VOICE OF MEN

MENTAL HEALTH NEEDS ASSESSMENT OF TURKISH / KURDISH AND CYPRIOT / TURKISH MEN IN HACKNEY

Research by

DERMAN for the wellbeing of the Kurdish and Turkish Communities

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Ferhat studied Sociology at Sivas Cumhuriyet Universitesi in 2000. After graduation he worked as a teacher at the University. In 2005 Ferhat started a postgraduate course in Philosophy at Konya Selcuk Universitesi but had to abandon his studies to come to England. He is married and lives in Hackney.

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ACKNOWLEDGEMENTS

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EXECUTIVE SUMMARY

Background and Aims of the Research

This research aimed to explore and identify mental health issues and needs amongst Turkish, Turkish-Cypriot and Kurdish men in Hackney. The study focused on service users and carers from these communities, as well as those at risk of developing mental health problems. This research is part of a national *'community engagement'* programme managed and supported by the Centre for Ethnicity and Health at the University of Central Lancashire and funded by the National Institute for Mental Health in England (NIMHE). Each research project contributes to the national *Delivering Race Equality* (DRE) Action Plan which aims to achieve equality and tackle discrimination in mental health services in England. The research was conducted by Derman (a local voluntary service that offers and promotes health and wellbeing and to improve the lives of Turkish and Kurdish communities)

Research Aims
- To identify the key issues with regard to developing culturally appropriate mental health service provision for Turkish, Turkish-Cypriot and Kurdish men in Hackney.
- To assess whether service users see current levels of provision are effectively meeting their needs.
- To gather feedback and information from service providers.

Objectives
- To explore cultural perception of mental health for men from these communities
- Identify the factors that impact these group's mental health and psychological wellbeing.
- Identify barriers in accessing and using mental health services
- To identify coping mechanisms in managing their mental health problems
- To capture their experiences of using existing mental health services

Method
- Quantitative and qualitative analysis were used. Two sets of questionnaires were developed.
- **Voice of Men** - General Public and service user's questionnaire. Total -100

participants.
- **Mental Health Service Providers**' Questionnaire – across voluntary and statutory sectors. Total 28 providers replied.
- 3 Focus Group studies- Carers (4), Service users (4) and public (7).
- 2 part-time paid researchers and 3 voluntary researchers were recruited.

Results

Demographic Groups reached

Ethnicity	Age		Length of Stay in the UK (years)		Immigration status of Refugees	
Kurdish 74	40-49	29%	11+	50%	British Passport holders	64%
Turkish 21	30-39	28%	6-10	33%	Indefinite 19%	
Turkish-Cypriot 3	20-29	25%	1-5	10%	Refugee Status	4%
Others 2	18-20	5%	-1	2%	Appeal	5%

- **76 %** said they either know someone who has or have themselves suffered from some form of mental health/stress related problems.
- **74%** said they used their GP, the hospital, talking therapies or their Locality Mental Health Team to get help with these problems.
- **94%** that they or their relatives or someone they know received mental health support. This included: medication/pills (31%), counselling/ talking therapies (30%), psychiatrist (12%) or staying in a hospital (11%).
- **81%** said they did not know of existing mental health services and treatments in Hackney.

Results from open questions and focus group discussions

- Experience linguistic and cultural barriers in accessing mainstream mental health provision.
- Lack of awareness of local service provision.
- A lack of understanding of their mental health issues and discrimination within primary and secondary care settings.
- Identified that women i.e. mothers, wives, sisters play an important role in caring and managing their male relatives' mental health problems. However, their carer role was not recognised within mainstream service provision leading to deterioration of mental health of carer.
- Identify that there was stigma within their own communities leading to isolation and resulting in some families sending their relatives to Turkey to receive culturally appropriate services particularly tackling substance misuse and gambling.

<u>Discussion</u>

In this study, through thematic qualitative analysis, the researchers identified wide range of key themes. However, five key themes emerged and highlighted as the most important for

analysis and discussion. These are;

1. Immigration, culture shock/conflicts and identity
The impact of migration and uncertainty around asylum status together with difficulties in assimilating mainstream British culture has lead to cultural conflicts.

2. Cultural assumptions made by service users and service providers in health care and culturally in appropriate service provision
- A lack of understanding amongst service providers of the mental health care needs of refugees and asylum seekers.
- A lack of understanding by refugees and asylum seekers about how services are designed and accessed in the UK.
- Underutilisation of mental health services.
- Supportive and positive experience from some GP's around their mental health issues i.e. friendliness, genuine listening, spending more time with them, and working with Turkish/Kurdish advocates.

3. Lack of information and language barrier
This study highlighted that refugees and asylum seekers from the Turkish, Kurdish and Turkish Cypriot communities do not have relevant information of mental health services. All respondent stated that language was a barrier to accessing these services.

4. Post-migration problems, the use of drugs and involvement in mafia-like organisations amongst the young generation.
Intergenerational conflicts attributing to substance misuse, gang culture within the young Turkish/Kurdish and Turkish –Cypriot.

5. Loss of status for men
The loss of traditional role as a breadwinner and sole guardian challenges the traditional patriarchal family structure.

Service Providers' Responses

In total, the researchers contacted more than 60 service providers and received 28 responses, two short of the target. Service providers consulted were GPs, community mental health teams, voluntary services.

Mental health issues identified by service providers:
- **Depression, Anxiety, Post Traumatic Stress Disorder** (PTSD), loss, isolation an addictions.
- **Psychosomatic disorders** such as headache, back pain, body pain, abdominal pain, palpitations, dyspepsia, breathing problems, fatigue and dizziness.
- **Language, cultural barriers** to accessing mainstream services.
- **Lack of understanding about the health system** in the UK and locally.
- **The lack of culturally appropriate services** leading to underutilisation of health service
- **Cultural awareness training health to service providers** to gain a better understanding of Turkish   and Kurdish men's mental health needs and partner ship working across sector.
- **To have a cultural reflective workforce** i.e. Therapist and mental health

professionals.
- **The importance of improving the provision of secondary care services**, such as psychotherapy, cognitive behavioural therapy (CBT) and counselling was also underlined.

Conclusion and Recommendations in relation to DRE Action Plan 2010

1. 'Satisfaction with the services'. The research highlighted dissatisfaction with the services and the lack of trust in the health system. To improve service experience by:
- To develop better partnership working between all stake holder groups in order to provide a culturally appropriate mental health assessment and care package.
- Mental health awareness training for front line community workers including local schools so mental health problems can be identified earlier and signposted to appropriate services.
- To develop a culturally appropriate rapid response service and 24 hr bilingual telephone help-line.
- To develop community mental health awareness and prevention programmes including guided self-help literature, newsletters and web-sites.

2. A more balanced range of effective therapies such as peer support services, psychotherapeutic and counselling treatments, as well as pharmacological interventions that is culturally appropriate and effective. In this study almost all the respondents identified that they would prefer to receive bilingual psychological therapies and mental health services. They would like to see Turkish and Kurdish speaking counsellors, psychologists, mental health workers and social workers.

- Establishing a community based crisis centre accessible seven days a week with multidisciplinary staff.
- Expansion of bilingual services particularly counselling and psychotherapy to young people.
- Enhance bilingual advocacy services across sector to improve service access and quality of care.
- To develop mental health peer education programmes for all age groups.
- To develop positive mental health promotion with existing community centres and Turkish and Kurdish voluntary sector organisations and the local community.
- To develop a culturally responsive drug service and support in the community particularly young Turkish and Kurdish people.
- To develop a more holistic care packages i.e. access to employment, education, arts and leisure services.

3. A more active role for BME communities and BME service users in the training of professionals, in the development of mental health policy, and in the planning and provision of services; and a workforce and organization capable of delivering appropriate and responsive mental health services to BME communities.
- To provide and develop clear career pathways and training opportunities for local Turkish and Kurdish people, students and graduates (particularly graduates from psychology, social work and sociology) into the NHS and community settings such as local surgeries, libraries or community centres.
- To provide transcultural training for primary and secondary mental health professionals to have a better cultural understanding of Turkish, Turkish Cypriot and Kurdish immigrant communities.

1. INTRODUCTION

1.1 Background Information on the National Project: The Centre for Ethnicity and Health's Model of Community Engagement

This introduction is based on the experience of UCLAN. It gives background information on the National Project which is based at the University's Centre for Ethnicity and Health and is based on their Model of Community Engagement.

We often hear the following words or phrases;

- Community Consultation
- Community Representation
- Community Involvement/Participation
- Community Empowerment
- Community Development
- Community Engagement

Sometimes they are used inter-changeably to mean the same thing. Sometimes the same word or phrase is used by different people in the same meeting to mean different things. The Centre for Ethnicity and Health has a very specific notion of Community Engagement, and this paper is an attempt to describe it.

The Centre's Model of Community Engagement evolved over a number of years as a result of its involvement in a number of projects. Perhaps the most important milestone however came in November 2000, when the Department of Health awarded a contract to what was then the Ethnicity and Health Unit at the University of Central Lancashire to administer and support a new grants initiative. The initiative aimed to get local Black and Minority Ethnic community groups across England to conduct their own needs assessments, in relation to drugs education, prevention, and treatment services.

The Department of Health had two key things in mind when it commissioned the work. First, the Department of Health wanted a number of reports to be produced that would highlight the drug-related needs of a range of Black and Minority Ethnic communities. Second, and to an extent even more important, was the process by which this was to be done. If all the Department of Health had wanted was a needs assessment and a 'glossy report', they could have directly commissioned a number of researchers who could have gone into local Black and Minority Ethnic communities, talked to them about their needs, written up a report, and produced a set of reports that may not have had any long term impact.

However this scheme was different and the Department of Health was clear that it did not want researchers to go into the community, to do the work, and then to go away. It wanted local Black and Minority Ethnic communities to undertake the work themselves. These groups may not have known anything about drugs, or anything about undertaking a needs assessment at the start of the project but what they would have is proven access to the communities they were working with, the potential to be supported and trained and the infrastructure to conduct such a piece of work.

They would be able to use the six month process to learn about drug related issues and about how to undertake a needs assessment. They would be able to benefit and learn from

the training and support that the Ethnicity & Health Unit would provide, and they would learn from actually managing and undertaking the work. In this way, at the end of the process, there would be a number of individuals left behind in the community who would have gained from undertaking this work. They would have learned about drugs, and learned about the needs of their communities, and they would be able to continue to articulate those needs to their local service providers, and their local Drug Action Teams. It was out of this project that the Centre for Ethnicity and Health's model of community engagement was born.

The model has since been developed and refined, and has been applied to a number of areas or domains of work. These include:

- Substance Misuse
- The Criminal Justice System
- Sexual Health
- Mental Health
- Regeneration
- Higher Education
- Asylum

New communities have also been brought into the programme: although Black and Minority Ethnic communities remain a focus to the work, the Centre has also worked with;

- Young people
- People with disabilities
- Service user groups
- Victims of domestic violence
- Gay, lesbian and bi-sexual people
- Women
- White deprived communities
- Rural communities

In addition to the Department of Health, key partners have included the Home Office, the National Treatment Agency for Substance Misuse, the Healthcare Commission, The National Institute for Mental Health in England and the Greater London Authority, New Scotland Yard, Aim-higher and the Welsh Assembly.

1.1.2 The Key Ingredients

According to the Centre for Ethnicity and Health model, a Community Engagement project must have the community at its very heart. In order to achieve this, it is essential to work through a host community organisation. This may be an existing community group, but it might also be necessary to set up a real or virtual group where one does not exist already. The key thing is that this host community organisation should have good links to the target community (1) (whoever this is) such that it is able to recruit a number of people from the target community to take part in the project and to do the work (see section on task below). It is important that the host community organisation is able to provide co-ordination and infrastructure (e.g. somewhere to meet; access to phones and computers; financial systems for the day to day activities that will be undertaken once the project is underway. One of the

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1 The target community may be defined in a number of ways – in many of the Community Engagement Projects that UCLAN have run we have defined it by ethnicity. We have also worked with projects where it has been defined by some other criteria however, such as age (e.g. young people); gender (e.g. women); sexuality (e.g. gay men); service users (e.g. drug users or mental health service users); geography (e.g. within a particular ward or estate) or by some other label that people can identify with or rally around (e.g. victims of domestic violence, sex workers).

first tasks that this host community organisation undertakes will be to recruit a number of people from the target community to work on the project.

The second key ingredient is the task that the community is to be engaged in. According to the Centre for Ethnicity and Health model, this task must be meaningful, time limited and manageable. Nearly all of the community engagement projects that UCLAN have run have involved communities in undertaking a piece of research or a consultation exercise within their own communities. Sometimes these have been met with an initial resistance to doing 'yet another piece of research', but this misses the point. As in the initial programme that UCLAN ran on behalf of the Department of Health, the process *(i.e. of getting ordinary people involved in doing the work)* is as important, if not more important, than the report that they produce at the end of the day. The task or activity is something around which lots of other things will happen over the lifetime of the project. Individuals will learn and new partnerships will be formed. Besides, it is important not to lose sight of the fact that it will be the first time that these individuals have undertaken a research project.

The final ingredient, according to the Centre for Ethnicity and Health's model, is the provision of appropriate support and guidance. UCLAN do not expect community groups to become involved for nothing. Typically we would make in the region of £15-20,000 available to the host organisation. We would expect that the bulk of this money would be used to pay people from the target community as community researchers [2]. We then allocate a named member of staff from our Community Engagement Team as a project support worker. This person will visit the project at for at least half a day once a fortnight. It is their role to support and guide the host organisation and the researchers through the project. We also provide a package of training – typically in the form of a series of accredited workshops.

The accredited workshops give participants in the project a chance to gain a University qualification whilst they undertake the work. The support workers will also assist the group to pull together a steering group for the project . The steering group is an essential element of the project [3] : without one, it is difficult to see who the community are engaging with and it is unlikely that anything out of the project will be sustained in the longer term. The group will be doing a needs assessment or a consultation exercise, but for what purpose? It is the role of the steering group to ensure that the work that the group undertakes sits with local priorities and strategies, and that there is a mechanism for picking up the findings and recommendations that the group may make. It is also their role to help identify the key individuals who are developed through the project process to help them to take their 'next steps'.

1.1.3 The Uclan Community Engagement Team

The Community Engagement Team comprises of 25 members of staff. They work across a range of Community Engagement areas of specialist, within a tight regional framework.

1.1.4 Programme Outcomes

Each group involved in any of our Community Engagement Programmes is required to

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2 This is not always possible, for example, where potential participants are in receipt of state benefits and where to receive payment would leave the participant worse off.

3 Very often we will have helped groups to do this very early on in the process at the point at which they are applying to take part in the project

submit a report detailing the needs, issues or concerns of the community that it consulted with. The qualitative themes that emerge from the reports are often very powerful, particularly when taken together with other reports produced by groups involved in the same programme. Such information is key to commissioning and planning services for diverse and 'hard to reach' communities. Often new partnerships between statutory sector and 'hard to reach' communities are formed as a direct result of community engagement projects.

The capacity building of the individuals and groups involved in the programme is often one of the key outcomes. Over 20% of those who are formally trained go on to find work in a related field.

1.1.5 The Statement

The views expressed in this report are the views of the Hackney Turkish, Kurdish and Turkish Cypriot communities, and are not necessarily those of the Centre for Ethnicity and Health at the University of Central Lancashire.

1.1.6 The Focus of Voice of Men

Since 2000 over 250 community groups have taken part in one or other of the Centre for Ethnicity and Health's Community Engagement Work Programmes. This particular study was part of the National Institute for Mental Health in England Community Engagement Programme. It was one of many research projects which took place across the country to find out how mental health services can be improved for Black and Minority Ethnic (BME) communities.

The research project is also linked to a national action plan for improving Mental Health services for Black and Minority Ethnic communities called 'Delivering Race Equality' (DRE) which was published in 2004.

This particular study, aims to contribute to five different elements of DRE. It will consider how mental health services can be promoted to Turkish/Kurdish and Turkish Cypriot men living in Hackney and how to tackle the stigma of men using appropriate services in mental health. It also considers how to increase their satisfaction with services and the proportion of service users who feel they have recovered from their illness. In addition, the study will reflect on how to balance a range of culturally appropriate and effective therapies such as peer support services, psychotherapeutic and counselling treatments, as well as pharmacological interventions. Lastly, it looks at how to provide a more active role for Turkish / Kurdish and Turkish Cypriot communities and service users in the training of professionals and in the development of mental health policy and provision of services.

It is our hope that the findings of this research will help develop and improve services in Hackney and more widely. We also hope to present the results and recommendations of this research project to the Local Health Trust and the Local Authority, who are responsible for delivering different services in Hackney and East London.

1.2 Hackney

One of the 32 London boroughs, Hackney is a multicultural area and is home to more than 207,000 people from more than 6 continents and a wide range of ethnic backgrounds. During

the latter half of the 20th century, Hackney's population started to grow due to natural increase and migration. One of the most striking characteristics of Hackney is its rich ethnic diversity. Residents from white ethnic backgrounds make up 59.4 of Hackney's inhabitants. Black and Black British residents are the second largest ethnic group in the area, accounting for 24 per cent of Hackney's residents. This is a significantly higher percentage of black residents than found in Inner London or London as a whole.

Table 1 Ethnic Groups 2001

Ethnicity	Hackney	Inner London	England and Wales
White	59.4 %	65.7 5	91.3 %
Mixed	4.2 %	3.9 %	1.3 %
Asian or Asian	8.6 %	10.6 %	4.4%
Black or Black British	24.7 %	16.4 %	2.2 %
Chinese or other Ethnic Group	3.2 %	3.4 %	0.9 %

Many of Hackney's residents originate from countries other than UK. In the 2001 Census 14,242 people living in Hackney stated their place of origin as the Central or Western African region. A further 10,074 people trace their roots to Jamaica and the Caribbean. Close to 10,000 of Hackney's residents are from Eastern Europe while 14,843 are from Asia.

Turkish-speaking communities are located in all parts of the Borough, though there is a greater concentration in North and Central parts of the Borough. Stoke Newington, Newington

Green and Dalston have the greatest concentration of the population and in particular Green Lanes, running from Manor House down to Newington Green Roundabout, has a high concentration of businesses and shops owned by people from these communities.

1.3 Derman

Derman was set up in 1991 by members of the Turkish, Turkish Cypriot and Kurdish communities in Hackney in partnership with local GPs and the Health Authority. The main purpose of Derman is to promote the wellbeing and to improve the lives of Turkish, and Kurdish speaking communities in London. Derman, offers holistic care for individuals and families through counselling, advocacy, advice and other services. Derman believes that mental health is a serious issue for the Turkish, Turkish-Cypriot and Kurdish communities.

1.4 Aims and objectives of the study

This study aimed to explore and identify mental health issues and needs among Turkish, Turkish-Cypriot and Kurdish men in Hackney. This was mainly a needs assessment study focusing on service users and carers from the above-mentioned communities, as well as those at risk of developing mental health problems. The key issues and questions the study sought to address included the extent to which service users from these communities need

culturally-specific projects and sanctuaries in the community, as well as whether they see current levels of provision in the area as sufficiently meeting their needs. In addition, the study seeks to find out: the cultural perceptions of mental health; factors affecting mental health and psychological well-being; the barriers in accessing or using the services; the solutions and coping mechanisms these men use to address mental health problems; what kind of support they would like or use; and what they like and dislike about existing services.

