Mental Health: Perceptions and understandings from a south Asian perspective.

A report from focus group discussions carried out by Manchester Public Health Development Service in collaboration with Neesa Well Women Project

Summary

This report aims to provide an overview of a partnership project between the mental health team within Manchester Public Health Development Service (MPHDS) and Neesa Well Women drop in project. A series of four focus group discussions were conducted with south Asian women currently accessing services offered by Neesa project. 22 participants were involved overall, totalling 5/6 individuals per session. The intention was to gain an insight into the perceptions and understandings of mental health and options for supporting mental health problems among this population. Detail about how the focus groups were designed and conducted is included in the appendix of this report. The discussions raised some interesting discussions and debate among participants and a number of themes emerged which have been discussed and presented within this document. The issues raised reflect much of what has been researched and written previously about mental health and ethnicity. However some clear messages about things could be improved were given.

Stigma and negative attitudes to mental illness were considered to be strong barriers to seeking help generally and in receiving support from friends and family. Therefore the value of group support was advocated highly as a crucial resource for gaining support for mental health problems, reducing isolation and increasing social networks. Cultural understandings of mental health problems and differences in what south Asian communities consider to be appropriate first line interventions differ to some extent from the general population, for example preferring a spiritual intervention to a clinical response. This has implications for mainstream clinically focused services in terms of how their provision is tailored to meet the needs of Manchester's diverse communities. Participants held positive attitudes to recovery but varied in their perceptions of which interventions were considered beneficial, citing some concerns about safety and confidentiality as a factor preventing them from accessing both spiritual and clinical responses at an early stage. A number of recommendations have been made within this report suggesting how these issues could be addressed which include addressing the stigma attached to mental health problems in south Asian communities, recognising the value of support groups as a preferred support option for south Asian women, collaborating with spiritual support providers and ensuring equity in provision and access of mental health support for south Asian communities.

Manchester's ethnic profile

Manchester is an ethnically diverse city and all indications are that the ethnic population is increasing. In the last 2001 census 20% of the Manchester population belonged to an ethnic group other than White compared to 9.1% of the population in England. The largest ethnic group is Pakistani (6%) and 'Asian' is the largest overall ethnic group in the city constituting 9.1% of the whole population and 48% of the city's total minority ethnic population.

Research shows that people from Black and minority ethnic communities can suffer from inequalities in access to mental health services, in their experience of those services, and in the outcome of those services. For example, BME patients are significantly more likely to be detained compulsorily or diagnosed with schizophrenia (Department of Health, 2005). South Asian women in particular are at increased risk of experiencing poor mental health, experience more social and cultural stressors for developing mental health problems and appear to have less access to specialist mental health services, counselling and primary care mental health services.

Introduction

The Mental Health Team within MPHDS provides mental health promotion and prevention services to the population of Manchester on behalf of Manchester Primary Care Trust. The team develops and provides resources, training and information and equips organisations to address the mental health support needs of their clients. The team aims to ensure that the services they provide are inclusive and recognise the diversity of the Manchester population, taking into account differing perspectives of mental health and support for mental health problems. The team is continually aiming to develop and adapt their services in response to changing trends, emerging evidence and feedback from the community it serves. Partnerships and links with local voluntary and community organisations that serve diverse communities are integral to this process.

Neesa Project is an established voluntary sector organisation supporting south Asian women in Manchester. The project is based in Cheetham Hill, an area with a high ethnic population. The project exploits its central position by offering a range of accessible services including social activity, education, childcare and emotional support. Neesa offers an outreach service to encourage women who are isolated and experiencing barriers to accessing many services to utilise the support offered by the project. MPHDS has a history of co-working with the project, developing courses, presentations and activities to benefit users. On this occasion the member of the public mental health team responsible for co-ordinating activity in the North of the city approached Neesa project with the aim of eliciting discussions with Neesa project users about their perspectives of mental health and mental health problems, in order to inform and develop mental health promotion activity relevant to this group. It was hoped that the discussions would also inform a mental health equity audit currently being carried out in the area by MPHDS. Details of how the focus groups were developed including, proposal, information sheet and consent form is included in the appendix.

Implementation

The community room at Woodville Resource Centre was used to hold the discussions. The room was available for our sole use, ensuring privacy and confidentiality. The room benefited from a small 'break out' room which was used for private one to one discussions after the group discussion.

