Community Renewal Fund

A Feasibility Study for the Establishment of Volunteer Mental Health Champions

August 2022

Acknowledgements

YAWR Services would like to thank Voluntary Action Rotherham for giving us the opportunity to undertake this feasibility study for Community Health Champions in Rotherham.

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1. Introduction

This report details the feasibility of Mental Health Champions as a method to support the mental health of people in Rotherham, particularly those from Black, Asian and Minority Ethnic (BAME) communities in central Rotherham which has high levels of both deprivation and ethnic diversity. The study is funded by the Community Renewal Fund which funds pilot initiatives to empower places to explore how best to tackle local challenges by supporting communities, businesses and places to build sustainable communities.

Rotherham has a long history of socio-economic and health challenges which are deeply embedded in local communities. The communities of central Rotherham are particularly disadvantaged in many ways including poor health. Whilst physical health problems are widely recognised, there are also mental health conditions which are often hidden and carry a stigma, especially in BAME communities. This study will focus on what can be delivered to support positive mental health and challenge the stigma which often surrounds poor mental health. The study will seek to identify the potential for volunteer mental health champions to make a difference to the mental health of people in their communities and develop a better understanding of mental health.

This report details the findings of a survey carried out by You Asked We Responded (YAWR) Services as part of efforts to promote a better understanding of mental health amongst people from disadvantaged backgrounds, especially those from BAME communities. People from minority ethnic backgrounds often have a low take-up of mainstream services which may reflect lower awareness of opportunities and lack of inclusive services.

2. Background and Context

Volunteer Mental Health Champions and Ambassadors

The Covid-19 pandemic has provided a renewed focus on community health projects, many of which involve recruiting volunteers to act as ‘champions’. A good example is the Sheffield Community Champion Project, co-ordinated by SOAR and funded by Sheffield City Council. The project works alongside 11 community organisations to recruit and support 80 Community Champion volunteers with the aim to empower communities in making informed health decisions. The Community Champions have been supporting their communities by:

- Listening to people’s questions and concerns
- Providing information on Covid-19 and vaccinations
- Helping people access services, such as vaccine clinics, testing sites and other health or community services

Community health champion projects can be found in many parts of the UK, in various settings. They usually cover a wide range of health and wellbeing issues which can include mental health but their emphasis tends to be on physical health and lifestyle issues. There are also similar projects which are aimed specifically at addressing mental health needs in the community.

The concept of community mental health champions is already established by the mental health charity Mind, including Rotherham and Barnsley Mind. Champions are volunteers who promote mental health and mental health services, and also combat stigma and discrimination. Voluntary Action Rotherham and Rotherham United Community Sports Trust have health champions whose remit includes both physical and mental health. Mental health champions are most often found within workplaces or sports organisations. There few examples of mental health champions active in informal community roles and fewer still with any remit to work with BAME communities. This feasibility study will explore the potential for such roles working with Rotherham's BAME communities.

The role of a community mental health champion is to support their peers to access mental health services, raise awareness of mental health issues, counteract stigma in the community and get people talking about their mental health. Mental health champions should receive some training for their role but should not be expected to diagnose or resolve mental health conditions or provide mental health support other than 'first aid' in their role. They would be provided with details of where to signpost people for professional or other specialist support.

According to the Yorkshire Sport Foundation, anyone over the age of 18 can be a Mental Health Champion. People do not need personal experience of mental health problems, but those who do have lived experience of mental health problems often find it helps them to start conversations and challenge stigma. Any action that a champion takes – no matter how big or small – can help to end stigma and raise awareness.

Being a champion is a voluntary role, so it's important for a person to give careful thought to how they can best use their time to bring about positive change. As with any volunteer role, this is an investment of time, so it should be a positive experience for the volunteer.

Mental health ambassadors sometimes have a similar role to champions although they are more likely to be people who already have a significant profile or influence. The national Ambassadors for Mind are well known celebrities. Ambassadors may require more training or expertise than champions and promote good mental health in a more strategic way, ensuring that agencies take mental health into account. Mental health champions and ambassadors both require training for their role. Mind offers a two-day Mental First Aid course divided into four specific sections covering:

- Mental Health First Aid, mental health, and depression

- Depression and suicidal crisis
- Anxiety, personality disorders, eating disorders and self-harm
- Psychosis, schizophrenia, and bipolar disorder

In each section participants learns how to:

- Spot the early signs of a mental health issue
- Feel confident helping someone experiencing a mental health issue
- Provide help on a first aid basis
- Help prevent someone from hurting themselves or others
- Help stop a mental health issue from getting worse, and aid faster recovery
- Guide someone towards the right support

The champion's role is to encourage communication & conversations about mental health in everyday life, connecting with people about such issues, as speaking to an individual or group who are experiencing similar things or have done so previously.