In order to explore the needs of the community, the study aimed to recruit service users and/or carers with a range of experiences of mental health services. The research team was confident in recruiting service users for the study because the majority of them were already Derman's service users through Derman's Mental Health, Health Advocacy and Parenting projects and there were already sound relationships between Derman staff and service users.

The study's target sample population consisting of a total of 100 men from the Turkish, Kurdish and Turkish Cypriot communities were asked to complete questionnaires titled *"Voice of Men: General Public Questionnaires"* and 30 service providers were asked to complete questionnaires titled"Voice of Men: Service Providers Questionnaires" . There were also 3 focus group discussions. The interviews would be carried out through semi-structured interviews. The aim was to run 3 focus groups of up to 8 people, based on themes and insights developed by the research team. The aim was that the study would result in the development of a model for culturally specific services and recommendations to both statutory and voluntary sector service providers.

1.5 The Myths of Mental illness

In the course of a year, about one in eight people in Britain consult their GP for problems which are predominantly psychological in nature and about ten per cent are referred to a psychiatrist by their GP (Gregory, 1987). Clearly the figures would be much higher if the number of people who experience various psychological problems who do not seek professional help were also taken into account.

The existing norms in society and the particular time in history, determine what is considered to be mentally normal or abnormal behaviour. Miles (1981) pointed out that the classification of mental illness is an ongoing process as throughout time notions of the nature of mental illness changes in any given society. For example, homosexuality was diagnosed a mental disorder until 1973 (Bayer, 1981 cited in Fernando 1995) and drapetomania was considered a disease of black slaves characterised by the symptom of running away from captivity (Cartwright, 1851 cited in Fernando, 1995).

Scheff (1966 in Miles 1981) argued that children learn how to behave in stereotypical ways towards mentally ill people from their peers and adults, and these stereotypes survive into their adulthood. Miles (1981) also argued that traditional images of madness are reinforced by the way the media represent mentally ill people. According to Furnham (1988), people learn behavioural attitudes about mentally ill people from their parents, teachers and media. Furnham also suggests that frequent media portrayal of mental illness does not help to reduce the hostile attitudes towards mental illness as the media misinforms the public through newspapers, television dramas and movies. For example, one analysis carried out in the Netherlands showed that *"more than half of all reports and articles which contained references to mentally disturbed persons were dealig with crime"* (Swarte, 1955 cited in Miles 1981 pp: 64).

According to Furnham, (1988) studies with different populations showed similar patterns of attitudes toward mentally ill people. In general, people showed more positive attitudes towards physically ill people than mentally ill people, and also as the severity of mental illness increases the social rejection of these patients' increases (Furnham, 1988; Socall and Holtgraves, 1992). People also tend to keep a distance between themselves and mentally ill people; however, this social isolation in turn forces more problems onto mentally ill people and makes it more difficult for them to recover. Furnham (1988) argued that negative attitudes are not held as a result of existing information about mental illness. On the contrary it is the result of lack of information.

Littlewood and Lipsedge (1989) pointed out that different societies have different ideas about normality and abnormality. For example, Fernando (2002) stated that whereas some inner experiences or altered states of consciousness are seen as abnormal in many of the Western countries, these behaviours are seen as normal in many cultures in Africa, Asia and South America.

1.6 Refugees, Asylum Seekers, Ethnic Minorities and Mental Health

Throughout history millions of people have moved from one place to another in order to flee war or persecution by their own governments because of their political, religious or ethnic origins. Throughout the twentieth century millions of European people were persecuted. These have included Jewish communities, Iranian people escaping from the Humeyni regime, about two million Sudanese families who have escaped from the Darfur conflict, and millions of Afghanis and Iraqis who have left their countries because of the recent wars. According to the United Nations High Commission on Refugees (UNHCR) figures at the start of the year 2005, the number of people of concern to the UNHCR was 19.2 million. They included 9.2 million refugees (48%), 839,200 asylum seekers (4%), 1.5 million returned refugees (8%), 5.6 million internally displaced persons (29%) and 2 million others of concern (11%) (www.unhcr.org).

Furthermore, in today's global world millions of people immigrate from developing countries to advanced capitalist European countries for economic reasons. Tribe (2002) explained that there is a significant difference between refugees and immigrants: immigrants make their own choice to move to another country, whilst refugees make a decision to flee for fear of their lives by taking a risk that they will lose everything they have. However, media misrepresentation of refugees and asylum seekers leads to confusion and misunderstanding of what an asylum seeker and refugee or immigrant is (see Box 1).

Clearly, whatever the reason, as a result of migration people move from one cultural setting to another. According to research this migration process is an unavoidably stressful process, and can lead to culture shock and mental illness. According to Rack (1982), *"…culture shock happens when the psychological cues that help an individual to function in society are withdrawn and replaced by new ones"* (pp: 56). Bhugra and Jones (2001) pointed to two different 'micro and macro' factors, which cause mental disorder amongst migrated people. Macro factors include the preparation the migrants undertake, their acceptance by the new host community and the process of the migration itself. Micro factors include personality traits, psychological robustness, cultural identity and social support.

Refugees and asylum seekers characteristically experience trauma and culture shock after displacement, and as a result of living in a new unfamiliar society. Earlier studies in the

United Kingdom have found that one in six refugees has a physical health problem severe enough to affect their life and two thirds have experienced anxiety or depression (Burnett and Peel, 2001).

According to Ager and Young (2001), four discrete phases of the refugee experience may be distinguished in order to understand the psychological and social challenges faced by refugees. The first phase was defined as the pre-flight, which refers to the period leading up to flight itself. During this period refugees generally face economic hardship, social disruption, physical violence and political oppression. The second phase of flight involves the experience of separation from home/family and the dangers of passage itself to a country of asylum.

This phase is followed by a temporary settlement or asylum seeking phase which involves accommodation in a formal refugee centre, where the outines of normal life are hard to establish. During this phase, asylum seekers frequently experience high rates of stress, as they cannot be certain about their application. Sales (2002) pointed out that the process of settlement which should begin on entry is openly postponed for months and in some cases years. Hondius et al. (2000) suggested that long period of uncertainty is a significant variable in psychological health complaints related to post-migration stress. Sales (2002) further pointed out that research with Turkish and Kurdish refugees in London highlighted the high incidence of mental health problems, often associated with anxiety over legal status in the early years. The fourth and last phase involves resettlement. Again during this process, refugees face considerable difficulties including racism, employment difficulties and culture conflicts. Many studies, particularly from the 1980's to today, compared the mental health of migrated groups with native people and showed that rates of anxiety, depression, post-traumatic disorder and schizophrenia were higher among migrant groups and ethnic minorities in many Western countries and the UK. According to One recent study black people are three times more likely than the rest of the population to be admitted to mental hospitals in England and Wales (The Guardian, 7 December 2005). Many studies for example showed that Somalian refugees have a high rate of diagnosed mental disorders in the UK (McCrone at al. 2005).

> **Box 1: Definitions according to the Refugee Council**
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> **Asylum Seeker:** One who is fleeing persecution in their homeland and on arrival in another country has made themselves known to the authorities and exercised their right to apply for asylum.
>
> **Refugee:** One whose asylum application was successful and who is allowed to stay in another country having proven they would have faced persecution in their homeland.
>
> **Economic Migrant:** One who has moved to another country to work.

Claasen et al. (2005) reviewed the peer-reviewed publications of research on mental disorders and their care in three major European countries (UK, Germany and Italy). Amongst them Germany has the largest Turkish immigration group and 9 of the 13 studies investigated Turkish patients. These nine studies showed that Turkish immigrants under-utilised the mental health services.

Haasen et al. (2000) argued that possible affective disorders are misdiagnosed as schizophrenia amongst migrants, and aimed to study potential misdiagnosis amongst Turkish immigrants in Germany. This study found that almost every seventh Turkish patient with paranoid-hallucinatory syndrome would potentially be misdiagnosed.

1.7 Turkish and Kurdish Population in the UK

In recent history Turkey received a substantial numbers of refugees from Bosnia, Kosovo and Iraq. Although, Turkey is a country which receives asylum seekers and immigrants, particularly from its neighbouring countries, a substantial number of Turkish people and people from ethnic minorities leave the country for religious, economic, ideological and ethnic reasons. For example, in Germany, 8.9 % of the general population are non-Germans with people from Turkey comprising 26.6 % of this group (Lay, Lauber, Rossler, 2005).

According to the 2001 census 92.1% of the UK population are white and the remaining 7.9% people belong to ethnic minorities. In Great Britain the number of people who came from other non-white ethnic groups grew by 53 per cent between 1991and 2001, from 3.0 million in 1991 to 4.6 million in 2001 **(www.statistics.gov.uk)**.

Since there was no separate census category for Turkish and Kurdish people in the 1991 and 2001 census it is very difficult to establish accurate statistics for the number of Turkish and Kurdish people in the UK. Population data is limited and Kurdish communities are thought to be under represented in this data. Thirty to forty thousand Kurds are estimated to have left Turkey and arrived in Britain since 1980. Mugerwa (1997) estimated that there were 24,000 refugees from those communities in Hackney. Today it is estimated that the Kurdish/Turkish population in the UK is around 100,000.

There are three main Turkish speaking communities in the UK, and the most recent group to arrive are people from the Kurdish community, the majority of who have come from Turkey. Kurdish people come from Turkey, Iraq, Syria and Iran, and the majority of Kurdish refugees and asylum seekers live in the boroughs of Hackney, Haringey, Enfield, Barnet and Waltham Forest. In this research the focus will be on Kurds from Turkey who have mainly escaped because of conflict between the Turkish army and the Kurdish rebel group, Kurdistan Workers Party (PKK) in the 1980's.After 1989 the UK government enforced a visa requirement for Kurdish people coming to the UK.

Turkish Cypriots have been in the UK the longest; the first immigrants came to England between 1930 and 1950. After this first wave of immigration a second group of settlers came between 1950 and 1970, as a direct result of the political events in Cyprus. Many of these Turkish Cypriots worked in restaurants and textile factories in the UK. Turkish people from the mainland have been coming since 1971, after the Army coup in Turkey. During the 1980's there was another military coup in Turkey and, political pressures forced a large number of people to leave Turkey. Turkish and Turkish-Cypriots reside mostly in Newington Green, Haringey, Hackney, Edmonton and Enfield. There are a large number of Turkish and Kurdish enterprises.

1.8 Turkish and Kurdish Attitudes to Mental Health

The causes of mental illness are often unclear and clinicians propose different models to explain and treat mental disorders. Particularly in Western cultures, psychiatrists have focused on possible biological explanations of mental illness. According to Fernando (1995) this medical approach in general rejects the significance of racial and cultural issues.

However, in order to provide better or more appropriate mental health care and treatment it is very important to know the health beliefs of individuals in any given culture which can be

attained by more academic studies and research. It is particularly crucial as countries become increasingly multi-cultural. Much research indicates that cultural and religious beliefs about the causes and cures of mental illness need to be taken into account as they greatly influence the diagnoses and treatment process (Cinnirella & Loewenthal, 1999; Angermeyer at al. 2004; Lay, Lauber & Rossler 2005; McCrone at al. 2005).

According to Dogra (cited in Williams 2004) the inequalities in healthcare delivery are related to different cultural origins and perceptions of different groups. She claims that the cultural assumptions of service users and the public, and of practitioners, can have fundamental effects on the delivery of services. She emphasizes that *"All of these beliefs and practices, in turn can influence how patients and healthcare professionals perceive health and illness and how they interact with one another"*.

There have been several studies in Turkey which have focused on the mental health beliefs of Turkish people in different social settings and regions. Two separate studies Eker (1989) and Arkar & Eker (1994) found that paranoid schizophrenia was the most widely recognized and yet the least accepted mental disorder. According to Arkar and Eker, Turkish people want to distance themselves from such a person and compared to a withdrawn schizophrenic or depressed person, people expect greater emotional and physical burdens from dealing with people suffering from paranoid schizophrenia.

Taskin et al (2003) pointed out similar results in another study which was carried out in rural areas of Turkey. According to Taskin et al (2003) the local population had a strong tendency to stigmatise schizophrenic patients. The rural public also do not want to have close contact with schizophrenic patients. Furthermore, Ozmen et al. (2004) studied public attitudes to depression in urban areas of Turkey and found that urban Turkish people had unfavourable attitudes about depression and a tended to isolate such people from society.

Sagduyu et al. (2001) investigated Turkish people's attitudes to schizophrenia, and found that the majority of the public identify schizophrenia as a mental illness (76.5%). People thought stressful life events (54.3 %) and weak mental constitution (52%) are the most commonly endorsed causes of schizophrenia, and 40% of people believed that schizophrenia cannot be cured. Amongst their sample 58.6 % of people believed psychotherapy, and 32.3 % believed pharmacotherapy to be an appropriate treatment. In addition, 44.8% of this group believed that the drugs used for schizophrenia may cause addiction, and 25.4% believed that these drugs have side effects.

Similarly, Ozmen et al. (2003) found that 86.6% of Turkish participants considered social environmental factors to be the cause of depression, and 68.2% thought it was also due to weak personality. Moreover, 43.3% of participants believed that people with depression are aggressive, and 22.8% believe their freedom should be limited. 94.5% considered depression to be an illness which is treatable, but 54.9% considered pharmaceutical drugs used for depression to have serious side effects.

A study by Sagduyu et al. (2003) focused on relatives' beliefs and attitudes to schizophrenia in Turkey. They found that social problems (62.9%) and personal weaknesses (65.3%) were the most attributed causes of schizophrenia, and almost all of their participants preferred medical methods, i.e. employing psychiatrists and the use of pharmaceutical drugs for the treatment. 72.2% of the participants believed that people with schizophrenia are dangerous and 91.8% believed these people could not take responsibility for their own lives

2 METHODOLGY

2.1 The Research Team

The research team consisted of four voluntary researchers, two part-time research assistants and a project co-ordinator. The project co-ordinator, who is also Derman's Mental Health Team leader, provided support and supervision for research assistants and voluntary researchers. The researchers were recruited within Derman and from the Turkish Kurdish communities.

2.2 The Steering Group

The Steering Group was made up of members of local strategic planning and commissioning bodies. As well as meeting every two months, the group maintained contact via e-mail and the telephone. They provided guidance and support, ensured that the research processes were in line with NIMHE guidelines and DRE objectives and managed any ethical issues arising from the running of the project. Regular meetings with the Steering Group were held every two months to discuss developments and any arising issues. The steering group guided the research, kept it on track, and discussed any ethical issues that arose.

The members of the Steering Group were the Project Co-ordinator, the Mental Health Commissioner from Hackney PCT, a Community Development Worker from the Locality Mental Health Team, a CPN in Primary Care, the Chair of Hackney Refugee Forum, UCLAN support worker and the six researchers.

2.3 Training and support for researchers

The researchers were trained at The Centre for Ethnicity and Health, University of Central Lancashire and attended most of the seven workshops. In addition to this training, UCLan support worker Imran Mirza supported researchers on developing the questionnaire, and understanding the assignment requirements of the course. Voluntary researchers attended the workshops and were supported by research assistants throughout the study. Voluntary researchers were accompanied by research assistants while carrying out field work in the community. Project coordinator Nursel Tas supported research assistants and volunteers through supervision, helped them to plan next steps and organised the team to meet the deadlines. The researchers participated in every step of the study. They set up the questionnaires carried out field work, recruited focus group members and run the groups, translated questionnaires in Turkish and English, attended steering group meetings and wrote the report.

2.4 Selection of Research Tools

The project aimed to collect both qualitative and quantitative data. Therefore the research team decided to collect both primary and secondary data.

2.4.1 Quantitative Data: Questionnaires

Questionnaires are a practical way to collect quantitative data and can also reach a high number of people. Analysing questionnaire data can also be easier than other methods. According to Kumar (1999), using questionnaires as a data collection method saves time

and financial resources and offers greater anonymity as there is no face-to face interaction. Therefore, two sets of questionnaires were designed as a research tool:

- Voice of Men: General Public Questionnaire and Information Sheet
  (see Appendix 1)
- Voice of Men: Service Provider Questionnaires and Information Sheet
  (see Appendix 2)

The questionnaire *"Voice of men: General Public Questionnaire"* was designed by the researchers and was completed by Turkish and Kurdish individuals in different social settings. The questionnaire comprised of two sections. In part one participants provided some demographical information about themselves and in the second part, their experiences; attitudes and opinions about mental health were investigated. The participants were recruited from community centres, coffee houses, social clubs, and snooker clubs.

A second set of questionnaires, *"Voice of Men: Service Providers' Questionnaire"*, was designed to be completed by service providers from a variety of settings such as mental health practitioners, GP's, health advocates, community sector representatives and professionals from educational settings. The purpose of this questionnaire was to learn if local service providers are reaching to our communities, the presentation of mental health problems by our communities and service providers' experiences, and their opinions on how to improve services to reach our communities better.

2.4.2 Qualitative Research: Thematic Analysis

In contrast to quantitative research, qualitative research seeks to acquire in depth and intimate information from smaller groups of people so as to learn about how and why people behave, think and make meaning as they do (Ambert et al. 1995). Qualitative study focuses on the context and integrity of the material. Qualitative research accepts that representations of the world are not straightforward and should always include an interpretative component, and it acknowledges that *"there will always be gap between the things we want to understand and our accounts of what they are like"* (Parker 1994 pp: 3).

Hayes (2000) suggested that there are almost as many ways of doing qualitative analysis, as there are ways of doing quantitative analysis. Hayes regarded thematic analysis as the most popular, which she also suggested as a useful way of exploring the richness of qualitative data. Thematic qualitative analysis involves sorting information into themes and *"is a coherent way of organizing or reading some interview material in relation to a specific research question"* (Burman 1994 pp: 57). Boyatzis (1998 pp: 4) explained a theme as *"a pattern found in the information that at minimum describes and organizes the possible observations and at maximum interprets aspects of the phenomenon"*.

A Focus Group is a group interview with 4-10 people who have common experience. A list of questions and topic areas identified to stimulate discussions was devised. (See Appendix 3: Focus Group Themes and Questions). This was an ideal way to collect qualitative data and more detailed information.

2.5 Selection of Research Sample

In order to reach our target of 100 Turkish, Kurdish and Turkish-Cypriot men in Hackney, the

project used quota sampling so as to incorporate different views related to mental health needs assessment e.g. men with mental health problems, their carers and general public. At the same time a convenience sampling technique was also used as participants were selected from those who agree to be interviewed.

The project, however, used purposive sampling for selection of our service providers to receive questionnaires and be focus group participants. Researchers believed that selecting people who have practical and valuable information e.g. carers, service users, and ex-service users would be beneficial to our research aims.

2.6. Data Collection

The project reached 100 Turkish, Kurdish and Turkish-Cypriot men and 27 service providers. The research team assisted men to complete the questionnaires. For instance, the questions were explained to the participants when required and practical help was provided for those who are illiterate.

