
Caribbean	1	<1%
Other Asian	1	<1%
Mixed ethnic group	1	<1%
UK	1	<1%

4.1.6 Living arrangements

LIVING ARRANGEMENTS	No. of Participants	% of Participants
With family	48	45%
Alone	34	32%
With spouse/partner	23	22%
Other	1	<1%

4.1.7 Living with a disability

LIVING WITH A DISABILITY	No. of Participants	% of Participants
Yes	70	66%
No	33	31%
Not answered	3	3%

4.1.8 Caring for someone

CARING FOR SOMEONE	No. of Participants	% of Participants
Yes	35	33%
No	69	65%
Not answered	2	2%

4.2 Data from Therapy Participants

4.2.1 Gender

GENDER	No. of Participants	% of Participants
Male	0	0%
Female	2	100%

4.2.2 Gender the same as at birth

GENDER THE SAME AS AT BIRTH	No. of Participants	% of Participants
Yes	2	100%

4.2.3 Age

AGE RANGE	No. of Participants	% of Participants
50 - 59	1	50%
60 - 69	1	20%

4.2.4 Sexual Orientation

SEXUAL ORIENTATION	No. of Participants	% of Participants
Heterosexual	2	100%

4.2.5 Postcode

POSTCODE	No. of Participants	% of Participants
BS16	2	100%

4.2.6 Ethnicity

ETHNICITY	No. of Participants	% of Participants
Pakistani	1	50%
Chinese	1	50%

4.2.6 Living arrangements

LIVING ARRANGEMENTS	No. of Participants	% of Participants
With family	1	50%
With spouse/partner	1	50%

4.2.7 Living with a disability

LIVING WITH A DISABILITY	No. of Participants	% of Participants
Yes	1	50%
Prefer not to say	1	50%

4.2.8 Caring for someone

CARING FOR SOMEONE	No. of Participants	% of Participants
Yes	1	50%
No	1	50%

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Oasis Talking Therapies CIC
The Willow Surgery
Hill House Road
Downend
Bristol BS16 5FJ

Tel: 0117 970 9423
info@oasis-talk.org

www.oasis-talk.org
Twitter: @Oasis Talk