Projects which involve community champions who address the mental health needs of BAME communities are uncommon but there are examples in Camden, Tower Hamlets, Haringey, Leicester, Sunderland and Salford.

Salford

In 2019, Salford CCG recruited 14 volunteers representing local BAME communities as mental health champions to help more vulnerable people in their own community. Engagement work with BAME groups, including the health needs assessment, highlighted that more mental health support was needed in BAME communities.

Each mental health champion was recruited to represent their own community - including African, Yemeni, Chinese, Polish and Jewish, to act as links to mental health services in Salford. The champions met every month for a year and undertook accredited 'Mental Health First Aid' training as part of their commitment. Their role includes sharing important information with their community and signposting people to the appropriate services.

Camden

Camden's Mental Health Champions are community workers or volunteers who aim to increase mental health awareness among Black, minority ethnic and refugee (BMER) groups. They are often of a similar background or culture to the communities they work with. Champions help to break down stigma and ignorance surrounding mental health issues by talking about mental health; delivering information, advice and guidance; raising awareness and knowledge of services through various activities including workshops, discussions and role plays. The project is hosted by Voluntary Action Camden.

Tower Hamlets

The Bangladeshi Mental Health Forum developed a training programme for people to become Community Mental Health Champions, proactive ambassadors of the forum. Their primary role is to raise awareness of mental health (challenge negative views/ stigma, signpost residents to services, promote positive mental wellbeing) to the Bangladeshi community in the community settings (e.g. schools, groups, mosques, community centres) via workshops, events and one to one interaction.

Sunderland

The “We Are Together” Health & Wellbeing Project in Sunderland has created Wellbeing Champions within the local BAME community. The aim of this project is to actively raise awareness of mental health issues and barriers to accessing services, using a variety of methods, techniques and tools to improve mental health in the BAME community. Wellbeing Champions represent people of their own ethnic community to increase awareness and knowledge to support vulnerable people with wellbeing issues. They build their confidence and skills in discussing wellbeing, teach mindfulness techniques, and support and overcome barriers in accessing health and wellbeing services for the BAME community. The project is run by a VCS partnership including the Sunderland Bangladesh International Centre and Mind.

YAWR Services

In 2010 Rotherham Ethnic Minority Alliance (REMA) was commissioned by Rotherham MBC to support the development of a Joint Improvement Programme (JIP) Toolkit to improve BAME access to adult social care services and address gaps in VCS service provision. This work resulted in the establishment of You Asked We Responded (YAWR) as a BAME social care advocacy project overseen by REMA and funded by the Yorkshire and Humber JIP and other external funding.

The project developed into a social enterprise which was approved as a social prescribing provider for the 2012 Social Prescribing Service pilot. YAWR has continued to deliver social care and advocacy services and from 2017, YAWR has also been delivering a befriending service under the mental health project through RDASH, managed by VAR. YAWR became a registered charity in November 2020.

Central Rotherham Communities

For the purposes of this study, Central Rotherham covers a radius of about 2 km from the town centre, including Clifton, Eastwood, East Dene, Herringthorpe, Broom Valley, Canklow, Ferham, Masbrough, Bradgate and Meadowbank. This area had a population estimated at 40,400 in 2020, an increase of 7.8 per cent since the 2011 Census. The working age population aged 18-64 in 2020 was 24,600 or 61 per cent of the total. The ethnicity of the population in 2011 is set out below, showing that 31 per cent of residents were from BAME backgrounds, almost four times the Borough

average of 8 per cent. Unfortunately, the results of the 2021 Census for ethnicity have not yet been published. For people aged 0-24 in 2011, who will now be aged 11-35, the BAME proportion is significantly higher at 42 per cent.