The research group ran three focus groups with Men, Carers and General public men to explore the mental health issues of Turkish, Turkish-Cypriot and Kurdish men in Hackney. The focus group participants were recruited from Derman's service users, coffee houses and social clubs.

2.7 Ethical issues

Having an Ethical Procedure is very important for research to ensure that no one is put at risk as a result of participating in the project. This can protect both the researchers and the participants of the project as well as other agencies involved.

The Research Team performed its duties within a framework of confidentiality and in compliance with data protection legislation. Everything was kept strictly confidential. This confidentiality would only be overridden in cases where it was likely to cause harm to the respondent or harm to another person. Fortunately this was not necessary. The interviews were held in private rooms at Derman's office and local community centres. The names of participants were not revealed to anyone outside the research team. In order to ensure confidentiality, no names or any identifiable data was placed on the questionnaires.

The completed questionnaires were kept in a locked filing cabinet in Derman's Hackney Office and no one had access to them except the research team members. As the researchers would be in contact with vulnerable people, every researcher had a Criminal Records Bureau (CRB) check. The research team was also trained on how to deal with conflict and aggressive behaviour, as well as receiving training on health and safety issues. An Information Sheet and a Consent Form were designed to clearly inform participants about the research project, its aim, what was expected and what they were consenting to. Potential participants read these before completing the questionnaires or taking part in a focus group. Focus group participants were also informed about the ground rules and boundaries of the group. The importance of confidentiality was particularly highlighted.

3. RESULTS

3.1 General Public Questionnaire

A total of 100 responses from the Turkish-Kurdish and Turkish Cypriot communities were analysed.

3.1.1 Results from General Public Questionnaire: Part 1

Figure 1 - Age
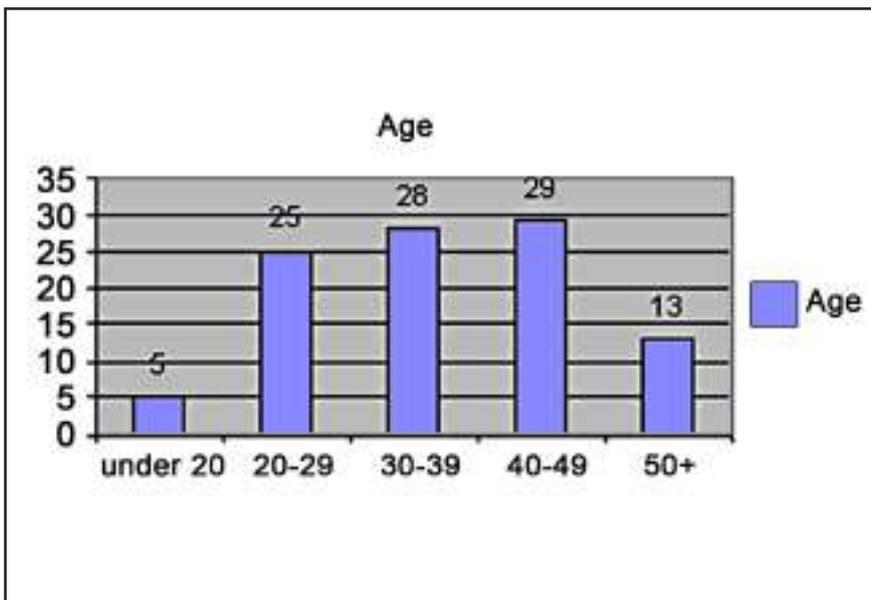
Age range in majority of participants (82%) was between 20 to 49 years old. Only 5% were under 20 and 13% of participants were over 50 years old.

Figure 2 - Place of Birth
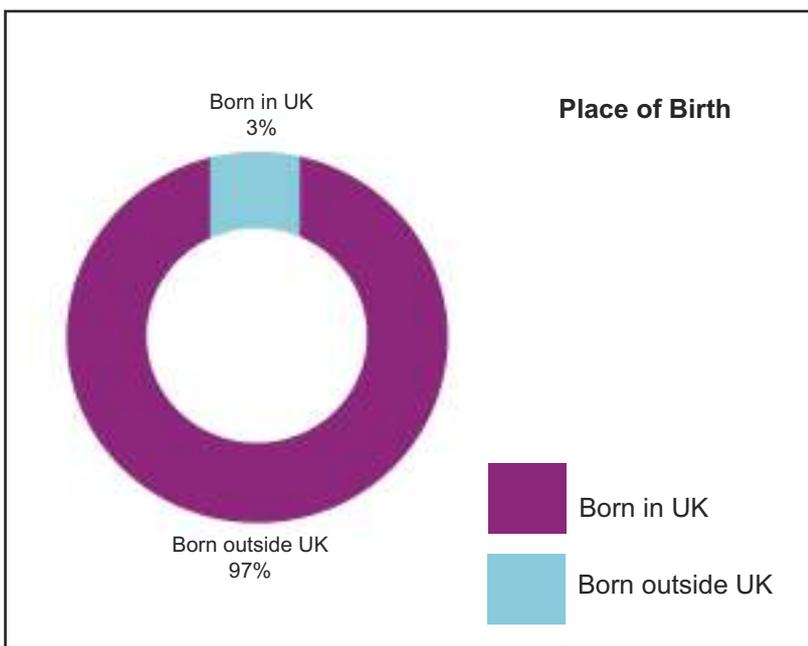
Only 3% of those who participated in this study were born in UK. The majority of men (97%) were born outside of UK.

Figure 3 - Length of in the UK
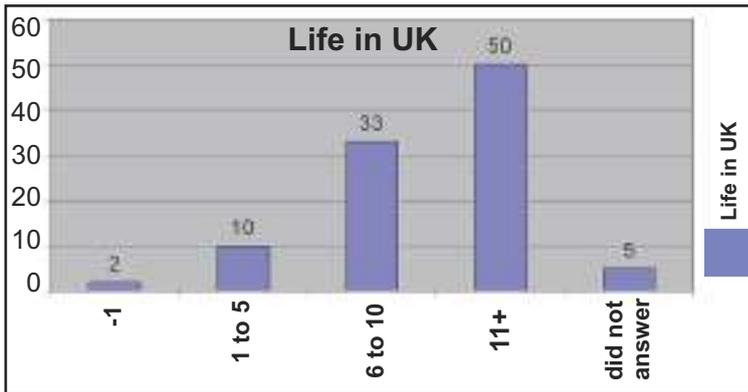
Half of the participants (50%) said the length of their stay in the UK was more than 11 years, 33% said they had been in the UK between 6-10 years and 10% stated that they had been in the UK for between 1 and 5 years. Only 2 % said they had been in UK for less than a year. 5% did not answer this question.

Figure 4 - Ethnicity
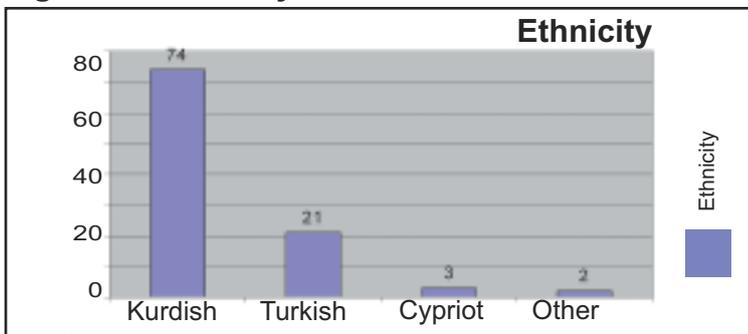
This study managed to reach 74 Kurdish, 21 Turkish and 3 Turkish Cypriot men. 2 participants stated their ethnicity as "Other" (1 stated his ethnicity as Zaza and 1 as Alevi)

Figure 5 - Citizenship / Immigration status
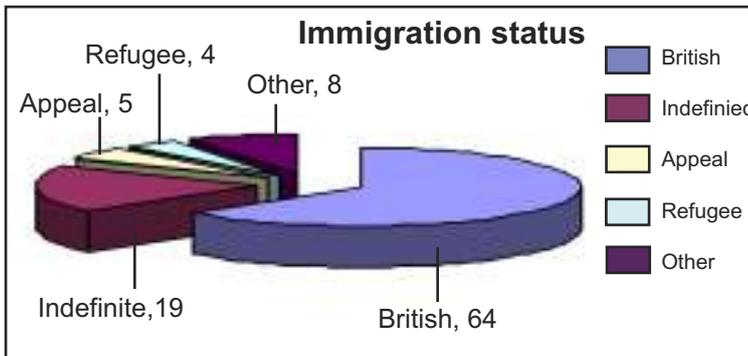
This diagram shows the immigration status of participants.

Figure 6 - Languages
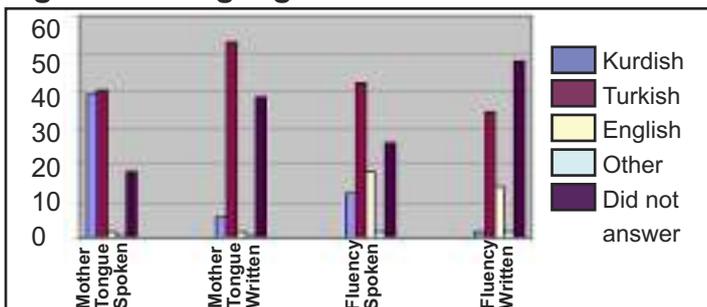
Data about languages was collected through Questions 4 and 5. We asked participants to state their mother tongue, spoken and written and their levels of fluency in the languages they can speak and write.

Figure 7 - English
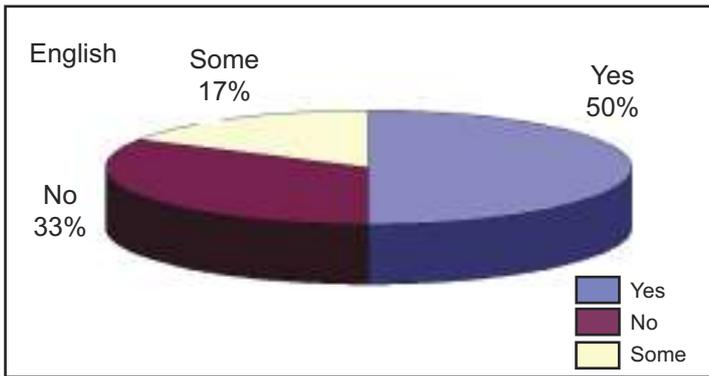
In Question 6.a, we asked participants: "Can you speak English?" 50% said they can speak English to an Intermediate or Pre-Intermediate level; 17% said they can but to an Elementary level and 33% said they do not know any English. In Question 6.b, we asked participants "What kind of barriers do they experience in learning English?" The results were as follows:

Table 2 - Barriers in Learning English

	Answered	Percentage
Long working hours	29	48.3%
Older Age and lack of literacy	6	10%
Financial difficulties	8	13.3%
Psychological problems e.g. isolation, depression and lack of motivation	**17**	28.3%
TOTAL	**60**	

Figure 8 - Religion
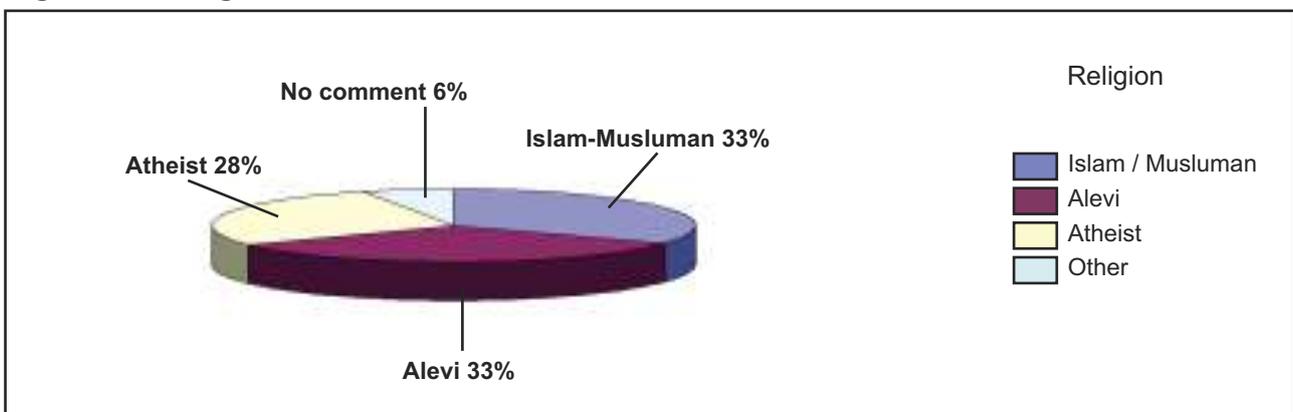
Figure 9 - Marital Status
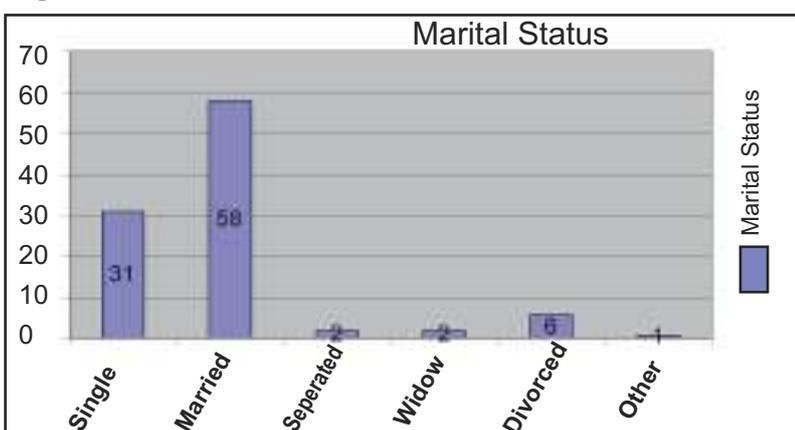
The majority of participants said they were married (58%).31% said they were single. A total of 11% said they were separated, widowed, divorced or in 'Other' category.

Figure10 - Level of Education

Education

Higher Education 11%

Other 7%

Primary 28%

High School 30%

Secondary 26%

Legend:
- Primary
- Secondary
- High School
- Higher Education
- Other
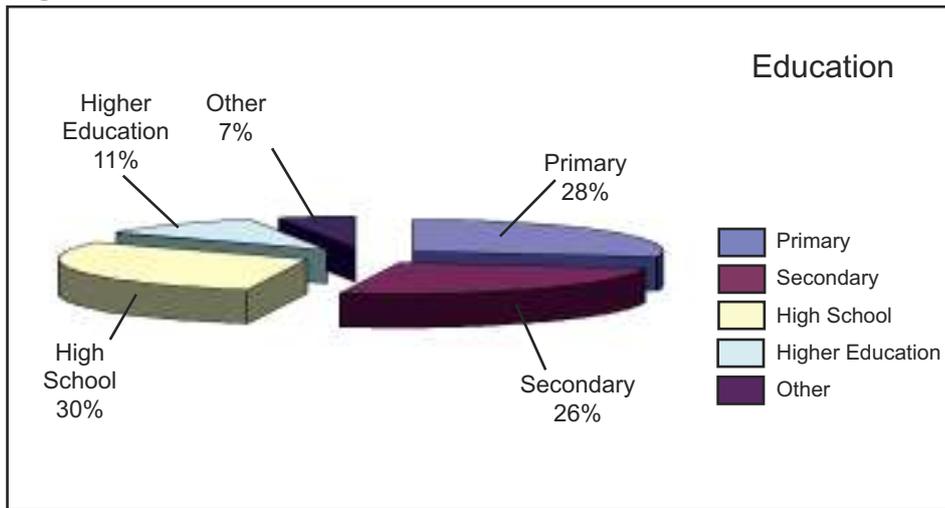
Just over half of the participants (54%) said that they held either a Primary School Degree 28% or a Secondary school Degree (26%). 30% said they had a High school degree and only 11% had a higher education degree. 5% said 'Other'.

Figure 11 - Place of Education

Place of Education

Other 5%

N/A 7%

UK 18%

Turkey 70%

Legend:
- Turkey
- UK
- Other
- N/A
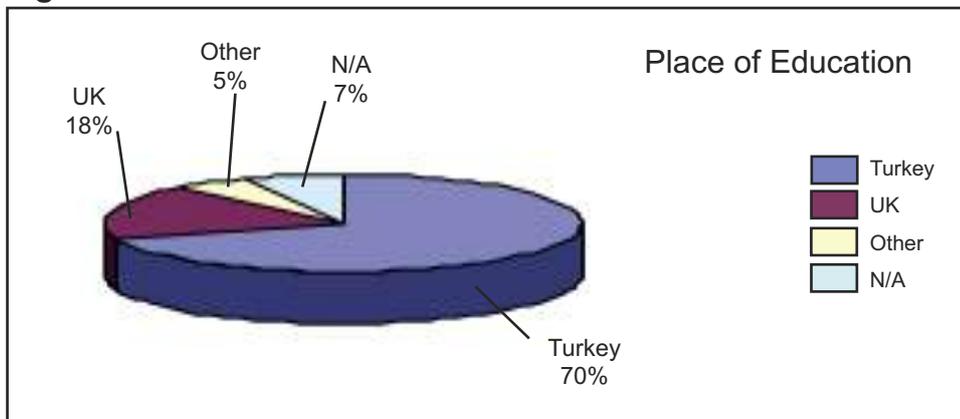
In Question 9.b we asked "In which country did you achieve qualification/s?"

70% stated Turkey, 18% stated the UK.

5% answered "Other" and 7% did not answer the question.

Figure 12 - Number of Children

Children

Legend:
- Children

X-axis: none, 1, 2, 3, 4, 5
Y-axis: 0, 10, 20, 30, 40, 50
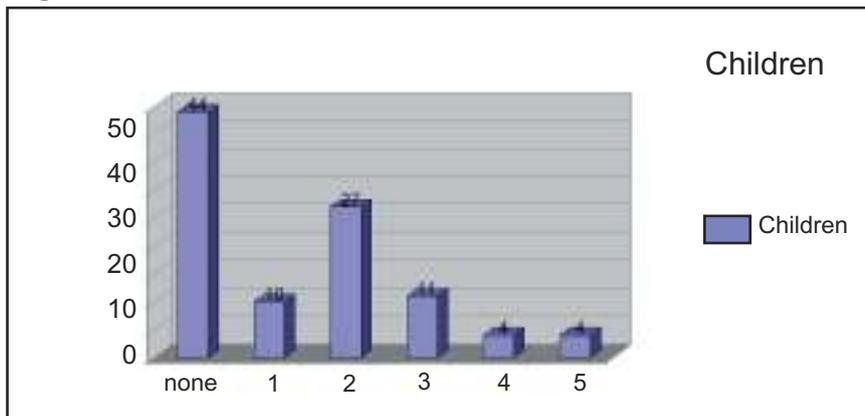
We asked participants the number of children they had:
44 answered "None"
10 said they have 1
27 said they have 2
11 said they have 3
4 said they have 4
4 said they have 5 or more

Figure 13 - Employment

Work

Legend:
- Work

Full	Part	Unempl	Retired	Self.	Benefit	Other
34	10	32	3	10	18	11
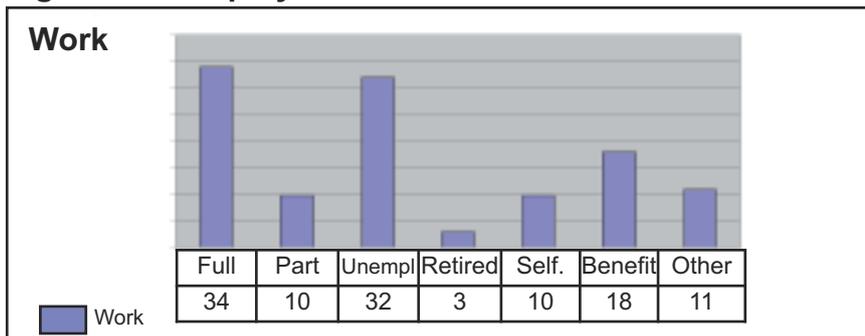
100 people answered and the number of answers is displayed in the table. 32 people said they were unemployed and of those, 18 of them also said they receive benefits.