Prior to each session beginning, the Facilitator introduced herself, MPHDS and her role within it. She explained again the purpose of the discussion and thanked everybody for volunteering to take part. She explained again the importance of confidentiality between discussion group members, how their anonymity would be protected (i.e. their names and personal details would not be published in any reports) and gained everybody's consent that it was still acceptable to record the discussion on tape.

It was important that the discussion was relaxed and reasonably informal. It was very much led by the participants, with the facilitator prompting as appropriate in order to guide the topic base. Variations on each of the following questions were routinely asked during each group:

1. What types of images/words/thoughts come to mind when we refer to the term 'mental health'.

2. How would you perceive someone who has a mental health problem?

3. Is this perception widely held by the community?

4. Is mental illness something that can be treated and something a person can recover from? If no – why not.

5. What types of problems affect mental health?

6. Where would you recommend a person goes to for help with a mental health problem?

7. What types of things keep our mental health healthy?

The discussions went well, with most people having the confidence to speak up within the group, those who were less confident spoke with the facilitator following the discussion. The group discussions were an hour long in duration and the facilitator and mental health support worker were available for a further 2 hours in the breakout room if any participants wanted to discuss issues in private. Each session ended with each participant sharing one thing they would do over the next week to promote their mental health. The intention was to end on a positive note where it was likely that difficult issues had been raised for some participants.

Results

The discussions were transcribed from the tape recordings, and responses were grouped by question in order to identify themes arising. The following provides an overview of the main themes arising and utilises relevant quotations as appropriate:

Themes arising:

(1) ***Perception of mental health and mental illness:***

On exploring the question 'What do you understand by the term mental health?' Most participants interpreted its meaning to refer to mental ill health and distress. This is not unusual or unique to the south Asian community as the term is often taken to mean 'illness' among the general population. There was however, less reference to actual diagnoses, with only a small number of responses referring to 'depression' 'anxiety' or 'stress'. These terminologies are not generally used in South Asian languages where cultural descriptions of mental health differ to those common to Western clinical language. Explanations of what mental health is referred to as the 'workings of the mind' and the mind not functioning well.

> "The mind is not working well, it's not right".
>
> "The mind is not at rest".
>
> "How our mind is working, is it weak or strong?"
>
> "Attention is divided, it looks like you're doing one thing but your mind is somewhere else".
>
> "The brain is not working properly"
>
> "Mentally, your strength, how you are thinking inside affects you that is mental health. Physically is different. Mentally we are worrying. We are stressed and we are having depression that is mental health".

When asked how people with mental health problems are perceived there appeared to be a general perception that people with mental health problems are difficult to communicate and engage with. The group expressed this through describing people as 'talking too much and not listening'. It was not clear what the routes of this perception are, whether it was based on experience, cultural interpretations or connected with the way the question was phrased and interpreted. In the main responses included:

> "Talking a lot, asking the same thing, can't sit down properly".
>
> "They're not right. They want a lot of attention. They don't want to listen, they just want to talk".

> "When people talk, they are either talking too much or talking less. That's why they can't decide to speak. They have some problem, some mental health problem. They speak too quick".
>
> "People think he's mad. They have to realise he's not mad but suffering depression or anxiety".
>
> "Sometimes they are withdrawn, inside themselves".

(2) ***Factors affecting mental health***

When asked what kinds of things affect mental health and if there are issues particular to south Asian women, the response was very mixed. Some members of the groups said that 'no' there wasn't any problem that was particular to south Asian women but general problems that affect society as a whole such as crime affect our mental health.

> "No not really. There's a lot of issues like violence in the community."
>
> "Not just for Asian women, for the community as a whole."
>
> "No, it's problems for us all, the community, crime."

Other members of the group identified 'family' as a major strain affecting mental health. Sharing the families worries, and a feeling of making 'sacrifices' in terms of their own wants and needs for the sake of the family featured strongly.

> "The family causes a lot of stress".
>
> "Teenagers, children, family, relations".
>
> "Even extended family, brother, sister, relations. They bring us problems, because we live with relations".
>
> "Asians very sacrificing for family. If something happens everybody has to share. So that brings mental affect as well".
>
> "Because we are daughter, mother, wife. Every responsibility. We think about lots of things: kids, mother-in-law, husband, home, very, very hard."
>
> "With extended family though we sacrifice ourself. I'm thinking I go to nice place, go out, but if something happen in the family, I not go. Share the grief with them".