2011 Census	All Ages		Aged 0-24	
Ethnic Group	**Number**	**Percentage**	**Number**	**Percentage**
White British	25,798	68.9%	7,792	57.6%
Other White	1,898	5.1%	768	5.7%
Multiple Heritage	825	2.2%	567	4.2%
Pakistani	5,796	15.5%	2,954	21.9%
Other Asian	1,374	3.7%	615	4.5%
Black	970	2.6%	452	3.3%
Other	800	2.1%	369	2.7%
Total	**37,461**	**100%**	**13,517**	**100%**

Some communities have fairly stable populations, namely East Dene and Herringthorpe which both have high proportions of council housing. Areas with much private rented housing, notably Eastwood and Ferham, have grown significantly due the migration of Roma and other people from Eastern Europe, whilst new housing in the Town Centre and Canklow has contributed to population growth there.

Almost two thirds of neighbourhoods within Central Rotherham are within the most deprived ten per cent of England, with Eastwood, Canklow, Ferham, Masbrough, the Town Centre and parts of East Dene being in the most deprived five per cent.

Central Rotherham is entirely within the Rotherham Parliamentary Constituency which allows for more localised employment information than using the whole Borough. Furthermore, the Rotherham constituency is the most deprived of the three covering Rotherham so better reflects conditions in deprived areas.

BAME Communities in Rotherham

Rotherham's Black, Asian and Minority Ethnic (BAME) population is a relatively small proportion of the Borough population compared with the national average but has grown and become increasingly diverse over the last two decades. According to the 2011 Census, there were 20,842 people from BAME communities or 8.1 per cent of Rotherham's population, more than double the number in 2001 when the percentage was only 4.1 per cent. As the 2011 Census is now 10 years old, more recent data needs to be taken into account. The school census (PLASC) shows that the percentage of BAME pupils in Rotherham schools grew from 13.7 per cent in 2011 to 18.7 per cent in 2020, which would suggest that around 11 per cent of the population is now BAME, about 29,000 people.

The largest BAME community in Rotherham is Pakistani/Kashmiri with around 10,000 people in 2019, just over a third of the total BAME population. Like almost all BAME communities, the Pakistani/Kashmiri community is relatively young. Other

Asian communities number about 3,400, the largest groups being Indian and Chinese. There are also around 700 Arabs in Rotherham, mainly Yemeni who are a well established community.

Rotherham's Black population has increased significantly from 400 in 2001 to around 2,300 in 2019, mostly Africans who include many refugees from Zimbabwe and other countries. There are a wide variety of backgrounds in terms of country of origin and circumstances.

The white minority population (mainly European) increased from 2,368 in 2001 to 4,320 in 2011, mainly as a result of immigration from the EU after 2004, a trend which continued until the UK left the EU in 2020. The largest group moving to Rotherham were Slovak Roma, who often arrived as whole families, intending to settle permanently. By 2020, there were 2,115 school children from non-British European backgrounds in Rotherham schools, part of a wider population estimated to be about 9,000. Around half of this population are Slovak/Czech Roma (4,600) and a further third are either Polish or Romanian. Almost all people from European migrant communities (post 2004) are of working age or younger.

Rotherham's BAME population is concentrated in the inner areas of the Borough with the majority living within two miles of the town centre. Using the Index of Multiple Deprivation 2019 and Census ethnicity, 44 per cent of BAME residents live in areas within the most deprived 10 per cent of England, double the average for Rotherham. Although English is widely spoken by BAME residents, there are many community languages in Rotherham, the most widely spoken being Punjabi, Urdu, Slovak, Polish and Arabic. In the 2011 Census, 44 per cent of BAME residents aged 3+ did not speak English as their main language and in 2020, 10.5 per cent of children in Rotherham schools spoke English as an additional language.

Rotherham has a diversity of communities whose characteristics and needs vary considerably. The same is true of their understanding of local services and ability to access them. People from new migrant communities often face language barriers and lack awareness of mental health services and their providers. People from longer established communities can still face language or cultural barriers, and have variable levels of awareness. Although most BAME communities are concentrated in central Rotherham, some such as the Chinese, Indian and Irish communities are widely dispersed across the Borough. White British residents in central Rotherham are often disadvantaged and have poor mental health which is reflected in the relatively high proportion claiming benefits for mental health reasons.

Mental Health Overview

Mental health is something everybody has. Mental health, as defined by the World Health Organisation, is: '.... a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to her or his community.'