Table 3 - Support Needed for Returning Back to the Work

Type of support needed	Frequency	%
Support in learning language	8	23%
Support in tackling with their health roblems	8	23%
Appropriate trainings to get jobs	9	26%
financial support e.g. loans to set up their wn business	5	14%
Help with their immigration problems/status	5	14%
TOTAL Response	35	

We then asked participants in Question 13.b: *"What kind of support would you need to return back to work?"* 35 answered this question as displayed in Table 3.

Figure 14 – Disability / Chronic Illness

Physical Disabilities

	Yes	6
	No	74
	Illness	18
	N/A	2
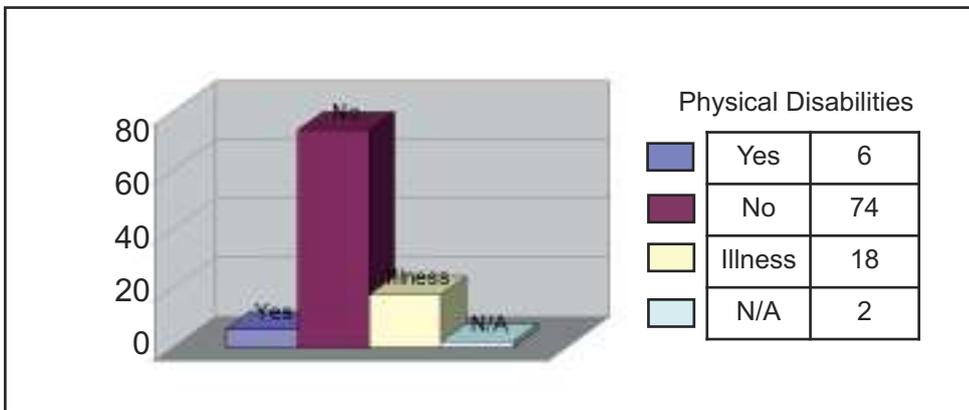
In Question 14 we asked participants: *"Do you have a disability or chronic illness?"*

- 74 considered that they had no disability or chronic illness
- 6 considered that they had some kind of disability
- 18 said they had at least one chronic illness that is affecting their quality of life
- 2 did not answer the question

3.1.2 - Results from General Public Questionnaire: Part 2

This part of the questionnaire investigated experiences, attitudes and opinions about mental health.

Figure 15- Sharing Emotions
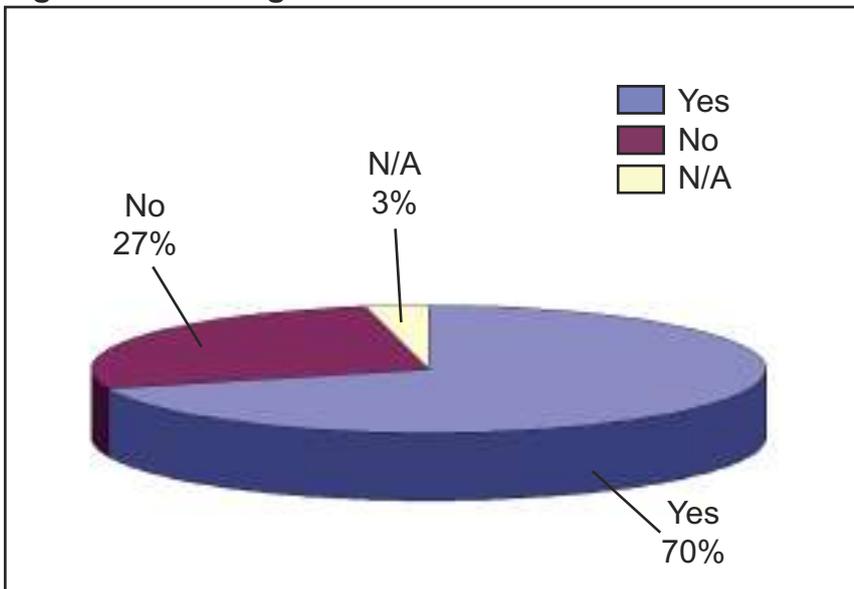
The respondents were asked if they were able to share their emotions/feelings. The majority of men (70%) said they were able to share their feelings and only 27% of them said they find it difficult to share their emotions.

Only 3% did not answer this question.

We then asked the participants of those that answered 'yes' to the previous question, "Who would you prefer to open up your feelings to?"

Table 4 - Sharing Emotions with…

Sharing Emotions With	Frequency	Percentage
Friends	52	33%
Spouse	34	22%
Partner	8	5%
Relatives	14	9%
GPs	12	8%
Psychologist	11	7%
Community Director	2	1%
Other	9	6%
Not answered	16	10%

70 participants answered this question. Some participants still answered this question despite having answered 'NO' in the previous question.

Figure 16 - Emotional Barriers

Emotional Barriers

- Finding Diffucult to Share
- Emberassment
- Male` shouldn`t share
- Traditional Upbringing
- Difficult to find someone
- No Barriers
- Others
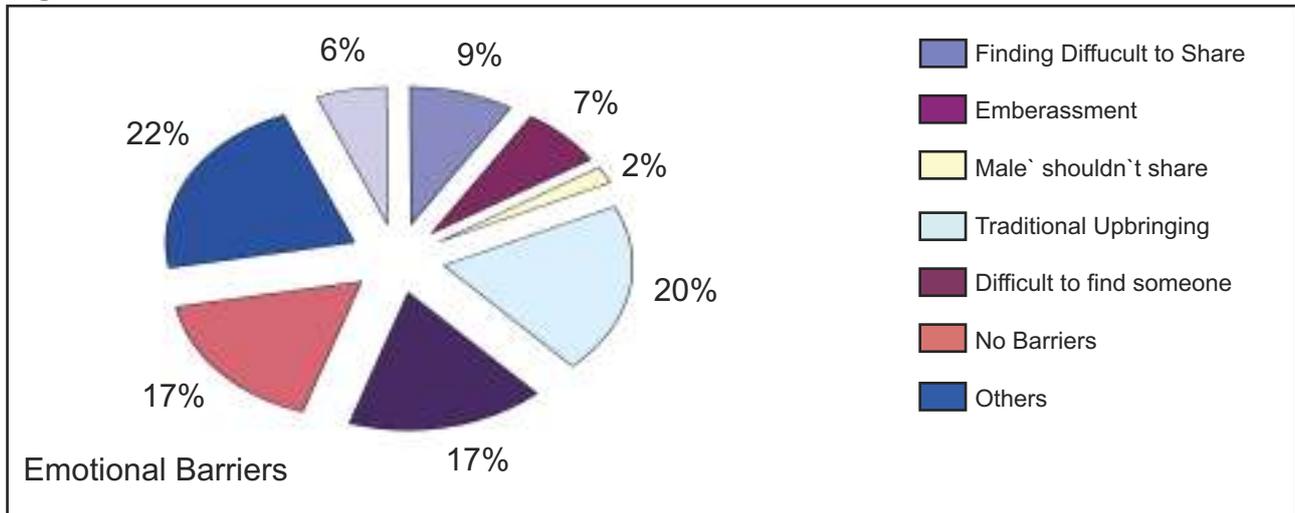
In response to this question, the majority of people (22%) answered "OTHER".

Other emotional barriers which were identified under 'Other' category were:
• Lack of trust of others (14 participants)
• Lack of support from others (5 participants)
• Lack of time in engaging others (2 participants)

Figure 17 - Coping Strategies

Coping Strategies

- Talk to Someone
- Coffee Houses, Community Centres
- Arguing
- Smoking
- Music
- Spend time alone-not disturbing others
- Alcohol
- Others
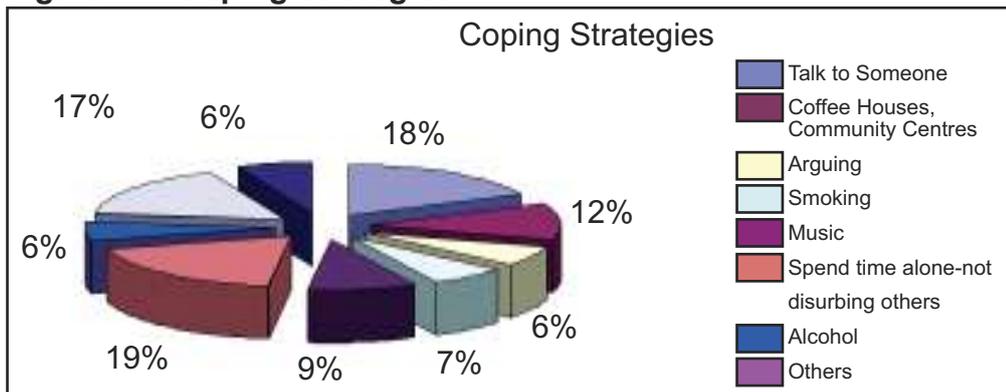
In Question 19, we asked: "How do you deal with excessive stress?" This question aimed to find out the coping strategies used by the sample population.

Participants were then asked if they have or their friends/relatives have ever suffered from mental health/stress related problems.

Figure 18 - Mental Health Problems
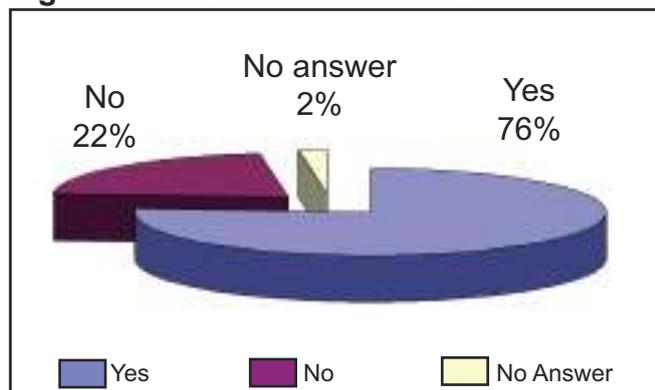
The majority of men (76%) said they have or someone they know has experienced/suffered from some form of mental health/stress related problems.

22% said they hadn't had any such experiences and did not know anyone who had such experience. Those who answered "YES" were also asked to tick the appropriate boxes to describe the type of mental health/stress related problems that they were referring to in this question.

Table 5 - Mental Health Problems

Mental Health Problems	Number of response
Depression	49
Anxiety	12
Panic Attack	11
Schizophrenia	6
Loneliness	16
PTSD	4
Insomnia	23
Manic Depression	2
Relationship Problems	7
Bereavement	9
Other	29
n/a	17
Total	185

Although 76 participants answered YES to the previous question, some participants still answered this question despite having answered 'NO' in the previous question.

Figure 19 - Sexual Problems
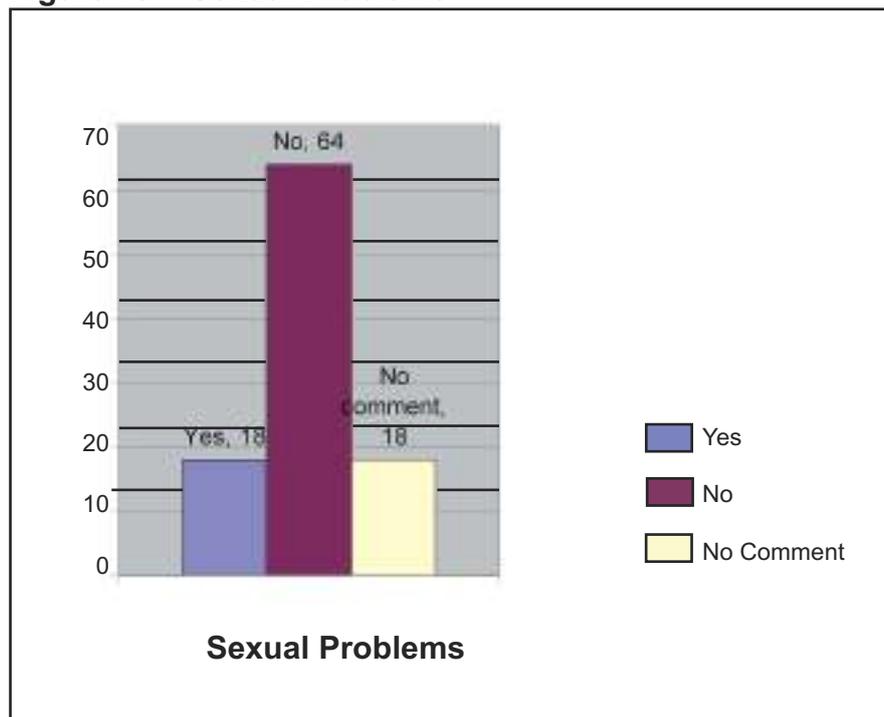
Figure 20 – Service
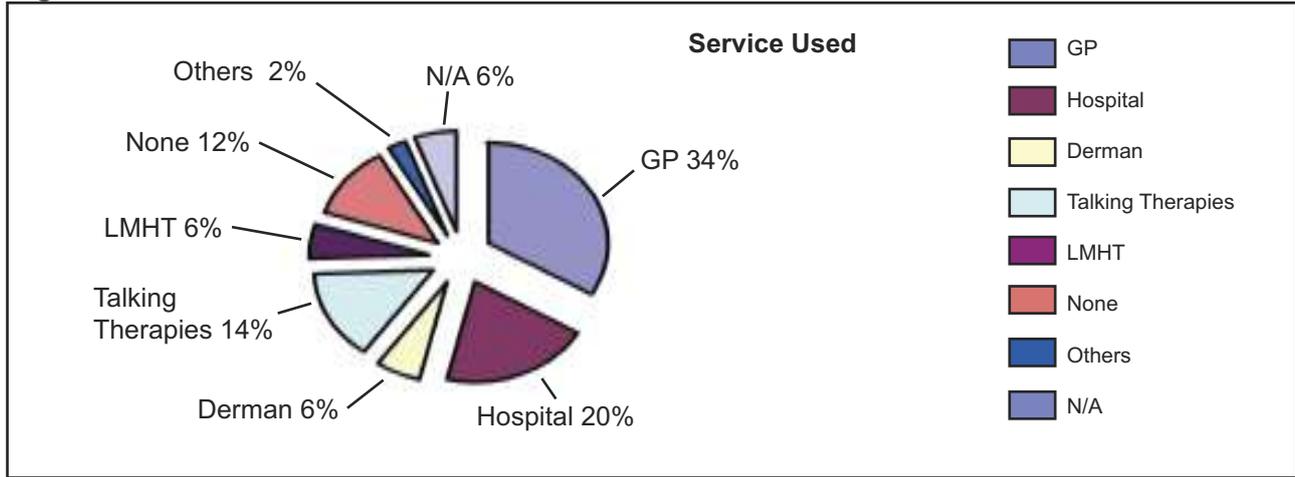
We asked participants: *"Have you or friends/relatives ever used any of the following services to help you with these problems?"*

The majority of them (34%) said they had used GPs to get help with these problems and 20% said they had used hospitals to get help. 14% stated that had had used talking therapy services and 12% had not used any service. Only 6% said they had used their Locality Mental Health team. 6% did not answer this question. 2% said they used 'other' services that are not mentioned in the category list.

We then explored the barriers to using services. We asked: *"If you or friends/relatives have not used these services please explain what prevented you or friends/relatives from using these services?"*

Figure 21 - Barriers in use of services
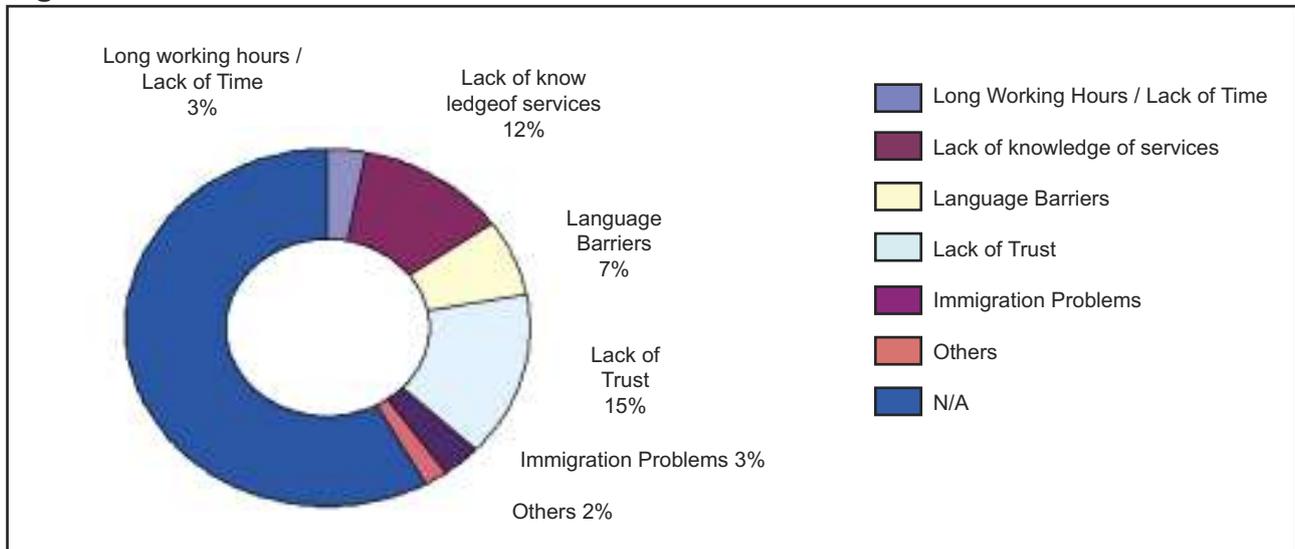
More than half of the participants (58%) did not answer this question. From those who answered, the majority (15%) said that they did not trust the mainstream services provided. 12% said they do not know what services are available for them. The language barrier (7%) was another reason for them not using the services alongside long working hours/ lack of time (3%). 3% said that immigration problems were a factor and 2% opted for the 'Other' category.