However, it was also felt that having a strong family bond and support network has its benefits offering the chance to socialise and problem solve.

> "But things are getting different now. With extended families we share each others problems".

There was also a sense that things are changing, particularly for the younger generation.

> "Everybody's problem is our problem, but with youngsters, it's getting slightly different now. Slowly the new generation is getting a bit different now…"
>
> "More sorting themselves out."

What was described in the most part by participants were problems with daily life and relationships. During the one to one sessions, two respondents described housing problems and money worries as making them "very depressed". Increasing understanding about mental health and strategies that support it would help individuals to distinguish what support is appropriate to suit their needs. For example, offering support to resolve the housing problem would provide more benefit than a mental health intervention.

Frontline staff working with women accessing Neesa project asserted that there are issues presented to them that were not raised during the focus group discussions which are important to highlight in this report. Domestic violence is considered a real issue with women often suffering in silence and not receiving early support. This is considered a precursor to developing mental health problems. It is also felt that a sense of powerlessness within the extended family where the mother-in-law has authority and is chief decision maker, often ruling with intimidation was a factor affecting mental health.

(3) ***Stigma and barriers to seeking help:***

There was general agreement among group members that mental health problems carry with them difficulties for people in admitting, explaining and gaining treatment. The disparity in attitudes to physical and mental health was recognised by the group with the stigma attached to mental health problems pivotal to this.

> "If someone breaks their arm they need emergency attention, but not for mental health".
>
> "We can show if something is broken. Depression is inside, it is not outside".
>
> "When the doctor is asking what is the problem we cannot explain what we are feeling and suffering. It is very hard to get treatment".
>
> "There's nothing more serious than being in depression or having a panic attack or having anxiety, not even a physical problem. They need more attention".

When asked if it is easy for people to admit that they have mental health problems, there was a consensus that it isn't. It was generally agreed among group members that stigma played a part in preventing people from admitting they were experiencing

difficulties and in need of some help and support. This presented a major overall barrier for people.

> "A lot of women say they don't even admit to themselves, it's so culturally unacceptable to admit the fact you've got a mental health problem, or you're depressed, or you've got a problem".
>
> "It's much harder to identify what is a mental health problem isn't it".
> "But unless they actually admit that they've got a problem and they identify it themselves, nobody can actually help them can they".

It was reported that personal and cultural understandings of mental health also play a part in preventing people from receiving support for mental health problems and influencing the type of support they feel is appropriate. This is particularly a barrier for the south Asian community where cultural understandings of mental health problems vary significantly. The language used to explain mental health problems as illness in Western clinical terminologies, does not necessarily translate literally and metaphorically in south Asian languages.

> "You don't actually know you've got a problem yourself so how are you supposed to admit it. Especially in our community, we're not aware of certain things like depression and anxiety. We don't know what these terms mean so how are supposed to identify our problem as this illness and actually say that I've got this problem".

Cultural understandings of mental health and mental health problems vary significantly between different individuals and groups of the population. For example, it was reported that spiritual explanations for mental health problems are common among the south Asian community. These varying understandings of mental health problems influence decisions about what support people feel is appropriate. This has implications for traditional clinical services making their responses irrelevant to many people.

> "They've done black magic on them, that's one major thing… they think oh, that's black magic".
>
> "There's this thing in the community where they think, that god, spirit, some evil spirit or something has took over, you're possessed, especially the Muslim community they do think that happens quite often…"

It was felt that fear about what the family or the community will think prevented people from admitting they needed help for mental health problems.

> "When I told my husband I was having problems, he said no you haven't, don't tell anyone, my friends will laugh at me. I said no, I think I should get some help".
>
> "We can't admit it, that we've got mental health problems, you are mad woman. But you have to tell somebody".

> "If someone was to have a panic attack in our family, some families will think 'oh they're mental, they're mad, send them to the mental asylum. They don't have the knowledge and understanding. Their thoughts are in the old days. That's what makes it hard to admit it, they think you're mad".

> "If someone finds out in the family or the community, that's embarrassing. That's one thing that scares them".

It was reported that the language and cultural barrier and lack of understanding/information about the availability of interpreters prevented some people from accessing formal support.