Good mental health is fundamental to how an individual, community and society functions. Improved mental wellbeing and reduced mental disorder are associated with: better physical health, longer life expectancy, reduced inequalities, healthier lifestyles, improved social functioning and a better quality of life. Improving people's mental wellbeing is also associated with positive outcomes in relation to education and employment, as well as reduced crime and antisocial behaviour.

One in four adults experiences at least one diagnosable mental health problem in any given year. Mental health problems represent the largest single cause of disability in the UK and have been a growing cause of long term illnesses which prevent people from working. The cost to the national economy is estimated at £105 billion a year, roughly the cost of the entire NHS. Mental health problems can affect anybody, from any ethnic group and at any age. For some people, the occurrence is temporary whilst others are affected by a lifelong condition. Half of those with lifetime mental illness (excluding dementia) first experience symptoms by the age of 14, and three-quarters by their mid-20s. It is vital that positive mental and emotional wellbeing is a priority at every age and for all communities. However, access to support and services for mental health services varies considerably between different ethnic groups.

A study of prevalence in 2014 found that around one in six people experience some form of mental health problem during any given week in England. Most incidences are temporary but some people experience long term mental health disorders. The most common mental health conditions are anxiety and depression which can vary considerably in seriousness. Generalised Anxiety Disorder affects about 6 per cent of the population. Around 4.5 per cent of the population nationally have long term depression and some people have both anxiety and depression. 21 per cent of adults aged 16 years and over experienced some form of depression (moderate to severe depressive symptoms) in early 2021, an increase from 19 per cent in November 2020. Rates in early 2021 were more than double those observed before the pandemic, where 10 per cent of adults experienced some form of depression. NHS data shows that 8.3 million people were prescribed antidepressant drugs in 2021-22, two thirds of them women. There are also less common disorders such as schizophrenia and bipolar. Learning disabilities and developmental disorders are another group of mental health conditions which affect a significant number of people.

Most people are also affected by stress during their daily lives which can have a negative impact on mental health and in some cases it can result in mental health problems such as anxiety, depression or post-traumatic stress disorder. However, it should be noted that stress can sometimes make people stronger. Negative mental health can result from a wide range of factors such as social isolation, loneliness, discrimination, bereavement, debt, redundancy and poor physical health. Changes in people's lives such as retirement can cause positive or negative changes in their mental health. Thus, the number of people who might benefit from support and advice about their mental health is far greater than many people assume.

Mental Health Conditions in Rotherham

Rates of mental health conditions tend to be higher in more deprived areas and this is certainly true in Rotherham. In England, 10.6 per cent of the population aged 16+ have a mental health condition (2020-21) but in Rotherham Borough the figure is 12.7 per cent and higher still in Rotherham Constituency at 15.3 per cent. GP data for 2017-18 follows a similar pattern with 13.4 per cent of adults in Rotherham having depression compared with 9.9 per cent in England. Suicide mortality 2017-19 in Rotherham was 14.6 per 100,000 compared with 10.1 in England.

Within central Rotherham, community mental health is poorest is areas with much social housing such as Canklow, Herringthorpe and East Dene, according to the Indices of Deprivation 2019. However, lower levels engagement with services by BAME residents, especially more recent migrants, are likely to depress drug prescription rates in areas such as Eastwood and Wellgate.

In Rotherham Constituency, 5.0 per cent of the working age population claim Personal Independence Payment (PIP) for mental health reasons, well above the Borough average of 3.6 per cent. The types of mental health conditions affecting people in Rotherham Constituency is revealed by data for PIP, although this only reflects those conditions with a more serious impact.

PIP Claimants, Rotherham Constituency, August 2021		
Condition(s)	**Claimants**	**Percentage**
Anxiety & Depression	712	28.2%
Global Learning Disability	389	15.4%
Autistic Spectrum Disorder	338	13.4%
Psychotic Disorders	266	10.5%
Mood Disorders	235	9.3%
Specific Learning Disability	115	4.6%
Others	460	18.2%
Total	2,525	100%

People of working age can claim Employment Support Allowance (ESA) if they are unable to work due to long term illness. In Rotherham Borough there were 4,827 people claiming due to mental and behavioural disorders in August 2021, or 3.0 per

cent of the working age population. The rate in Rotherham Constituency was higher, with 2,128 people claiming ESA for mental health reasons or 4.2 per cent of working age residents.