We then asked: *"What types of treatment have you or friends/relatives received?"*

Figure 22 Type of Treatment

Type of Treatment

- Medication 31%
- Therapy 20%
- Pychiastristl 12%
- Hospital 11%
- Other 5%
- None 9%
- N/A 11%
- I don`t know 1%

Legend:
- Medication
- Therapy
- Pychiatrist
- Hospital
- Other
- None
- N/A
- I don`t know
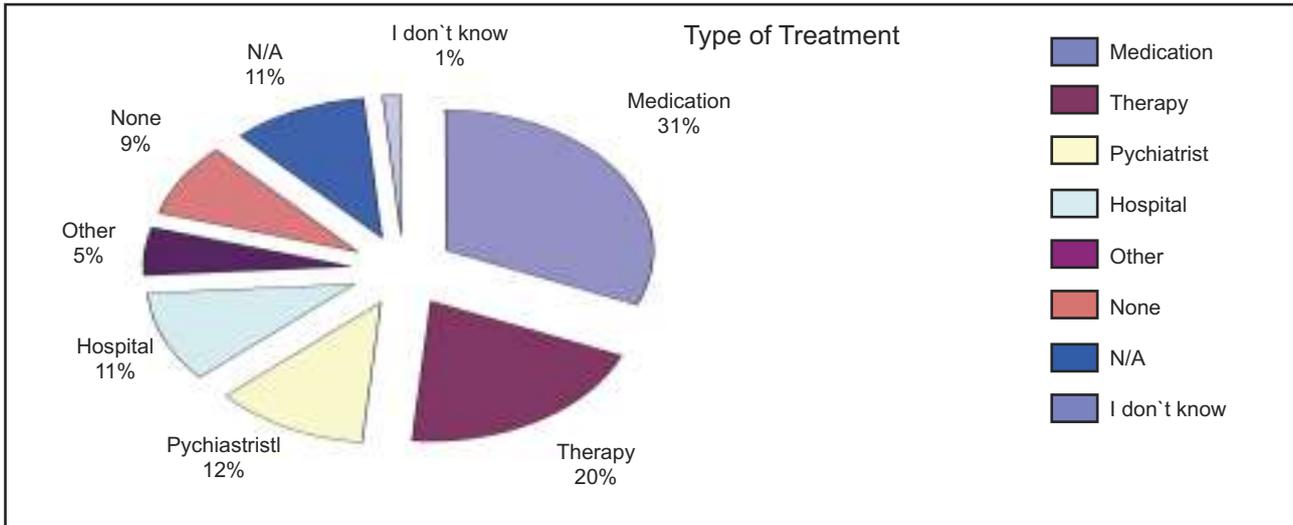
The most popular answers to this question were medication/pills (31%) and Counselling/Talking therapies (30%). Following these, seeing a psychiatrist (12%) and staying in a hospital (11%) were the most frequent treatments. 9% said they did not have any treatment, 5% said they had 'Other' type of treatment that is not listed and only 1% said that they were not sure about the treatment that their relatives or people they know had received. 11% did not answer this question.

We then explored service quality in terms of providing enough time for intervention, providing advocacy and interpreting services and their trust of the services/ treatment they have received. At the end of this set of questions we asked participants to rate their overall satisfaction and evaluate the services.

The results are presented in the tables under the relative headings together with the original questions:

Figure 23 - Service Time

Yes	42
No	29
I don`t know	16
No answer	13

"Were you or friends / relatives given enough time to discuss your/their condition and treatment?"

- Yes
- No
- I don`t know
- No answer
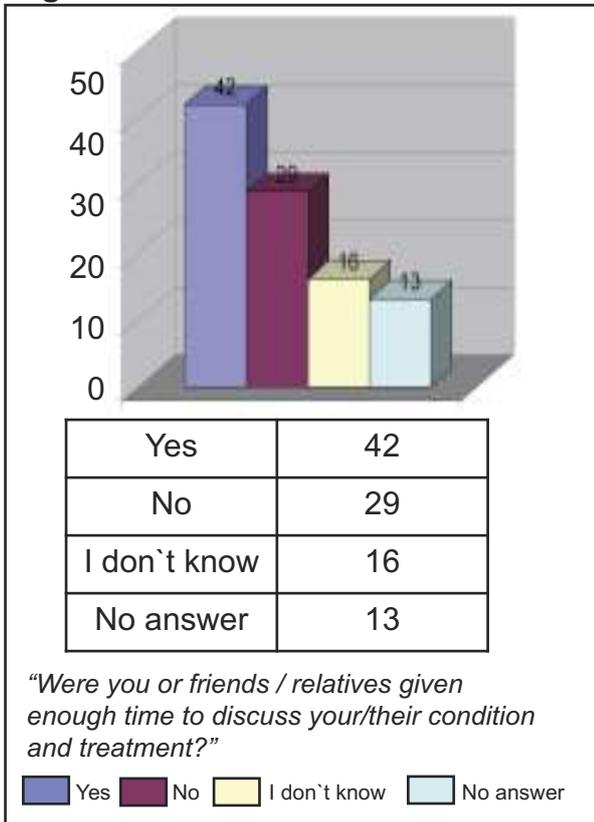
Figure 24 - Advocacy / Interpreting

Yes	46
No	25
Sometimes	6
No need	5
I don`t know	9
No answer	9

- Yes
- No
- Sometimes
- No need
- I don`t know
- No answer

"Were you or friends/relatives given enough time to discuss your/their condition and treatment?"
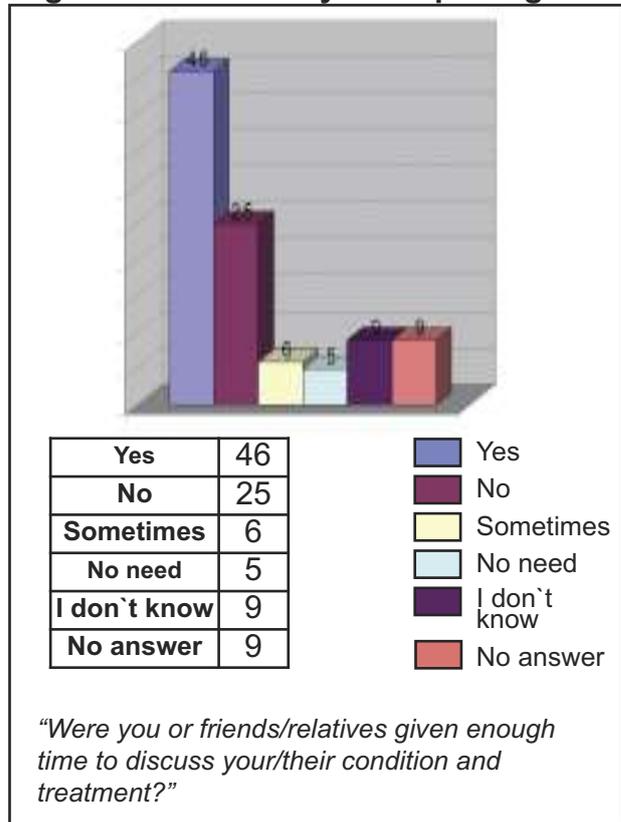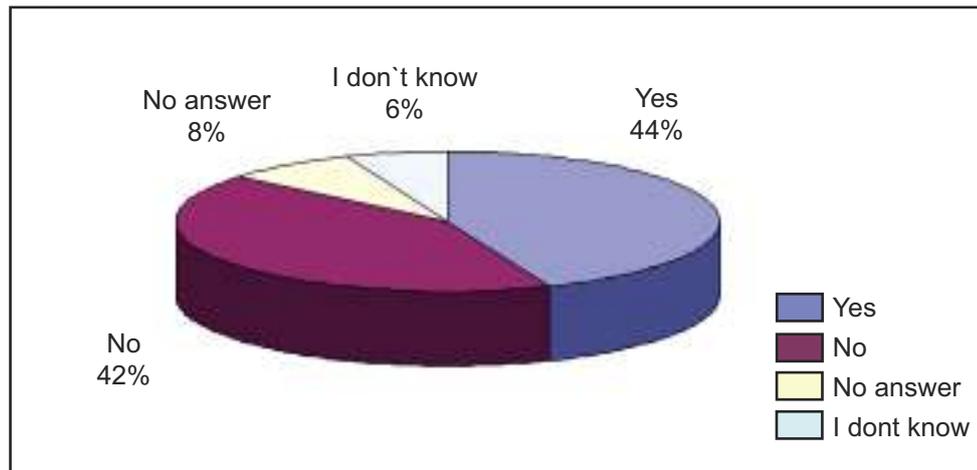
Figure 25 - Trust

"Did you or friends/ relatives have trust and confidence in the service provider?"

Overall how satisfied are you or friends/relatives (please delete acordingly) with the help you received from these services?

Figure 26 - Satisfaction
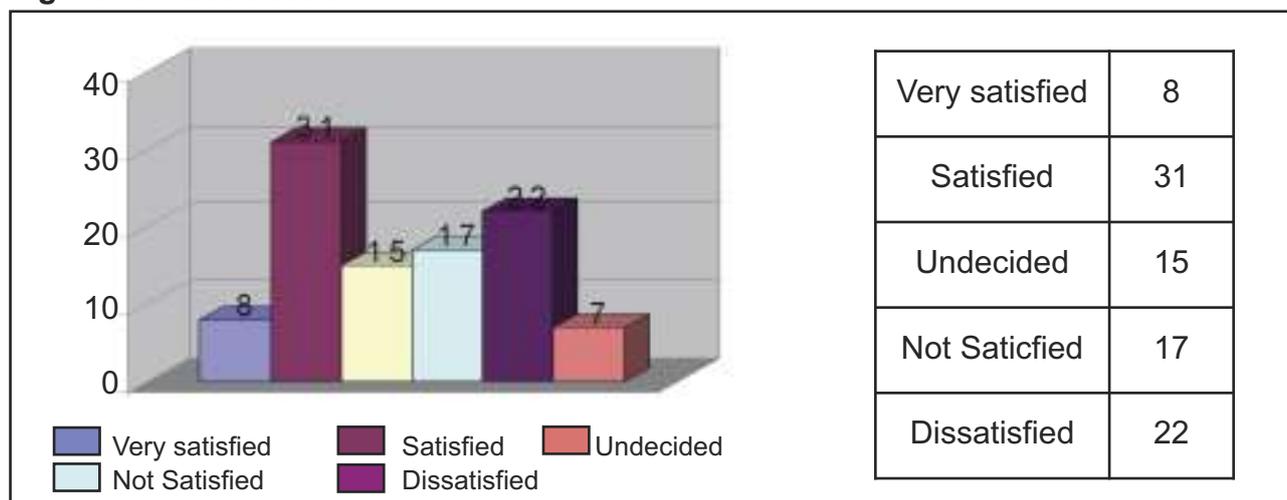
Very satisfied	8
Satisfied	31
Undecided	15
Not Saticfied	17
Dissatisfied	22

Figure 27 - Service Evaluation

	Information		Accessibility		Treatment		Support		After Treatment	
Yes	16	0	45	0	38	0	13	0	5	0
No	46	0	24	0	25	0	39	0	41	0
Some	7	0	4	0	2	0	1	0	1	0
I don`t know	2	0	27	0	0	0	4	0	1	0
N/A	29	0		0	35	0	43	0	52	0
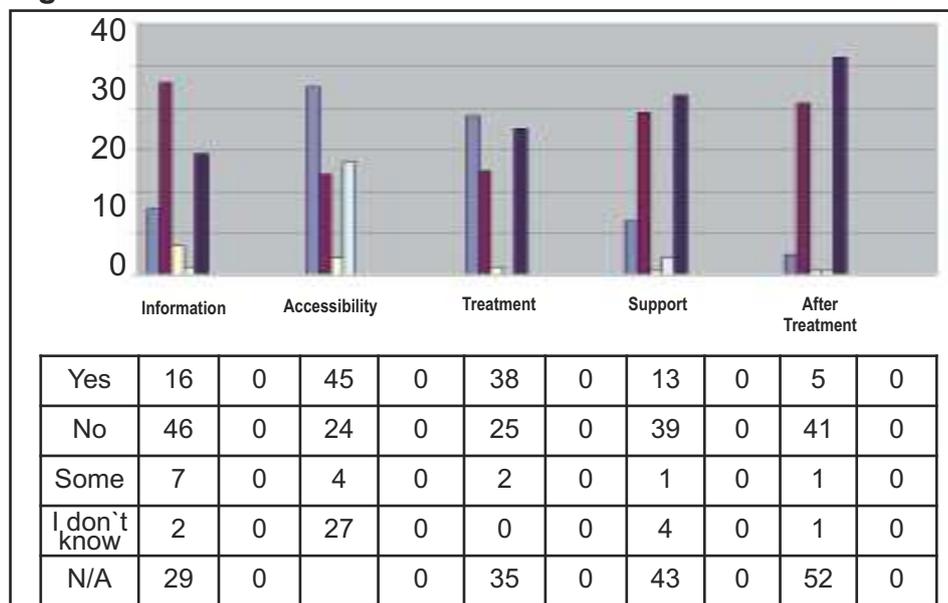
In Question 28, we asked participants: *"What are the barriers to accessing mental health services?"* and asked them to express their experiences in terms of Information they were provided about services, Accessibility, Treatment, Support and After treatment support.

Figure 28 - Knowledge of Services Available in Hackney
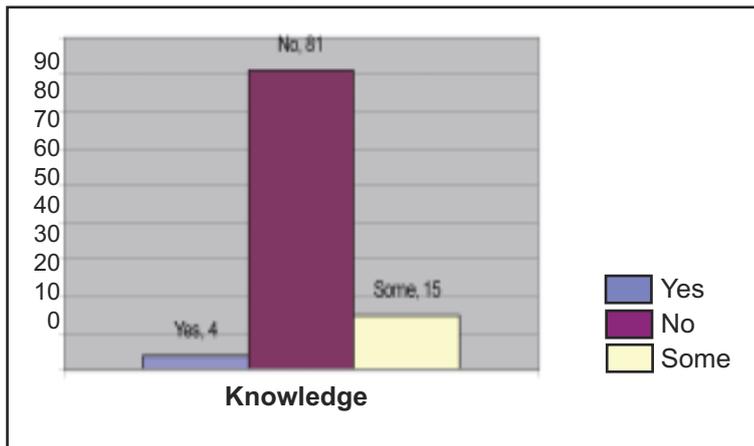
We then explored the knowledge of participants of available services. We asked: *"Do you know what the available mental health services in Hackney are?"* The majority of participants (81%) said they did not know services available for them in Hackney. 15% of participants said they were aware of some of the services available in Hackney.

Generally these were Derman and other community services. Only a small number of participants said they knew about their Locality Mental Health Team. 4% said they knew about services available but did not state which services they are.

Figure 29 - Alternative Therapies
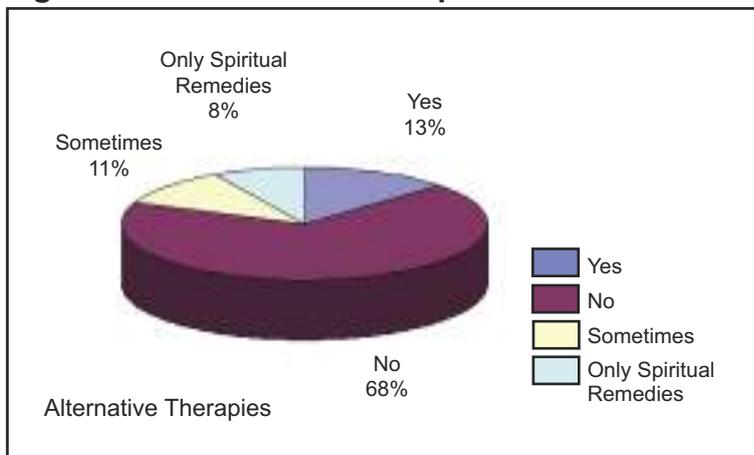
"Do you also use any alternative ways like aromatherapy, massage?" 68% participants said they do not use alternative therapies and 11% said they only use them sometimes (mainly fortune telling and massage). 8% said they only use spiritual remedies e.g. amulet, religious or spiritual leaders.

Following this, we asked participants: *"What kind of mental health support service/s do you think Turkish, Turkish-Cypriot and Kurdish communities need in Hackney?"*

The participants identified various services needed in the community. The results are displayed in Figure 30. Some of the needs identified in this question shaped the discussion and recommendation of this report together with other open questions and focus group discussions.

Figure 30 - Recommend Service by participants
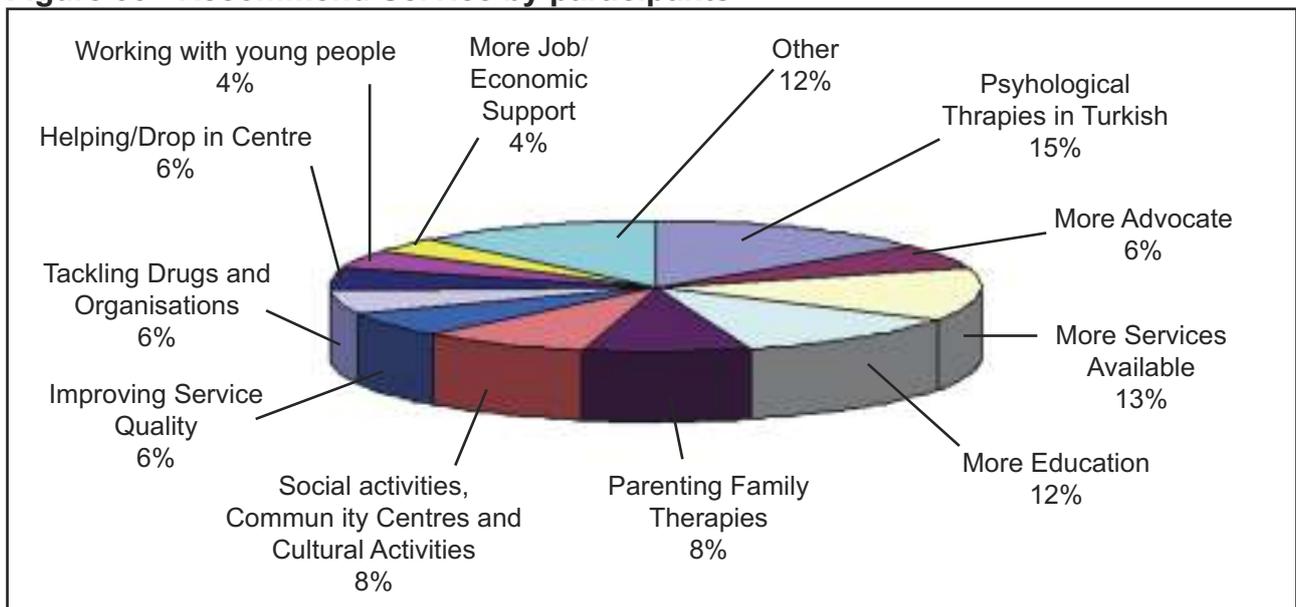
3.2 QUALITATIVE DATA

3.2.1 Thematic Analysis

In this study through thematic qualitative analysis the researchers identified fifteen themes. However, five main themes emerged as the most important for analysis and discussion. These are:

- İmmigration "culture shock-conflicts" and identity;
- The cultural assumptions of service users and service providers in health care and level of health services,
- Lack of information and language barrier;
- The loss of men's patriarchal status;
- The involvement of young people in drugs and mafia-like organizations

3.2.2 Service Providers' Responses

• The Main Psychological Problems that Turkish and Kurdish People Experience According to the service providers' responses to this study depression, anxiety, PTSD, loss, psychosomatic disorders, isolation and addictions are the main psychological problems that Turkish and Kurdish people experience in Hackney. They suggested that the main causes of these mental health problems are being an asylum seeker or refugee, the result of waiting years for the outcome of their application, the violence and traumas that they have experienced cultural adaptation problems and men's loss of status.