> "We have a common problem its language".
> "If we can speak with someone in our own language from our own culture it's easier to speak with them, and that's why the GP recommend you to go to your local community and go and seek help".

The added benefits of an outreach service offered by Neesa group, to encourage people who are isolated or have barriers to attending groups was considered important.

> "This service is good, the way she goes to your house first and gets you in the mood to actually want to come out and come into the group. Then you just don't feel like leaving it, there's so much going on and so many activities that you just get into it and your social circle starts getting bigger and bigger and you just start enjoying it".

> "Sometimes it's very hard for these kind of people to come out and come here".

> "It's hard to convince people to come out because people don't want to come to these groups. Ghazala has a very hard job. But when they do come they benefit. Hundreds of people have benefited from coming here".

(4) ***Recovery and treatment.***

When asked if mental health problems are something you can recover from there was consensus that yes you can recover from mental health problems, but there were differing opinions about what interventions and combinations of treatments were useful. Responses were varied and focused more on social, spiritual and community rather than clinical support. Taking comfort in prayer, community connections and family support was considered most important. However, it should be noted that a preference for these types of interventions in place of clinical support could be a result of a lack of understanding or awareness of what clinical support is available and how it can be accessed.

> "Come to groups like Neesa".

> "Community connections".
>
> "Talk to each other, encouragement".
>
> "Listen to each other".
>
> "Family support".
>
> "Pray to God".
>
> "Household work is a comfort but courses here work our mind differently".

Participants discussed the value of a range of interventions:

i. Groups and social support

There was a strong feeling reflected across each focus group that social support, groups and sharing experiences with others in similar situations was of most importance. There is an element of bias considering that participants were currently all accessing support from groups offered through Neesa project. However it was recognised by participants that other more traditional treatments such as counselling, medication and visiting the GP were important, but the 'added value' of groups provided more useful benefits such as increasing social networks, reducing social isolation, developing friendships, sharing information and experiences, learning new skills and having 'time out'.

> "When the ladies talk together they release frustration, anything can happen in this world and they can solve problems together and they are very helpful by themselves".
>
> "You should make more groups like this, I enjoyed it. She has got another problem and she has got another problem. When we listen to each other, we know we are not alone"
>
> "Because with the Asian women more, not necessarily all of them but most of their problems do start because they are stuck at home and they don't know where to go in terms of socialising….but even religion…religious wise it's not allowed we can't really do much of that. Groups like this give us the surroundings and opportunity to come and socialise meet new friends kind of everything, it gives them the opportunity to come out more".

ii. The GP

The GP was considered a valuable source of information and advice, but it was conveyed that there were limitations in what the GP could offer.

> "The doctor can't give you company only tablets".

> "The community helps when doctors don't"
>
> "The doctor can recommend groups you can go"
>
> "The GP is very nice and the staff is very nice"
>
> "He (the GP) tells you where all the groups are meeting".

It was conveyed that other interventions offered by the GP such as medication were not always appropriate as a first response for mental health problems.

> "That's like the second stage you can try, it depends on the nature of how, how deep it is. You know maybe sometimes its family. If you can take yourself and show yourself as having problems maybe it can be helped without, maybe only after then maybe medicines should be written".

Following further discussion with Neesa frontline staff it was conveyed that despite this there is still a tendency for GPs to prescribe medication as a first line and not offer early intervention, counselling or alternative options to women presenting to them.

iii. Counselling

There was some disagreement about the usefulness of counselling services. Again, many group members advocated the benefits of support groups such as Neesa, but other group members challenged the idea that all problems could be shared and resolved in a group setting.

> "They like coming here more and they say coming here has benefited them more than going to see a counsellor".
>
> "It depends on the problem, wouldn't want to share everything with everybody".
>
> "One to one's here (Neesa) are confidential. It's very relaxing to speak just to Ghazala (mental health worker)".
>
> "Group is fine, but some problem confidential".

iv. Spiritual Interventions

Discussions arose in two of the groups about the use of healers and spiritual interventions. Some negative experiences from using healers were shared, and it was suggested that if the NHS could recommend spiritual healers this would help individuals feel safer and more confident.