Mental Health and Ethnicity

Mental health problems affect people from every ethnic group although there are variations between ethnic groups and within them. Black people are four times more likely to be detained under the Mental Health Act than White people. Weekly experience of common mental health disorders varies most for women, with 29.3 per cent of Black women and 23.6 per cent of Asian women affected, compared with 20.9 per cent of White British women. Refugees and asylum seekers are particularly likely to have poor mental health due to past trauma they have experienced.

There is little local data published about the ethnicity of people with mental health problems but there is a breakdown for ESA by ward. Of those where ethnicity was known (2021) in the three central wards, 16.7 per cent were from BAME backgrounds, including 10.4 per cent Asians.

Pakistani women in the UK have high levels of mental illness but have the lowest rate of mental health service use, compared with women in other ethnic groups. Further, Pakistani women were more likely to be socially isolated than White women, but there are few differences between Pakistani women and other BAME women in the structure and function of social networks. Evidence suggests that social networks indirectly reduced mental health service use via their impact on mental illness. There are only small ethnic differences in the indirect effect of social networks on mental health service use, and these differences do not explain Pakistani women's under-use of mental health services.

People from BAME backgrounds have the same right as everyone else to access mental health treatment and services but research shows that they can face a range of barriers to getting help, including:

- not recognising they have a mental illness because mental health was stigmatised or never talked about in their family or community
- feeling ashamed or embarrassed about a mental health illness due to stigma in their community
- not knowing that help is available, or where to go to get it, lack of publicity
- language barriers, publicity and awareness raising in English only
- turning to family or friends rather than professional support, especially for people who don’t trust formal healthcare services
- financial barriers, such as paying for private counselling
- not feeling listened to or understood by healthcare professionals

- White professionals not understanding their experiences of racism or discrimination, lack of BAME professional

There is help available from the NHS via GPs and referrals to RDaSH, as well as VCS organisations such as Rotherham and Barnsley Mind. However, most services are generic and it can be difficult for some people from BAME communities to relate to them, assuming that they are aware of them. Mental health services are often over-subscribed and unable to meet current levels of demand.

One of the main challenges facing mental health in BAME communities is the level of stigma attached to the subject. Stigma can result from feelings of embarrassment, drawing attention to your family name and the perception that it is wrong to talk openly about mental health. The result is that people from BAME communities are less likely to talk about their mental health than White British people, and tend to keep problems to themselves. Not knowing who to talk to and fear of what others will think exacerbates this problem

Impact of the Covid-19 Pandemic on Mental Health

The rapid spread of Covid-19 as part of a global pandemic led the Government to introduce a national lockdown of society and much of the economy on 24th March 2020, to reduce pressure on the NHS and bring infection rates down. The lockdown severely restricted the everyday lives of everyone and had a wide range of socio-economic impacts. The magnitude of change, its rapidity, its indefinite nature and lack of precedent in living memory all had a severe and rapid impact on community mental health. Many health and care services were affected by restrictions on access, reduced outreach and fear of infection. In addition to the effects of lockdowns and restrictions, 70 per cent of people in England have been infected with Covid-19 and 1.5 million people nationally are thought to have ‘long-covid’, which both have the potential to impact on mental as well as physical health.

Research has shown that mental health distress increased rapidly at the beginning of the pandemic due to fear of infection and death, financial worries, general uncertainty and isolation. Measures used to control the spread such as social distancing have subsequently been linked to increases in anxiety, depression and loneliness in individuals. After the first lockdown, variable restrictions remained in force for a long period and there were two further national lockdowns, in November 2020 and January-April 2021. Whilst many people became accustomed to daily life during the pandemic, others continued to suffer adverse mental health impacts.

Worst affected were people from BAME groups; older adults, particularly those told to shield (shut themselves away); children and adults with learning disabilities; younger adults; mothers (balancing childcare, home schooling and making adjustments for work); people with existing mental health problems; those living with domestic abuse; those living in more deprived areas and those living in small homes lacking outdoor space.

At the beginning of the pandemic, referrals to mental health services were not as high as expected as people did not come forward. However, this gradually changed with local mental health services and community organisations across Rotherham reporting an increase in people presenting with anxiety.