• Presentation of Mental Health Problems They stated that Turkish/Kurdish speaking men present their psychological problems by means of physical health problems such as headache, back pain, body pain, abdominal pain, palpitations dyspepsia, breathing problems, fatigue, dizziness etc.

• The Extent of Alcohol and Drug Abuse and Relationship with Mental Health Service providers did not provide any tangible information or explanation as to the extent of alcohol and drug abuse amongst these communities. However, there are some responses to this question presented in the discussion part of this report.

• Barriers to Accessing Mental Health Services; Service Improvements According to service providers, the three main barriers to accessing mental health services are: language, cultural barriers and a lack of information about the system in the UK and the lack of culturally appropriate services. Service providers proposed various solutions to these issues.

4 DISCUSSIONS

4.1 Immigration, "culture shock-conflicts" and identity

The participants (%100) in this study emphasized how their lives have been affected by the asylum process and the cultural difficulties which they have experienced. However, whereas the participants who have been living in this country for more than ten years focused on cultural conflicts and adaptation problems, the participants who have been living in this country less than five years particularly spoke about difficulties they faced during their flight and the uncertainties about the asylum application processes.

For example, one participant defined cultural problems and social, geographical changes as possible causes of stress and psychological problems that Turkish, Kurdish and Turkish Cypriot men experience in Hackney.

> "…where many of us were living in Turkey, it was villages surrounded by trees and green grass. When we came to this crowded city we got depressed… I think when our surroundings changed it affected us… in Turkey there was sea, forests and sun, air, nice neighbours. We came to the big city and didn't find what we expected."

Similarly, one participant, whose younger brother suffers from mental illness, spoke about the cultural and economic difficulties they faced during the first years:

> "I think it was loneliness; a foreign country with a foreign language and no friends. For example, when we were in Turkey we were free, we grew up in our village, and there were trees everywhere with many people around us. When we came here we didn't have our friends. Instead there was a foreign language. My brother wanted to learn English and he worked very hard at it, changing colleges so as to get the best education. In addition, when we came here our financial situation wasn't very good. Sometimes he couldn't go to college because he didn't have any money to buy a bus pass. A different country, different language, and economic hardship all affected him and made him ill. These are the things which caused his illness."

According to Bhugra (2005) low ethnic density may play a role in increasing the incidence rates of mental illness. He argues that the reason for low rates of schizophrenia amongst South Asians in the UK may be the result of living in high –density areas where there are other Asians who have similar traditions. Bhugra divides cultures into two types: individualistic (idiocentric) and collectivist (allocentric). Bhugra (2005) describes the individualistic society as one *"where the ties between individuals are relatively loose" and where "everyone is expected to look after himself/herself and his/her immediate family"* pp: 86. On the other hand collectivist cultures *"prioritise common good and social harmony over individual interests. Individuals are bound by relationships which emphasize common fate. Individuals are encouraged to put other people and the group's interest before their own"* pp: 87.

Therefore, Bhugra argued that;

> "It is possible that vulnerable individuals who come from collectivist cultures and are of an allocentric nature, their beliefs about themselves, aspirations vs. achievements and self-esteem are likely to be hit harder if they feel discriminated against and alienated…The feelings of alienation from the majority culture and attempts to belong to either of these groups may act as chronic continuing difficulties making vulnerable individuals more prone to psychosis" pp: 90.

Turkish and Kurdish people traditionally are collectivist therefore, social connections, support and daily social activities are important for them to continue their lives and feel "healthy" psychologically. This study suggests that when Turkish and Kurdish people left their countries to come to live in the UK they experienced cultural problems, which left them isolated and led them to experience mental health problems. In addition, second generation children experience deeper cultural conflicts as a result of growing up in an individualistic society

whilst still being forced to adopt collectivist cultural norms. For example, a forty-eight year old participant clearly pointed out cultural problems and behaviours of young people as the main cause of the mental distress amongst Turkish speaking communities in Hackney.

> *"The main problem is cultural conflict.   This is the main cause of psychological distress.The young people are spoiled; they are out of control and have lost their balance… we can't integrate well with this society and system. And the system here doesn't pay usenough attention. They don't care about us; anything can happen to us, we are not their priority. The system here is based on money and it forces our people to forget their values and go after money all the time".*

Turkish and Kurdish men who were born in Turkey or Cypriot and migrated to England try to continue their traditional life. Every day they go to coffee houses, community centres, watch Turkish TV, talk about their favourite Turkish football teams and expect their spouses to also adopt traditional behaviour in their daily life. Older participants in this study emphasized the role of their cultural values and beliefs which they believe are strong elements of their identity. It could be that this way of thinking and these daily practices provide a sense of security and bring meaning to their lives. Furthermore, they expect their children to continue and maintain these traditions. As they get older they visit their homeland more frequently and buy properties there. They try to find spouses for their children from their homeland in the hope that their children will maintain this lifestyle and adopt their cultural and national identity, which they believe will provide them with security and meaning in the future.

4.2 Cultural assumptions of service users and service providers in health care and level of health services

Service providers lack understanding of the mental health care needs of refugees and asylum seekers and there is a similar lack of understanding amongst refugees and asylum seekers about how services are designed in the UK.

In Turkey every Turkish working citizen and their employer pays a premium to the state in re-turn for the provision of health services by the SSK (Social Insurance Association). However, the social security system of Turkey is not able to serve non-working or officially working citizens. Since June 2000, unemployed citizens have been able to obtain health services if they match the criteria (green card system). In Turkey there is no General Practitioner system therefore, when a member of the public becomes unwell s/he needs to go to SSK hospitals or State hospitals according to his/her social or employment situation. Moreover, in Turkey, the study of Medicine to become a doctor is one of the most respected professions. In general, doctors in Turkey represent an intelligent authoritative figure that is respected unconditionally.

Although they have lived here for many years Turkish speaking people in Hackney still find it difficult to understand the British health system or to adapt to UK healthcare provision. They trust hospitals as their main healthcare providers and do not think that GPs represent an authoritative figure. Many of the participants in this study expressed their mistrust of GPs, regarding them as inadequate trainee doctors who need to look at their books before prescribing any medicines. For example one of the participants said that;

> *"I find it difficult to trust doctors because they can't make a diagnosis before looking at a book. When they start looking at their books it makes me anxious. There are*

many times when I have thought about committing suicide but I never disclose my feelings to anyone…I have never had a very good doctor…I want to share my emotions. Currently I feel isolated and sometimes think about suicide but I know I won't do it because… I don't want to hurt my mother and make her unhappy. Everyday I live under a l ot of stress because I have lost my appeal and I'm staying here without any legal papers".

Researchers believe that this quotation reflects a common belief amongst Turkish/Kurdish speaking people in Hackney. The difference between the approaches of health professionals in Turkey and England affect people's attitudes towards doctors. In Turkey people expect to see a doctor in a hospital. They expect that doctor to know their job by heart. They also expect that patients will respect doctors' authority and trust their knowledge. Obviously these differences in techniques and approaches cause confusion and misunderstanding for both GPs and service users.

On the other hand, a large number of people in this study praised their GPs' hard work and friendly attitudes. Some talked about how their GP had saved their lives or how they had been supported by their GP during difficult times. When these participants were asked about their GP's style, the characteristics identified were friendliness, genuine listening, spending more time with them and working with advocates. These people clearly have benefited from their GP's techniques. The researchers believe these approaches need to be utilised more widely by health professionals.

Nazroo (1997) pointed out that those who could not speak English well were three times more likely than others to prefer to see a doctor of the same ethnic background as themselves. For example in this study one participant said that:

"In the hospital you have to wait for too long and it wears you out. Many times we went to hospital and had to wait for hours. For example when they see a patient with mental health problems they should intervene straight away because otherwise he might shout and run around and the people next to him will start laughing at him and this makes him angrier. The hospital really didn't help. We as his family provided more support. You go to the hospital for 5-10 minutes or they visit your home for 5-10minutes then they leave straight away. What can you expect from them in such a short space of time. The family is much more important. Of course the doctors are important too but they can only give 15 minutes or at maximum half an hour no more than that".

In this study many interviewees expressed their dissatisfaction with health and mental health services in general. For example, one participant said that;

"We didn't get enough support from them because we don't have asylum status… when we go to hospital they don't genuinely believe you. Because they sometimes treat us very badly. I don't know how they can treat a patient like that. They treated us in such a hostile manner, I wanted to complain I am telling you from my own experience. I went to a hospital and expected them to do something for me, to save me but they told me to relax and did nothing. One day I went to the GP and there was a female doctor, I was very sick and didn't have enough energy to raise my head and, she started to in terrogate me by asking questions like; why didn't you learn English? I was barely speaking about my problems because I was so sick and

instead of helping me she was interrogating me. ".

4.3 Lack of Information about services and language barrier

This study clearly indicates that refugees and asylum seekers do not have relevant information about how British mental health services are designed, how they are organised and how to access them. In addition, language barriers and the difficulty of finding suitably trained interpreters and advocates adds to the difficulties of accessing appropriate mental health services for Turkish, Kurdish and Turkish Cypriots. The majority of participants spoke about how they found it very difficult to communicate with their GPs about what they experience. For example one participant said:

> *"I couldn't speak with them. He (my son) didn't want me to go to the hospital with him. Although I really wanted to talk the doctors I couldn't…we found it difficult to find interpreters so his sister helped us."*

In one study conducted by Tarling (1995) it was found that language was associated with stress, anxiety and depression. Tarling interviewed people from various minority groups including Turks and Kurds. He pointed out that individuals who spoke no English were more likely to experience psychological problems than those who speak good English. According to Tarling this might be explained by the fact that those who had difficulty speaking the language were more likely to feel isolated and less able to adapt to the culture.

> *"The biggest problem we experience is the fact that we can't speak English…You try to solve one of your problem but cannot solve it…you receive a letter but you cannot understand it, when you are un able to solve your simple problems, you feel depressed then you stop talking to your children and showing an interest in their problems"*

All the participants in this study talked at length about the language problems they experienced whilst seeking help for their physical and mental health problems. They all complained about the lack of opportunity to find a mental health worker or psychologist who can speak their own language and pointed out the difficulties of talking via interpreters.

Although, 76% of participants said that they or somebody they know have experienced mental health problems during their stay in the UK, in this study 81% of participants said that they do not have any information about mental health services in Hackney. These figures clearly show the high prevalence of mental health problems amongst Turkish, Kurdish and Turkish-Cypriot men in Hackney and the lack of information about the services to meet their needs.

4.4 Post-migration problems and use of drugs and mafia-like organizations among young

> *"The problems vary depending on age groups. Particularly young people who have grown up in this country are experiencing huge cultural problems. They haven't learned both the Turkish or English culture and parents have not paid enough attention to their children's needs. They have only been concerned with money, money, money. This might be because they didn't know how long they would stay in this country. Young people have been isolated by young white British people*

and black people and have grown up without a sense of purpose. Their parents opened takeaways and grocery shops and focused on the money, being a parent only in the biological sense. Young people have become rootless, cultureless beings. They have become outcast and started relationships with the wrong people and started to use drugs and organize and join mafia like groups like "Tottenham Boys", "Bombacilar (Bombers)". They started to take drugs like cannabis and heroin because they are bunch of aimless people who want to kill time and feel important.

The above quotation is from a Kurdish participant who is in his mid thirties and came to this country in late 1990's. Like him almost all the participants in this study talked about the high prevalence of drug use and mafia-like gang organisations amongst Turkish speaking young people in Hackney (London). According to Hackney Council for Voluntary Service Strategic Priorities Unit currently there are 17 identified gangs in Hackney, mainly focused on a postcode basis.**(www.hcvs.org.uk)** Significant gang activity is focused in 3-4 areas of Hackney; Dalston, Homerton, Clapton and London Fields with minor activity in other areas of the borough such as Lordship and Stoke Newington. Although, Turkish speaking communities are distributed fairly evenly throughout Hackney the above areas are among the main areas where Turkish, Kurdish and Turkish-Cypriots live.

Participants in this study talked about many possible causes of involvement in substance misuse and gangs amongst Turkish speaking people in Hackney. They mainly blamed parents for not paying enough attention to their children's needs. On the other hand parents themselves complained about the immigration process and the complexity of raising children in a different country where they can not speak the language and struggle to teach the cultural values which they regard as a very important aspect of their lives.

The largest population of Turkish and Kurdish people from Turkey came to London in the late 1980's and early 1990's. When these groups arrived they were not sure about their future and did not know how long they would stay in the UK.

"When we came here first we thought about earning as much money as we could. We worked for many hours in textile factories…at that time there were hundreds of factories. We were not sure about our future, so we worked and left children at home, sometimes on their own sometimes with our friends or relatives. Some of us left our children in Turkey for many years".

When they arrive in the UK, asylum seekers must apply immediately to the Immigration and Naturalization service. In the majority of cases, the Home Office decides negatively on requests for asylum. After a negative decision, an asylum seeker has to leave the UK. However an asylum seeker can appeal against a negative decision. If the judge assesses that the Home Office decision was correct, the asylum seeker can still make a further appeal. Thus, in the UK the process of obtaining eventual refugee status can take many years. Nearly half of the participants in this study said that they did not obtain their refugee status for more than 5 years.

Certainly, having to wait for many years to know whether they could stay in the UK caused many Turkish speaking people in Hackney to experience significant psychological uncertainty and stress. The life of a young Kurdish man (24 years old) who allegedly committed suicide in summer 2007 in Hackney can be given as a tragic example of this. According to a Times newspaper article the bureaucratic Immigration System took years to decide to deport him

to a country that he had left as a 12 year old child. This broke up his family and the man lost his job after his work permit was revoked. On the day he learnt that his fight against deportation was over, he killed himself.

> *"I know a boy he was about 19 maybe 20 years old. He used to steal in order to feed his drug habit and   looked to black people as a role model. I know later he started treatment for his addiction. However, after starting medication he became isolated. They should have helped him start a training course or something… This boy hanged himself 3 years after receiving treatment… I myself attempted to kill my self but, I did not have the courage to hang myself because I thought it would be very painful. So I   took   tablets… I don't trust anyone. I slept at the coffee houses for one and half years. Drug dealers forced me to deliver drugs…they threatened to kill me. I went through so many things. For many years I did not get any benefit, I was racially abused…after I was forced to become a courier (drug) I started drinking alcohol and it took me many years to quit. "*

The above quotation is from a 44 year old Turkish participant who came to the UK in the early 1990's. Currently he is suffering from depression and panic attacks, sees a psychiatrist every month and has regular contact with the locality mental health team and his GP. After taking one handful of tablets he said he thought about his daughter and did not want to make her unhappy and forced himself to vomit. For three days he suffered from nausea and dizziness alone in his one bedroom rented flat. He was not able to go out and ask for help.

During this study researchers were able to visit snooker clubs and coffee houses where Turkish and Kurdish young people spend their time together. Many of them knew some of the victims of recent suicides but were unable to give clear explanations as to why these people had taken their own lives. When they were interviewed, they struggled to talk about their own emotional issues and preferred to give short, flat answers. The alienation and isolation of these people from their families and the society they live in was obvious to the researchers. These people feel excluded at the colleges they study. They try to gain respect (which they do not receive from their family and society) and feel important among their peers (and to be accepted) by adjusting their dress style, accent and life style according to mainstream trends.

4.5 Loss of men's status

In Turkey particularly in rural Anatolia, the family is structured around a strict patriarchal hierarchy. For example marriage rules are arranged so that a newly married couple are sometimes expected to live with the husband's family.

After the establishment of modern Turkey in 1923 and in the early years of the Republic the laws affecting women's status were changed significantly: from religious rules to a secular civil code, from unequal rights regarding divorce and ownership of property to equal legal treatment, from none to full political representation and participation rights. All these reforms provided the legal and institutional structures for the equal treatment of women under law. However, these structural changes were not directly reflected in the everyday lives of women and men.

In the late 20th century through the processes of modernisation and urbanisation, cities enabled the development of new identities and ways of living which would have been impossible within the conservative rural areas. Therefore, with this prominent development

in cities, the internalized patriarchy started being questioned and challenged. However, the majority of Anatolia, particularly eastern Turkey where Kurdish people live, remained strictly patriarchal.

From this perspective when Turkish-Kurdish immigration is observed it can be seen that the immigrants consist almost exclusively of people from rural areas, most of whom had never lived in a town for any extended period of time prior to emigrating (Manco, 2004).

> *"What is more, these people had never co-existed with a European culture or language before emigrating since, unlike the other countries of emigration in the Muslim world, Turkey was never colonized. In the host countries these peasants-turned-workers tend to settle in clusters according to their localities of origin. To the extent possible, people from the same village or the members of a family will settle close to each other. So, one quarter of the Turkish immigrants over 18 who live in Belgium was born in Afyon Province. There is a similar concentration of Turks from notably Karaman Province in the Netherlands. The Turks living in Sweden come primarily from Kulu (Konya Province), while 60% of Denmark's Turkish immigrants come from the Kurdish areas of South-east Anatolia. Family ties (akrabalık) and regional ties (hemserilik) are still just as strong. The community lifestyle and resulting social control are still largely intact among Turkish immigrants. The traditional family hierarchy is reproduced as well to a great extent, notably through marriages in the native villages.These alliances can be interpreted as a partial but constant renewal of the first generation of immigrants (Manco, 2004).*

Likewise, the Turkish and Kurdish community in London continues to have strong community ties. This can be seen clearly by observing their socio-economic structures and practices. For example, they cluster in under privileged neighbourhoods that are highly ethnically structured (coffee houses, community centres, off-licences, takeaway shops, groceries). Many young people continue to respect the custom of wedding someone from their parents' native village, and in many cases the spouses even belong to their extended family. These young people are expected by their parents and their community to continue their most valued traditional lives and patriarchal family structure.