> "For awareness they (NHS services) should be in contact with our spiritual people that we go to so they are aware, NHS is aware of what they believe in and what Asians believe in, what Muslims believe in about being

> possessed so they have better understanding when they see people like that".
>
> "Working together with them (spiritual healers), they will be able to help them a lot more effectively".
>
> "The NHS should have them (spiritual healers) working for them, people will be aware that this is a genuine person, that's the main thing, coz like they (ladies in the group) were saying a lot of them are there just to make money and they make the situation worse".

It was suggested that the NHS could oversee spiritual healers working for them through a regulatory body as there were concerns that some healers were operating without being fully qualified, or affiliated to any organisation. This discussion led to some interesting debate amongst group members about confidentiality and safety. It was felt that concerns about confidentiality prevented some people from visiting somebody from the community for mental health support.

> "A girl in our community got pregnant and had an abortion and the doctor told everyone. How do you solve a problem like that? If you can't trust them, you can't trust them".
>
> "You can't even ask to see a doctor that's not from the community because then everyone will be wondering what you've got to hide".

However, some group members felt they would be safer seeing someone from the community who worked for the NHS:

> "They are recommended".
>
> "In the community we don't know if they're confidential, but someone from NHS would be bound by confidential rules, it would make it more comfortable to go and see them wouldn't it".

Conclusions and Recommendations

The results of these focus group discussions reflect much of the existing research and literature exploring mental health in south Asian communities. Many of the issues that were raised about mental health, particularly in relation to stigma and attitudes to mental health problems and the impact on seeking help cuts across population groups and society as a whole. However, the approaches we would take from a public mental health perspective in how to tackle these issues would vary between these population groups. Guidance we would take from these discussions and associated literature and research in relation to mental health and ethnicity would include provision for language, cultural understandings of mental health and interventions that are preferred.

Attitudes to recovery and treatment among the groups were very positive, although preferences about which interventions are found to be helpful were very much

focused on groups and social support. As previously mentioned, the fact that all participants were currently accessing Neesa group suggests some element of bias in responses. However, participants identified some particular issues which they felt had an effect on their mental health including isolation which the provision of groups where women can meet would address.

There were some very specific issues that were raised by the groups which would be more difficult to tackle initially. Particularly the concerns about confidentiality acting as a barrier to seeking support for mental health concerns. There was a difference of opinion between groups, with some feeling very confident and safe accessing support services, whilst others did not feel confident. It was not apparent whether these perceptions were based on direct experience or through verbal networks.

Overall, the feedback gained through these discussions will be invaluable in helping to guide, inform and develop services provided by the public mental health team, and in informing public health intelligence in Manchester.

Recognise the value of group activity and support in responding to the mental health needs of south Asian women and consider the need to sustain and expand on current activities as a preferred option for mental health support.

Collaborate with individuals offering spiritual interventions for mental health problems in the city, providing opportunities for research, consultation and partnership working.

Consider the value of targeting a campaign aimed at reducing the stigma attached to mental health problems among south Asian communities.

Support services supporting mental health in primary care (for example GPs and Primary Care Mental Health Teams) to take measures to improve their accessibility to the whole population. In particular consider the benefits of providing service information in translation, targeting specific clinics to different population groups (e.g. within settings such as Neesa group), and explore and address concerns about confidentiality.

Develop further focus group based discussion with service users to inform service development and delivery and ensure services are informed by the communities they serve.

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Appendices

Appendix 1:

Focus group development: An explanation of how the focus group project was set up.

Appendix 2:

Project proposal letter sent to the Neesa Project Management Committee.

Appendix 3:

Participant Information Sheet: Information for participants to help them make an informed decision about whether to participate in the discussions.

Appendix 4:

Informed consent form for participants: Consent form signed by participants who agreed to participate, understood the conditions and purpose of the research and agreed to it being audio taped.

Appendix 1

Focus group development

Session dates and number of participants

8th March 2007:	6 X participants
29th March 2007	5 X participants
5th April 2007	5 X participants
12th April 2007	6 X participants

The public mental health team member for North Manchester wrote a proposal for submission to the Neesa Project Management Committee (see appendix 2). The intention was to develop a series of 4 group discussions with Neesa service users, supported by an interpreter and a volunteer support worker provided by the project. Lunch and refreshments would be provided and pamper sessions offered following the discussion as a token of thanks to participants. MPHDS would pay a management fee to Neesa project to cover these expenses. The Neesa project mental health support worker was on site and available to support participants for whom sensitive issues had been raised if required.