Young people in Rotherham participated in a school-based survey about their mental health three times over a 12-month period during the pandemic, with a total of 11,058 young people sharing their views. Students were asked to think how they felt about their mental health in March/April 2020 and again in June 2021. The findings showed a decline in how well they rated their mental health. The survey also found students to be more anxious, stressed, bored and feeling sad/low in June 2021 than they were at the beginning of the pandemic.

Some parents in Rotherham reported that their children suffered from being in the home for too long leading to increased anger, frustration, loneliness and mental health deterioration.

Reports from some Rotherham carers showed that they felt more anxious, isolated, worried and physically exhausted during the pandemic (surveys conducted by Crossroads).

Suicides

There were concerns that the pandemic would see a rise in suicides. However, in line with national trends, the latest data shows that Rotherham saw a small decrease in suicides for the period 2018-2020 to 13.3 per 100 000 which is a decrease by 1.4 per 100,000 from 2017- 2019. Rotherham's rate is still significantly higher than the all-England rate of 10.4 per 100,000.

Males still account for most deaths by suicide in Rotherham. The rate for Rotherham in 2017-2019 was 22.3, and this has now dropped to 19 per 100,000 for 2018-2020. Female deaths for Rotherham for this period have risen by 0.4 to 7.9 per 100,000.

As we emerge from the pandemic and some of the short-term support (financial and services) is removed, concerns remain with regard to longer term impacts on suicide rates. January 2022 saw a rise, with 7 suicides reported, the highest number since 2019.

Bereavement

Sadly, many people have experienced the death of a loved one during the pandemic, not just for the 992 people who had COVID-19 as a cause of death on their death certificate during the pandemic (data to week ending 28th Jan 2022) but to other illnesses too. The restrictions meant that some people could not be there at the end of the person's life or give their loved one the funeral they would have wanted.

In early 2020 Rotherham Council and RCCG worked with the other councils in South Yorkshire to put in place support for people bereaved during the pandemic.

Loneliness

Loneliness was a public health concern both nationally and locally prior to the pandemic with all ages experiencing loneliness. The pandemic has heightened this as an issue and referrals for befriending support in Rotherham have reinforced that this is an issue across the life course.

Inequalities in society have meant that experiences and patterns have not been the same. Particularly vulnerable groups include:

- Those living alone
- People living in areas of higher deprivation
- Those caring for people for someone particularly those with dementia
- Parents/carers living with a child with SEND needs
- People recently bereaved or widowed
- Older people and those who are digitally disadvantaged

The easing of restrictions has alleviated loneliness for many people. However, reports from the voluntary and community sector indicate that other people continue to experience high levels of anxiety, which makes engaging in a range of social activities difficult.

The impact of the Covid-19 pandemic on mental health was exceptional but provides an example of how wider social, health or economic crises can affect the mental health of any community. The growing cost of living crisis, especially rising energy costs, will be having an adverse effect on the mental health of many people who are worried about how they will cope. Developing and maintaining good mental health resilience will always be valuable to help people through such episodes.

3. Survey Methodology

YAWR Services was commissioned to undertake this feasibility study by Voluntary Action Rotherham (VAR) to assess the potential for BAME Community Mental Health Champions. The choice of YAWR Services to conduct the study was intended to provide a focus on the views and needs of BAME, primarily South Asian people. YAWR has growing experience of community research, notably involvement in BAME access to Social Prescribing research in 2021. YAWR has many years experience as a social care provider and has experienced BAME staff delivering to BAME service users.

YAWR developed and conducted an online survey from May to July 2022. A questionnaire was designed (see Appendix) for self completion although YAWR staff also conducted some interviews where this suited the respondent better. The questionnaire was piloted with YAWR staff to ensure that the questions would be understood. A link to the questionnaire was then sent to service users and other YAWR contacts, some via partner organisations.

A total of 65 people took part in the survey and the results were compiled to provide aggregated information. The respondents were all adults from a range of age groups and socio-economic backgrounds. There was a focus on BAME respondents from the Pakistani/Kashmiri community although a small number of White British people and others also completed the questionnaire. The majority of respondents were women which may reflect the profile of YAWR contacts.