However, like industrialization and urbanization in the second part of the 19th century in Turkey, life in one of the most advanced modern capitalist city has strained the patriarchal family network. Turkish and Kurdish women have started to enjoy more of their "freedom" and use available support services to challenge their partners' traditional macho approaches. In this study many participants passionately talked about their problems with their wives and their children which they think has weakened their traditional patriarchal role as a breadwinner and sole guardian of their family. For example, one participant said that;

> *"In this country we have lost everything, we are not men anymore. Let me tell you something, in this country there are four classes of citizens. The first class is women, the second class is children, the third   class is dogs and the fourth is men".*

And another one said that;

> *"The main reasons for the latest suicides are the problems with family life, especially with children. Women and children… they have so many rights. For example, a father cannot touch (slap) his children, because they will threaten their fathers…"*

"When you go to a doctor he doesn't know your culture. For example, they think it is normal for a teenage girl to come home 12:00 at night. But this is unacceptable for us. If my daughter tells her doctor that she wants to go to a party that I will not allow, the doctor would regard me as an oppressive father. However, what maybe he doesn't know is that I act according to what is right in my culture. …"

The role of children is also identified as one of the reasons for the older generation of men to feel threatened with regard to their social and cultural status. Children who were born in the UK or who came here at an early age learn the language and system much faster than their parents. This undermines the patriarchal hierarchy of the traditional family structure. At an early age children take on many responsibilities; reading letters, interpreting at the DHSS, job centres and at GP appointments, or accompanying relatives or neighbours to appointments to help with interpreting and translation. As a result children take a much more active role important family matters, are given an opportunity to express their opinion and affect decision making which would not have happened before.

"You cannot put pressure on your children in this country because they are more educated than you, they know more than you…in Turkey when your children reach the age of 15 – 17 or even 20 mother, father or uncles can force them to do things which they think are right for them…girls and boys all haveto listen. But here children say they are free… who is father who is mother? They think swamp (drugsand other bad habits) is the solution to their problems. As parents we feel powerless"

4.6 Service Providers' Responses

Numerous studies in the past suggested that Black and Minority Ethnic people underutilise existing services. Some suggest that existing services in the mainstream are not organised according to their needs and these services alienate these communities instead of encouraging them to seek support for their problems. However, the aim of this study is to explore the mental health needs of Turkish, Kurdish male and it is well known that men in general seek less support and go to GPs less frequently regarding their health, particularly psychological problems.

Turkish and Kurdish people have lived in Hackney in large numbers for more than two decades. Therefore, the researchers believed that asking service providers about their experiences of Turkish and Kurdish men would provide important information about the needs of these communities and possible solutions to their problems.

In this study the researchers aimed to receive 30 responses to their questionnaires from service providers including, GP's, mental health workers, psychologists, community psychiatry nurses, health advocates, counsellors etc. In total, researchers contacted more than 60 service providers during the research but received only 28 responses. Although, this was only two less than the original aim it was apparent that service providers displayed less enthusiasm than expected, particularly after 10 alleged male suicides in the past 6 months in the Turkish and Kurdish community. Among the participants GPs provided more responses than others which researchers believe is due to the trust and professional communication which has developed between Derman health advocates and GPs over the years.

The service providers in this study said that they see on average twenty Turkish and Kurdish patients every week and more than this at the GP surgeries where there are Turkish/Kurdish

health advocates and Turkish/ Kurdish only clinics. The majority of service providers said that they collect ethnicity data at their premises. However, there is no information about the percentage of Turkish/Kurdish people amongst their patients.

4.6.1 The Main Psychological Problems that Turkish and Kurdish People Experience

According to service providers' responses, depression, anxiety, PTSD, loss, psychosomatic disorders, isolation and addictions are the main psychological problems that Turkish and Kurdish people experience in Hackney. They suggested that these mental health problems are mainly caused by being an asylum seeker or refugee and waiting for years for the outcome of their application; the violence and traumas that individuals have suffered in the past; cultural adaptation problems and men's loss of status. Moreover, service providers think that marital problems between parents, unemployment and the lack of education amongst Turkish/Kurdish men are other main factors which affect their mental health. A response from one service provider neatly summarises service providers' thoughts on this subject.

> *"Depression, anxiety and panic attacks, psychosomatic symptoms, PTSD, psychotic disorders such as schizophrenia, paranoia etc. are some of the main psychological problems they experience in the UK.*
>
> *Psychological problems experienced by these communities are mainly a direct result of the social and economic life they have in this country. The major problems are unemployment, homelessness, isolation, not being able to speak English, family problems, living with unknown, immigration problems etc."*

Some participants said that the older generation and younger generation experience different types of problems. The problems facing the older generation tend to be: grief because of the loss of loved ones and their former life; illness; family conflicts; a lack of financial security and close family support. The younger generation experience more hopelessness, cultural conflicts and a lack of educational opportunities. However, older and younger generations together experience the effects of racism, anger, and addiction problems.

4.6.2 Presentation of Mental Health Problems

Interestingly on this subject all the service providers provided similar answers. They stated that Turkish/Kurdish speaking men present their psychological problems by means of physical health problems such as headache, back pain, body pain, abdominal pain, palpitation, dyspepsia, breathing problems, fatigue, dizziness etc. For example one participant said that;

> *"They find it difficult to express their needs, feelings and showing their vulnerability therefore most of the time they come out as anger and frustration. There are though some men who talk about their emotional problems and agree to see a therapist or counsellor."*

Some participants emphasized that Turkish/Kurdish men talk about family problems and conflicts with their children as a way to convey their psychological vulnerability. Aggression, irritability, low mood, poor sleep, lack of motivation and worries are the main psychological

symptoms that they present. Some GPs said that often it is wives and mothers who will complain about their husbands and sons as they attend GP surgeries more often than Turkish/Kurdish men.

4.6.3 The Extent of Alcohol and Drug Abuse and Relationship with Mental Health

Researchers aimed to obtain statistical data about alcohol and drug abuse among Turkish/Kurdish speaking people in Hackney and how it is related to psychological health but there was not any statistical information on this subject. In addition, service providers did not provide any tangible information or explanation of the extent of alcohol and drug abuse among these communities. However, they did make some useful comments in response to this question:

> *"Drug issues seem to be a problem with some of the younger men. Extent of drinking not often dis closed"*

> *"No robust data. Alcohol drug problems fairly common in this community"*

> *"Nothing specific. I believe many say they don't drink when they do. Some younger Turkish men have been involved in drugs as have their English counterparts"*

> *"No actual figures, however several of the patients with schizophrenia use cannabis"*

> *"Not clear what percentage has alcoholism but rough estimates 25% although probably higher"*

4.6.4 Barriers to Accessing Mental Health Services; Service Improvements

The participants provided thorough information on this subject. The three main barriers according to service providers in this study are: language; cultural barriers and lack of information about the system in the UK; and a lack of culturally appropriate services.

In general participants highlighted language as the main factor which prevents particularly older Turkish/Kurdish speaking people in Hackney from accessing services. Respondents suggest that this is because of a lack of trained interpreters and health advocates in health services. They confirmed that the recent cuts in interpreting services have had a negative impact on these communities and left service providers struggling to cope with the current demand and needs of these groups. Secondly, cultural barriers such as the view that 'men don't cry' and the social stigma leave men denying their problems. Shame, guilt and embarrassment are very strong impediments for men from these communities to seeking support for their difficulties.

Thirdly, participants suggested that the lack of culturally appropriate services and the lack of information on existing services is one of the main reasons for the underutilisation of health services by Turkish and Kurdish men.

> *"Primarily linguistic, although cultural barriers undoubtedly come a close second. Historically, we have always had to depend on external agencies for interpreting services but these were, invariably, unsatisfactory. We need to proactively recruit*

Turkish/Kurdish professionals in different disciplines"

"Difficulty in expressing emotions, often having to do this via an advocate & the lack of a Turkish speaking GP…not really understanding the role of counselling – wanting tablets instead"

"Possibly in an older age group there might be problems with language & access to interpreters. This group do not always know what services are available e.g. one of our clients has a mother who does speak English but doesn't have knowledge about what services are available"

Service providers proposed various solutions and improvements to overcome these barriers. There was a strong emphasis on the need for more culturally sensitive or appropriate services and for more trained psychologists and mental health workers who can speak Turkish or Kurdish. Providing suitable education about the services to these groups in order to encourage them to access mental health services was also suggested. Moreover, they stated that more accessible language classes and better employment services would improve Turkish and Kurdish men's circumstances which would in turn improve their confidence and access to services.

The majority of respondents said that, apart from Derman, they are not aware of culturally appropriate services for Turkish, Turkish-Cypriot and Kurdish speaking people in Hackney. Some suggested that existing services are inadequate to meet the complex needs that Turkish and Kurdish speaking men present and that existing services are limited by budget and statutory constraints. For example, many GPs underlined the importance of Derman's services and said that Derman is their greatest asset in accessing mental health services for these patients. They highlighted how their services have been stretched after advocacy services have ended and it has therefore been suggested that further funding is needed.

Some service providers suggested that Turkish and Kurdish speaking men's mental health needs should be more widely acknowledged by NHS Mental Health Trusts and that existing services need to focus to make their services easily accessible to them. It was stated that mainstream service providers need to take this issue onboard and should liaise more with voluntary organisations. It was suggested by one GP that primary care psychology in the statutory sector should employ more Turkish counsellors and psychologists. This would allow patients from Turkish, Turkish-Cypriot or Kurdish communities to be treated within mainstream services. Although, some believe services have come a long way, there is still not enough Turkish, Turkish-Cypriot or Kurdish staff in health care.

Some suggested that "facilitator" outreach workers be created who would access families, or older people who had difficulties leaving home. The importance of better provision of secondary care services such as psychotherapy, cognitive behavioural therapy (CBT) and the need for an expansion of counselling were also underlined.

On the other hand a few participants claimed that such services may reinforce ghettoisation, encourage medicalisation of social problems, and validate incapacity, victim hood and compound disability and stress. It was also suggested that younger people need to be encouraged more to use existing NHS services as they do not have language problems.

Other solutions suggested by service providers to overcome these barriers are;

• More male therapists and mental health workers.
• More culturally specific resources e.g. supported accommodation, crisis teams, leaflets, brochures, posters and booklets.
• Increasing awareness, organising meetings.
• 24 hours helpline – a website
• Walking in or Drop in Centres.
• A day centre
• More advocates – more advocate times at GP surgeries
• Free ESOL classes
• Turkish speaking social workers
• More opportunities for social activities, encouraging sport among young
• Turkish & Kurdish well being centre

5 REFLECTIONS

5.1 Positive Aspects of the method used

This study has been an important opportunity for Turkish, Kurdish and Turkish-Cypriot community members and service providers in general in terms of raising awareness of issues such as the mental health needs of men in these communities. The semi-structured interviews and the focus group discussions were an important process, a non-directive and reflective way to help service users and the general public develop their awareness around issues such as:

• Their attitude to mental health
• The stress factors which affect the quality of their lives
• The negative and positive aspects of the coping strategies that they are using and their effect on the quality of their lives
• The reasons they do not get involved with mainstream statutory services and medical care

They also had the opportunity to express their opinions on mainstream services; challenges that they encounter when accessing statutory services, their expectations and service improvements they want to see.

Another positive aspect of the project was the training and the qualifications the research team obtained. From this project;

• Two of the researchers obtained the University Certificate in Community Research and Mental Health
• The Project Team Leader and two of the volunteer researchers obtained the University Certificate of Achievement in Community Research

5.2 Challenging aspects of the method used

The main challenge we have faced in carrying out this research was the ethical approval procedures. Unfortunately, the ethics form came back needing more changes regarding working away from the office and we incorporated these into our own procedures as appropriate. All of these changes were mandatory and fieldwork could not go ahead until the changes were made.

Therefore we visited the premises we planned to use to carry out a risk assessment before we agree to hold interviews there. Additional precautions were taken to manage the risks that we have already identified. We adopted a clearer position around when confidentiality may be breached, so that this was not just when we may be required to do so by law but also when we believed that someone may be at risk of serious harm. The ethics were approved in October after a two months delay.

There were also a number of disadvantages to using semi-structured interviews. The main difficulty was arranging appointments with the participants. Although many service users were remarkably supportive and willing to participate in this study, the majority of them found it difficult to make an appointment due to the researchers' busy schedules and for other practical reasons. The solution was to meet with them in community centres where they can be easily reached in their leisure time. This was the most convenient way to reach the sample population. Another difficulty was that some of the questionnaires had to be completed in a rush because they were no scheduled appointment.

Participants' level of education affected their understanding and the responses that they provided. The questionnaire was designed to meet participants' sociological and cultural background but sometimes it was difficult for participants who were illiterate to understand the questions. Therefore, guidance and support throughout the interviews were provided particularly for those who were illiterate.

It was also challenging to continue with the project for some of the volunteer researchers due to their family matters or commitments. Of these, two of them withdrew from the study and did not participate in collecting data. Another challenge was collecting data from service providers. The response rate was low and some participants failed to return their responses in time.

These factors caused an unavoidable delay in our target timetable. Analysis of data was delayed and researchers had to work extra hours to get the study back on track. It has been particularly challenging for the researchers to meet UCLan's deadline.

5.3 Skills have been developed during the project

The research team has developed many skills through this study. Some of the skills gained include: time management, team work, co-ordinating volunteers, multi- tasking , working and liaising with professionals, working with the community, understanding mental health issues within our community, developing research skills from designing research materials to collecting data and analysing and report writing. These are valuable resources at both a personal and professional level and will contribute to the quality of existing services as well as supporting the project's volunteers and researchers in furthering their careers in related areas.

6 CONCLUSIONS and RECOMMENDATIONS

One of the objectives of the DRE is that by 2010 there will be ***increased satisfaction with the services***. In the result and discussion section of this study participants talked extensively about their dissatisfaction with the services and their lack of trust in the health system and organizations. These can be improved by;
     • To develop better partnership working between all stake holder groups in order to

provide a culturally appropriate mental health assessment and care package.
- Mental health awareness training to front line community workers including local schools so mental health problems can be identified earlier and signposted to appropriate services.
- To develop a culturally appropriate rapid response service and 24 hr bilingual telephone help-line.
- To develop community mental health awareness and prevention programmes including guided self-help literature, newsletters and web-sites.

Another objective of the DRE to reach by 2010 is *a more balanced range of effective therapies such as peer support services, psychotherapeutic and counselling treatments, as well as pharmacological interventions that is culturally appropriate and effective.* In this study almost all the respondents stated that they need to receive psychological therapies and mental health services in their own language or from people who can understand their culture. The suggestions below for improving services have been put forward by Turkish and Kurdish men in Hackney:

- Establishing a community based crisis centre accessible seven days a week with multidisciplinary staff.
- Expansion of bilingual services particularly counselling and psychotherapy to young people.
- Enhance bilingual advocacy services across sector to improve service access and quality of care.
- To develop mental health peer education programmes for all age groups.
- To develop positive mental health promotion with existing community centres and Turkish and Kurdish voluntary sector organisations and the local community.
- To develop a culturally responsive drug service and support in the community particularly young Turkish and Kurdish people.
- To develop a more holistic care packages i.e. access to employment, education, arts and leisure services.

Another important objective of the DRE to reach by 2010 is a *more active role for BME communities and BME service users in the training of professionals, in the development of mental health policy, and in the planning and provision of services; and a workforce and organization capable of delivering appropriate and responsive mental health services to BME communities.*

- To provide and develop clear career pathways and training opportunities for local Turkish and Kurdish people, students and graduates (particularly graduates from psychology, social work and sociology) into the NHS and community settings such as local surgeries, libraries or community centres.
- To provide transcultural training for primary and secondary mental health professionals to have a better cultural understanding of Turkish, Turkish Cypriot and Kurdish immigrant communities.

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APPENDIX 1

Information Sheet and Consent Form for Service Providers

We would like to invite you to take part in a research study. Before you agree it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Please ask if there is anything that is not clear or if you would like more information.

Derman was set up in 1991 by members of the Turkish, Turkish Cypriot and Kurdish communities in Hackney in partnership with local GP's and the Health Authority. The main purposes of Derman are to promote the wellbeing and to improve the lives of Turkish, and Kurdish speaking communities in London. Derman, offers holistic care for individuals and families through counselling, advocacy, advice and other services.

Derman believes that mental health is a serious issue for the Turkish, Turkish-Cypriot and Kurdish communities. Therefore, in order to explore and identify mental health issues and needs among Turkish, Turkish-Cypriot and Kurdish men in Hackney, Derman is conducting this research. The research is funded by NIMHE (National Institute for Mental Health in England) and supported by UCLAN (University of Central Lancashire). As a service provider your input will be valuable insights into Mental Health needs of Turkish, Turkish-Cypriot and Kurdish men in Hackney.

In this study you will be asked to complete a questionnaire which will take you 30 minutes to complete. You can complete the questionnaire in your own time. The data that you provide will be used for analysis and subsequent publication. It is very important for you to know that participation is entirely voluntary, the data collected during the research will not be identifiable, and will be kept strictly confidential, apart from in very exceptional circumstances. These exceptional circumstances will arise if you give us information which leads us to believe that either you or someone else is at risk of serious harm, including child abuse.

However, if you do not mind your views being attributed to you in the report please write your title, name and tick the box next to it. You do not have to answer any questions that you do not want to. The research proposal was reviewed by the Centre for Ethnicity and Health Community Engagement Ethics Committee at the University of Central Lancashire.

Name………………………………………… ☐ **I agree to take part**
☐ **I do not agree to take part**

We would like to thank you for reading the information sheet and agreeing to take part in this study.

APPENDIX 2

VOICE of MEN
(Questionnaire for Service Providers)
Mental health needs assessment of Turkish, Turkish-Cypriot and Kurdish men in Hackney

1. Do you collect ethnicity data?

   ☐ Yes   ☐ No (do you plan to collect)

2. How many Turkish, Turkish-Cypriot, Kurdish patients do you see on average in a week?

3. In your experience what are the main psychological problems that Turkish, Turkish-Cypriot and Kurdish men in Hackney experience? And why?

4. What are the signs and symptoms Turkish, Turkish-Cypriot and Kurdish patients present with?

5. Do you have statistical data which shows the extent of alcohol and drug abuse among your Turkish, Turkish-Cypriot and Kurdish patients? If yes, can you provide this and how do you think this particular problem affects their mental health?

6. What do you consider to be the barriers to accessing mental health services for Turkish, Turkish-Cypriot and Kurdish men?

7. How do you think these problems can be addressed?

8. What sort of service improvement would you like to see?

9. Do you think there are enough culturally appropriate services for Turkish, Turkish-Cypriot and Kurdish men in Hackney? What do you think about these services?

10. How do you think your service is coping with providing care to Turkish and Kurdish patients?

11. Any other comments, please write

APPENDIX 3

Information Sheet for general public

We would like to invite you to take part in a research study. Before you agree it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Please ask if there is anything that is not clear or if you would like more information.Derman was set up in 1991 by members of the Turkish, Turkish Cypriot and Kurdish communities in Hackney in partnership with local GP's and the Health Authority. The main purposes of Derman are to promote the wellbeing and to improve the lives of Turkish, and Kurdish speaking communities in London. Derman, offers holistic care for individuals and families through counselling, advocacy, advice and other services.

Derman believes that mental health is a serious issue for the Turkish, Turkish-Cypriot and Kurdish communities. Therefore, in order to explore and identify mental health issues and needs among Turkish, Turkish-Cypriot and Kurdish men in Hackney, Derman is conducting this research. The research is funded by NIMHE (National Institute for Mental Health in England) and supported by UCLAN (University of Central Lancashire). Your participation will provide valuable insights into Mental Health needs of Turkish, Turkish-Cypriot and Kurdish men in Hackney.