The proposal was accepted and Neesa staff promoted the discussion groups to users and engaged up to 5/6 people per session. A private room was made available following the discussions for participants to speak confidentially with the group facilitator if there were experiences they wanted to share outside of the group, or if the discussions had prompted feelings for participants that they wanted to discuss with the Neesa mental health support worker. The public mental health team member facilitated the sessions. An information sheet was produced for participants detailing what would be involved in participating in the discussions (Appendix 3) and a consent form was designed for participants to sign, which allowed the Facilitator to tape record the discussions (Appendix 4). The paperwork was given to Neesa project staff in advance of the discussions for them to pass to participants. The information was read to participants in their first language if they were unable to read English ensuring informed consent.

Staff

Neesa project staff present at each session:	1 X interpreter
	1 X Volunteer
	1 X mental health Support Worker

MPHDS: the public mental health team worker facilitated each session

Appendix 2

23rd January 2007

To whom it may concern

The mental health promotion team in Manchester Public Health Development Service is carrying out a health equity audit of statutory mental health services in North Manchester (primary care and hospital services). The intention is to identify whether services are accessed equally by all members of the community, and in particular those people from Black and minority ethnic communities in North Manchester. Ethnicity monitoring data collected by those services will be analysed and compared against the population data held for North Manchester.

Different cultural perceptions of mental health and differences in the way diverse communities approach treatment for mental health problems means that mainstream mental health service provision isn't always appropriate for people. To gain a more detailed picture of any access issues revealed by the audit, we would also like to speak to individuals from Black and minority ethnic communities about their perceptions of mental health, mental health problems and service provision. We would like to partner with voluntary and community services to help us do this. We hope to work with a number of agencies, and in particular Neesa project as we have always had a good working relationship with the project.

As the mental health promotion worker for North Manchester, I will be leading on the majority of this work. After a preliminary discussion with Ghazala, we came up with a proposal which I would like to present to the management Committee of Neesa Project.

In partnership with Neesa project I would like to run up to four focus groups including up to 5 women in each group, to discuss their perceptions of mental health (possible questions are attached). As a thank you for participant's time we will offer massage sessions afterwards to help relaxation. Neesa project will provide room space and refreshments, a volunteer to help set up, and possibly a worker to interpret, plus a sessional massage therapist. Manchester Public Health Development Service would meet any costs incurred.

An estimated cost for four focus groups and an evaluation event:

Pamper sessions: 4 x 2 hour sessions = £120
Interpreter: 4 sessions = £80
Volunteer: 4 sessions = £40
Evaluation event and refreshments = £200
Neesa management fee (room hire, engaging and supporting participants) = £200
Total: = £640

Continued…

We would structure the sessions over 3 hours. 1 hour for focus group discussion. 2 hours for pamper sessions and one to one time with myself if required. This allows opportunities for all participants to contribute their views, both as part of a group and more confidentially on a one to one basis. The sessions will be tape recorded with participant's permission, purely for the purposes of collecting discussion thoroughly. The anonymity of participants will be maintained, and participants will be fully briefed on the project and how their comments will be used before the session.

We anticipate that the results of these focus group discussions will also help to inform Neesa project and provide valuable evidence for their own use.

With the permission of the Management committee we would like to commence these focus group sessions as soon as March 2007.

I have attached some information about the audit project, and some questions which I would want to ask the focus groups (as a guide only). I would be happy to answer any questions you may have about this proposal

Yours Faithfully

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Appendix 3

Research Project: Health Equity Audit of Mental Health Services in North Manchester.

Participant Information Sheet

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Project Partner Contact name and address: Ghazala Hussein, Neesa Well Women Project, Woodville Resource Centre, Shirley Road, Cheetham Hill, Manchester.
Contact telephone number: 0161 740 2995
Contact email: neesa01@tiscali.co.uk

What are some general things you should know about research studies?
You are being asked to take part in a focus group as part of a research project for Manchester Primary Care Trust in partnership with Neesa Well Women Project. To join the focus group is voluntary. You may refuse to join, or you may withdraw your consent to take part in the focus group, for any reason, without penalty.

Research projects are designed to obtain new knowledge. This new information may help people in the future. You may not receive any direct benefit from being in the research study.

Details about this study are discussed below. It is important that you understand this information so that you can make an informed choice about being in this research study. You will be given a copy of this consent form. You should ask the researchers named above, or staff members who may assist them, any questions you have about this study at any time.

What is the purpose of this study?
The purpose of this research project is to understand better what support for mental health problems is required by different black and minority ethnic communities in North Manchester, how different communities view mental health problems and what barriers they find to accessing mental health services provided by Manchester Primary Care Trust.

How many people will take part in this study?
If you decide to take part in the focus group discussion you will be one of approximately 40 people involved in focus group discussions.

How long will your part in this study last?
Your participation in this focus group will last approximately one hour. The researcher will be available afterwards for a further hour if you want to speak to her individually.

What will happen if you take part in the study?
The group will be asked to discuss thoughts and opinions about mental health and mental health problems in their community. They will be asked to discuss what sources of support

they feel they have available to them and whether they are aware of mental health services provided by Manchester Primary Care Trust. They will be asked to give recommendations for mental health support which Manchester Primary Care Trust could provide. No questions will be directed to you individually, but instead will be posed to the group. You may choose to respond or not respond at any point during the discussion. The focus group discussion will be audio taped so we can capture comments in a transcript for analysis.

What are the possible benefits from being in this study?
Research is designed to benefit society by gaining new knowledge. You may not benefit personally from being in this research study but your comments will be used to influence mental health promotion initiatives and inform mental health service provision.

What are the possible risks or discomforts involved from being in this study?
It is possible that the discussion may raise some personal responses from you based on your experiences. As you are currently a service user of Neesa project, all of their services will be available to you as usual. The project mental health support worker who you currently work with will be available to support you during and after the discussion.
Even though we will emphasize to all participants that comments made during the focus group session should be kept confidential, it is possible that participants may repeat comments outside of the group at some time in the future. Therefore, we encourage you to be as honest and open as you can, but remain aware of our limits in protecting confidentiality.

How will your privacy be protected?
Every effort will be taken to protect your identity as a participant in this study. You will not be identified personally in any report or publication of this study or its results. Your name will not appear on any transcripts; instead, you will be given a code number. We will not take your name but instead refer to you as participant (code number). After the focus group tape has been transcribed, the tape will be stored in a locked cabinet. The tape will be retained as we would like the opportunity to re-analyse the data for possible inclusion in future reports.

Will you receive anything for being in this study?
You will not receive any payment for taking part in the focus group but we will provide refreshments and a massage therapist for a relaxation session following the discussion.

Will it cost you anything to be in this study?
There will be no costs for being in the study

What if you have questions about this study?
You have the right to ask, and have answered, any questions you may have about this research. If you have questions, or concerns, you should contact the researchers listed on the first page of this form.

What if you have questions about your rights as a research participant?
All research on human volunteers is reviewed by a committee that works to protect your rights and welfare. If you have questions or concerns about your rights as a research subject you may contact, anonymously if you wish christina.ireland@manchester.nhs.uk

Participant's Agreement:
I have read the information provided above or the information has been read to me in my first language. I have asked all the questions I have at this time. I voluntarily agree to participate in this research study.

Appendix 4

Informed Consent Form for Project Participants

Project Title: Health Equity Audit of Mental Health Services in North Manchester.

I agree to take part in the above research project. I have had the project explained to me, and I have been given a copy of the Explanatory Statement, which I may keep. I understand that agreeing to take part means that I am willing to:

Take part in a focus group discussion
allow the discussion to be audio taped

Data Protection
I understand that any information I provide is confidential. The researcher will not take my name or address or include any information in any reports that could identify me.

Extracts from the focus group discussion will be used in a final report shared with Manchester Primary Care Trust, Salford University and Neesa Project. Each organisation is bound by strict rules of confidentiality.

I understand that confidentiality cannot be guaranteed for information which I might disclose in the focus group, but I will have time to speak individually with the researcher if I want to share information which I do not want other participants to hear.

I consent to extracts of the focus group discussion being used in further research projects and additional reports provided by Manchester Primary Care Trust and Neesa Group.

Withdrawal from study
I understand that my participation in the focus group is voluntary and that I can choose not to participate or leave the group at any stage of the project without being penalised or disadvantaged in any way.

I confirm that I have read and agree with the statement above

Signature: ....Date:

Independent witness to participant's voluntary and informed consent
I believe that ………………………….. understands the above project and gives her/his consent voluntarily

Name:... (Please print)

Signature...Date:..................................

Address:..

....