In this study you will be asked to complete a questionnaire which will take you approximately forty-five minutes. If you need to ask any questions during the process researchers will answer and help you to complete the questionnaire. The data that you provide will be used for analysis and subsequent publication however, it is very important for you to know that participation is entirely voluntary, the data collected during the research will not be identifiable, and will be kept strictly confidential, apart from in very exceptional circumstances. These exceptional circumstances will arise if you give us information which leads us to believe that either you or someone else is at risk of serious harm, including child abuse.

You do not have to take part and if you get part way through and decide to change your mind that is fine. You can stop the interview at any time. Also, you do not have to answer any questions that you do not want to. The research proposal was reviewed by the Centre for Ethnicity and Health Community Engagement Ethics Committee at the University of Central Lancashire.

If you decide to take part you will need to tick the appropriate box below to give your consent.

  ☐**I do agree to take part**   ☐ **I do not agree to take part**

We would like to thank you for reading the information sheet.

Derman Research Group

APPENDIX 4

Community Engagement Research Group
Written Informed Consent

I have read the information sheet and understood the details of the research asexplained to me by the researcher, and confirm that I have consented to act as aparticipant.

I understand that my participation is entirely voluntary, and that the data collectedduring the research will not be attributable to me. I know that I do not have to answer any of the questions if I do not want to and that I can stop the interview/focus group at any time. I understand that there are limits to the degree of confidentiality that can be offered to me, and that this has been explained to me.

I further understand that the data I provide may be used for analysis and subsequent publication, and provide my
consent that this might occur.

.

    ☐ **I do agree to take part**   ☐ **I do not agree to take part**

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APPENDIX 5

VOICE of MEN
(Questionnaire for General Public)
Mental Health needs assessment of Turkish, Turkish-Cypriot and Kurdish men in Hackney

PART 1.

1. Age last birthday ……...............

2. a) Were you born in the UK?
☐ Yes ☐ No
  b) If no, how long have you lived here?
☐ Less than 1 year ☐ 1-5 years ☐ 6-10 years ☐ 11 years more

3. Ethnic Origin (please indicate by a tick in the appropriate box).
☐ Kurdish ☐ Turkish ☐ Turkish-Cypriot ☐ Other, please, define your ethnicity

4. What is your first language?
Spoken or signed:…………………………………………….................
Written:…………………………………………………….................

5. Which languages are you fluent in?
Spoken or signed:…………………………………………….................
Written: :…………………………………………………....…......

6. a) Can you speak English?
☐ Yes ☐ No
  b) If no what are the barriers to you learning English? Please write ....

7. What is your religion?
☐ Please write……………………………………………………........

8. Are you currently (please tick one):
☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Divorced
☐ Other, please write...

9. a) Please indicate your highest level of education?
☐ Primary ☐ Secondary School ☐ High School ☐ University ☐ other
  b) In which country were educated, please write……………………………………………………………

10. a) Have you any children?
☐ No ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 and above

11. Could you please indicate which of the following best describes your status in the UK?
☐ British Citizen
☐ Refugee Status
☐ Indefinite Leave to Enter/Remain
☐ Exceptional Leave to Enter/Remain
☐ Humanitarian Protection
☐ Asylum Seeker
☐ Refused/Appeal
☐ I am a student
☐ other, please write...

12. Which of the following best describes your current employment situation?
☐ Employed full-time ☐ Employed part-time ☐ Unemployed
☐ Retired ☐ Self-employed ☐ Benefits, please
Specify……………………………………………………………………
Other…………………………………………………………….....

13. a) Have you worked before? Please write what kind of job have you done?
  b) What kind of support would you need to return back to work? ……………………………………………………

14. Do you have a disability? Or chronic illness
☐ Yes (please explain)....................………………… ☐ No

PART 2

15. What are the three most important factors which you think contribute to Turkish, Turkish-Cypriot and Kurdish men experiencing stress? Please rank following options. (rank 1 for the highest).

- ☐ Immigration problems
- ☐ Relationship problems
- ☐ Financial difficulties
- ☐ Unemployment
- ☐ Physical Health
- ☐ Bereavement
- ☐ Sexual Issues
- ☐ Loneliness
- ☐ Children
- ☐ Because, they don't share their feelings
- ☐ Other (please writen...

16. Do you share your emotions/feelings with anyone?

- ☐ Yes (Please answer the next question)
- ☐ No (please go to question 18)
- ☐ Do not wish to answer

17. Who would you prefer to open up your feelings to?

- ☐ Friend
- ☐ Wife
- ☐ Partner
- ☐ Relative
- ☐ GP
- ☐ Psychologist/Counsellor
- ☐ Community Leader
- ☐ Other, please write…………………....................................…………………………

18. What prevents you from opening up your feelings?

- ☐ I don't know how to start
- ☐ Embarrassment/shyness
- ☐ Men should not talk about their feelings
- ☐ Traditional upbringing
- ☐ I don't know who I can talk to
- ☐ Other, please write...……………...……………………

19. How do you deal with excessive stress?

- ☐ I talk to someone
- ☐ I would go to a social club
- ☐ I argue with my wife (partner) or family members
- ☐ I smoke cigarette
- ☐ I do not want to disturb others
- ☐ Other, please write

20. a) Have you or friends/relatives (please delete acordingly) ever suffered from mental health/stress related problems?

- ☐ Yes   ☐ No

b) If yes please tick appropriate boxes below.

- ☐ Depression
- ☐ Anxiety
- ☐ Panic Attack
- ☐ Schizophrenia
- ☐ Loneliness
- ☐ PTSD
- ☐ Insomnia
- ☐ Manic depression
- ☐ Relationship problems
- ☐ Bereavement
- ☐ Other, please write.....................………………'………'………………………………

21. Have you experienced any sex related problems? and how do you think these problems has affected your mental health?

....

22. a) Have you or friends/relatives (please delete acordingly) ever used any of the following services to help you with these problems?

- ☐ Hospital
- ☐ Derman
- ☐ Counselling/Talking therapy
- ☐ Locality mental health team
- ☐ None
- ☐ Other, please write…………………………………………………..........…………………

b) If you or friends/relatives (please delete acordingly) have not used these services please explain what prevented you or friends/relatives (please delete acordingly) from using these services?

…………………………………………………………………………………………….....

23. What type of treatment have you or friends/relatives (please delete acordingly) received?

- ☐ Medication/pills
- ☐ Counselling/talking therapy
- ☐ Psychiatrist
- ☐ I stayed in Hospital
- ☐ Other, please explain...............………………………………………………

24. Were you or friends/relatives (please delete acordingly) given enough time to discuss your/their condition and treatment?

☐ Yes   ☐ No (can you explain please)........…………......................….........……

25. Did they provide you or friends/relatives (please delete acordingly) with an advocate or interpreter?

☐ Yes   ☐ No

26. a) Did you or friends/relatives (please delete acordingly) have trust and confidence in the service provider?

☐ Yes   ☐ No

b) Please explain your answer?...........………………………………………………………

27. Overall how satisfied are you or friends/relatives (please delete acordingly) with the help you received from these services?

☐ Very satisfied   ☐ Satisfied   ☐ Neutral   ☐ Dissatisfied   ☐ Very dissatisfied

28. What are the barriers to accessing mental health services? Please say something about your experiences of the following:

- ☐ Information (e.g. leaflets, brochures)…………………………………..…………
- ☐ Access (e.g. appointments, advocacy, interpreting services)..........……………….
- ☐ Treatment (e.g. consultation time, language issues, medication)……………………
- ☐ Support (e.g. support workers, carer support, community support).......................…
- ☐ After Care (e.g. job, training opportunities)..
- ☐ Other, please write..…………………….

29. Do you know what mental health services are available in Hackney? Please write…………………………

30. What kind of mental health support service/s do you think Turkish, Turkish-Cypriot and Kurdish communities need in Hackney? …………………………………………………………………………………………

31. Do you also use any alternative ways like aromatherapy, massage, amulet (muska), religious leader, relaxation, fortune telling, spiritual leaders etc.

....…………………………………………………………………

32. Would you like to add any other comments?

…………………………………………………………………………………………….

APPENDIX   6

Centre for Ethnicity and Health – Application for Ethical Approval	
Name of Group	Derman
Address	The Basement 66 New North Road London N1 TG
Name of Support Worker	Imran Mirza
Date:	19.07.2007

Section: 2

What kind of work does the group intend to do as part of this project?	Derman aims to carry out research into the mental health needs of Turkish, Kurdish and Turkish Cypriot men in Hackney.
How do they intend to do this?	Derman will develop two questionnaires for the general public and service providers. Derman aims to reach 100 Turkish, Kurdish and Turkish-Cypriot men and about 30 service providers. The research team will assist respondents to complete the questionnaires (see attached). For instance, if required they will explain the questions and help those who are illiterate. The group also intends to run three focus groups (with up to 8 participants for each groups), one with carers, one with service users and one with Turkish, Kurdish and Turkish-Cypriot women to explore mental health issues of Turkish, Turkish-Cypriot and Kurdish men in Hackney. The focus group participants will be recruited from Derman's service users and various community centres. Focus group meetings will be held at Derman's main office. Questionnaire study will be conducted at Derman's main office, community centres and some coffee houses. These community centres and coffee houses will be visited in advance in order to check their suitability, safety and adequacy. Participants will complete the questionnaires by themselves in separate rooms at community centres. However, researchers will be present in order to assist, answer their questions and explain some of the questions when it is necessary. At coffee houses, the owner's offices will be used to provide participants with aconfidential environment (most of the Turkish-Kurdish coffee houses owners have their own office rooms). When this is not possible participants will be invited to complete questionnaires at Derman's office or main community centres. For this study coffee houses that are close to main community centres will be used. Mainly coffee houses will be visited for recruitment purposes.
Who will the respondents be?	Kurdish, Turkish and Turkish-Cypriot men in Hackney who are aged 18 and above from Derman's service users.
Who will they get to do the work?	Derman community engagement research team which consist of four voluntary researchers, two part-time research assistants and a Project Co-ordinator.
Where they will undertake the work?	The work will be undertaken at Derman's office, various community centres, coffee houses.
How will those who are doing the work be supported and supervised?	The research group will be lead by Derman's Mental Health Team leader who will provide support and supervision for research assistants and voluntary researchers. The research team will also hold meetings to discuss developments and any arising issues. The voluntary researchers' travel expenses will be paid and also £10 will be paid for their daily contributions (one day per week only). In addition, the project co-ordinator and the research assistants will be able to assist volunteers by e-mail and telephone.

How they will ensure that participants in the project have given consent? You should have an information sheet about the project which is read out and given to potential participants which explains to them (a) what the project is about.(b) that participation is voluntary (c) what will happen to the information that they provide (d) that they can stop the interview at any time and (e) that they do not have to answer any questions that they do not want to.?	The information sheets about our research have been prepared for the participants (see attached) because it is important for potential participants to understand why the research is being done and what it will involve. Before completing the questionnaires or taking part in a focus group the potential participants will read the information sheet. Separate information sheets will be prepared for each different group. These information sheets will provide information about the project and will inform them that participation is voluntary and the data that they provide will be used for analysis and subsequent publication and that they can stop the interview at any time and finally that they do not have to answer any questions that they do not want to. In addition a separate consent form will be prepared and if participants do decide to take part, they can tick appropriate boxes indicating that they have agreed to take part. This separate consent form will clearly inform participants about what they are consenting to.
Please enclose the information sheet and confirm that it addresses issues (a), (b), (c), (d) and (e) above	Information sheet enclosed (√) tick to confirm Issue (a) covered (√) tick to confirm Issue (b) covered (√) tick to confirm Issue (c) covered (√) tick to confirm Issue (d) covered (√) tick to confirm Issue (e) covered (√) tick to confirm
How they will the project ensure confidentiality? Note: you will not usually need to know (or collect) the names or addresses of respondents. If you know them already, or if you are going to ask people their names as a matter of courtesy, these should not be recorded on the questionnaires or the notes that relate to the interview. Note: you cannot guarantee confidentiality to anyone taking part in a focus group. You can request that people keep things within the group, but you cannot guarantee that the will. This must be made clear to people who agree to participate in focus groups.	All those employed at DERMAN perform their duties within a framework of confidentiality and in compliance with data protection legislation. Everything will be kept strictly confidential except in cases where we believe that either the respondent or someone else may be at risk of serious harm, including child abuse, in which case we may disclose such information as is necessary to appropriate third parties in order to try to prevent or stop the harm. We will hold the interviews in private rooms in Derman offices and local community centres. The names of participants will not be revealed to anyone outside of the research team. In order to ensure confidentiality, there will be no names or any identifiable data on the questionnaires. The completed questionnaires will be put in a locked filling cabinet in Derman Hackney Office and no one will have access to them except the research team members. The data will be destroyed by the researchers once the project has been completed. No data will be held beyond that. Focus group participants will be informed of the ground rules, the boundaries of the group and the importance of confidentiality will be especially highlighted. They will be required to keep what is said within the group and not to talk about it outside. However they will also be clearly told that we cannot guarantee that people will not talk outside. Therefore, they will be reminded to be aware of this before revealing any information that they would feel uncomfortable disclosing outside of the group.
How will data generated by the project be handled and stored?	The research team have a locked filing cabinet in Derman Hackney Office. All completed questionnaires and any other notes will be stored in a locked filing cabinet. Only research team members will have access to them. The data will be destroyed by the researchers once the project has been completed. No data will be held beyond that.

What risks are there? How will risks be identified and managed?

Note you need to think about risks to researcher and volunteers and risks to participants. For some people, simply taking part in the research may be a risk (e.g. if the parent of a young Muslim woman finds out that she has been talking to someone about drugs). For others, particular situations may be risky (e.g. if you are using ex-drug users to work on the project, are you putting them at risk of relapse by asking them to go back into situations where drugs are being sold or used? If something gets stolen from an office, will they get blamed for it [regardless of whether or not they did it] because everyone knows they are a drug user?). Are the interviewees particularly vulnerable or frail? Are interviewers likely to be vulnerable to allegations of misconduct?

Are the risks of carrying out or participating in individual interviews different form those of taking part or running a focus group? They probably are, and you need to show that you have thought about and addressed this.

THIS IS ONE OF THE MOST IMPORTANT SECTIONS OF THE FORM. YOU MUST THINK CAREFULLY ABOUT WHAT THE POSSIBLE RISKS ARE AND ABOUT WHAT STEPS CAN BE TAKEN TO REDUCE AND MANAGE THEM. THE ETHICS COMMITTEE UNDERSTANDS THAT IT IS USUALLY IMPOSSIBLE TO ERADICATE EVERY RISK, BUT THE ETHICS COMMITTEE MUST BE SATISFIED THAT ANY RISKS ARE REASONABLE, AND THAT STEPS HAVE BEEN TAKEN TO MINIMISE THEM

In order to manage the risks we have to identify what a risk is. These risks may be identified by individual researcher, project co-ordinator, and steering group's members or in the team meeting. After identifying the risk we can minimize the risk either by eliminating constrains or by reducing risk factors. Risk management is an ongoing process. Project Co-ordinator for keeping an eye on the possible risks and ensuring that the necessary mitigating actions are actually carried out.

The identified risks so far are:
Being offensive due to the stigma attached to the mental health:
It is possible that some participants might be offended and be aggressive due to the stigma attached to mental health in Turkish, Kurdish and Cypriot Turkish communities. In order to avoid this risk we will try to use a simple language and not use jargon. Participants will be reminded that their participation is voluntary and that they do not have to take part.

Handling anger tantrums / violence and distress from the participant:
It is possible that one or two participants may become disturb during the interview due to their sensitivity around mental health issues. To avoid this risk, the research team will be trained on how to deal with conflict and aggressive behaviour. The Researchers have received training about health and safety issues such as:
- The researchers should enter clearly the ad dress of the community centre in the office diary with the time of the interview
- The researchers should agree a procedure for phoning in before and after the interview with the project lead in order to confirm when the interview is beginning and when it has ended and that they are safe.
- Have a mobile phone and personal alarm
- Researcher may decide not to continue if the person is agitated
- Wear sensible clothing
- Refer to appropriate agencies
- Researchers should not work on their own – they should work in pairs
- Researchers should terminate interviews if they feel they may be at risk themselves.

Managing disclosure serious harm or possible serious harm
It is important that any disclosure of personal information will not be passed on to anyone outside of the service without the person's permission except where the researchers believe that an individual (whether a respondent or some other person) may be at risk of serious harm, including child abuse This will be explained to participants before starting the interview as part of the information sheet in order to obtain their consent.

Minimising the risks to researchers e.g. when interviewing outside of Derman office In order to minimise the risks to researchers when interviewing outside the Derman office, measurements must be taken as follows:
- Before conducting interviews a meeting will be held about how to conduct the research safely.
- Each community centres and coffee houses will be visited in advance to check their ade quacy, safety, confidentiality and availability.

	• Before conducting interviews a meeting will be held about how to conduct the research safely. • Each community centres and coffee houses will be visited in advance to check their adequacy, safety, confidentiality and availability. • The researchers walk in pairs when they conduct the research outside the main Derman office. • Interviews will be conducted at the community centres during opening hours when particularly sufficient numbers of people and officials around. • Some interviews take place at coffee houses. These coffee houses will be on the main roads where a lot of Turkish and Kurdish people will be around and will take place during midday when the owner of the place will be around. However when confidentially is not provided participants will be invited to respond questionnaires at Derman's main office or one of the nearest community centres. • Researcher will inform the responsible team leaders the time, venue and the dates of the interviews. • The research will not be contacted at participant's houses. • Researchers will be provided personal alarms and mobile phones (if they have not posses any). Note: The researchers will be in contact with vulnerable people therefore in order to avoid high risk around this; every researcher is having CRB check.
Please confirm the make up of the steering group	The steering group consist of the Project Co-ordinator, the Mental Health Commissioner from Hackney PCT, Community Development Worker from Locality Mental Health Team, CPN in Primary Care, the Chair of Hackney Refugee Forum, UCLAN support worker and six researchers.
How often does the Steering Group meet. It needs to meet often enough to both guide the research and keep it on track, and to pick up on any ethical issues that may arise.	Once every two months.

Is the Steering Group clear that is has responsibility for helping to manage the ethical issues that may arise as a result of running this project?	Yes. The steering group meets once every two months. They will be responsible to guide, support and discuss various stages of research. They will support researchers to access and obtain information when needed. They will also assist researchers to recruit participants for interviews and focus groups. They provided their e-mails and telephone numbers to team members in order to answer their possible questions about research. They also help the team to understand NHS rules and regulations about the ethical issues.

Section 3: To Be Completed By UCLan internal ethics committee

Date received:	*Jez Buffin, Christine Brown*
Reviewed by:	
Decision:	*Some additional steps are needed. The support worker and senior support worker must work with the group to see that these are acted upon. All of these changes are mandatory.*

bos

Derman

for the well-being of
the Kurdish & Turkish communities

March 2008