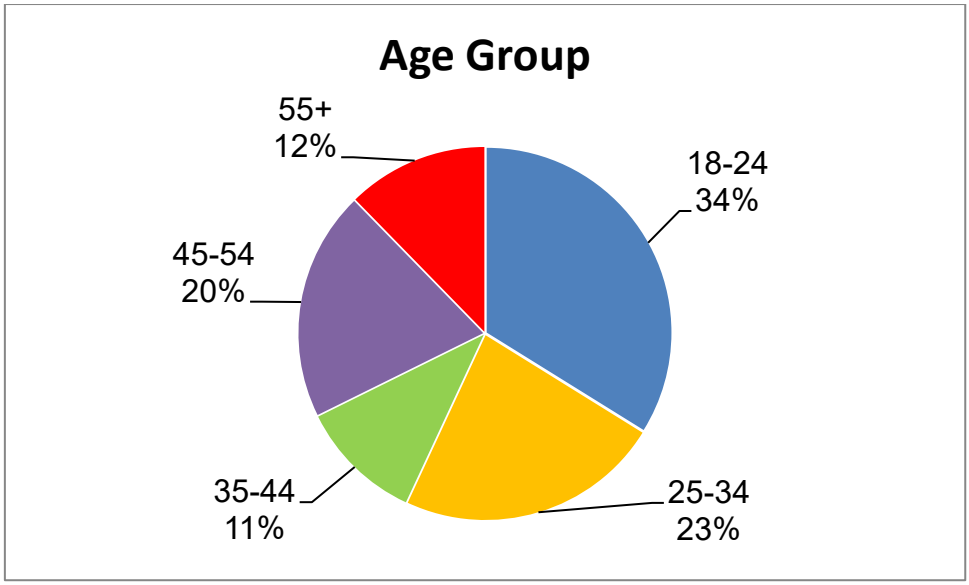
The confidentiality of all respondents has been respected in how the results are presented in this report. It should be noted that this is a relatively small sample and provides results which are more qualitative than quantitative. Whilst the survey did not mention the Covid-19 pandemic, it may have some impact on both engagement and the results.

4. Research Findings

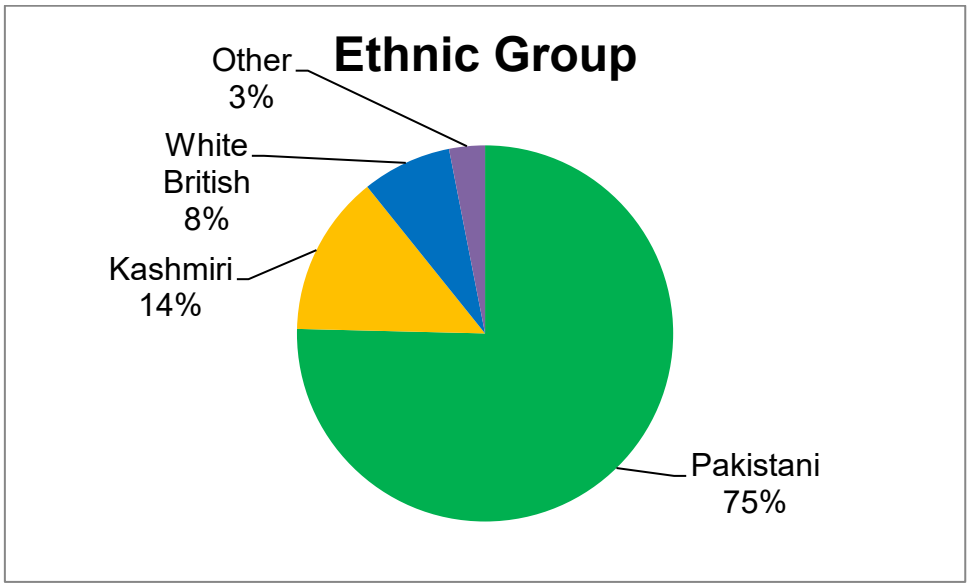
This section details the results of YAWR's survey of adults in Rotherham, mainly from BAME communities, who were asked about their mental health and related issues.

Participant Profile

The majority of respondents were women, with 71 per cent compared with 29 per cent who were men. This may reflect a greater willingness to participate amongst women and/or the profile of YAWR's contacts. This gender balance may affect the results so wherever there is a significant difference between genders, this will be shown. 94 per cent of respondents were heterosexual or straight, 5 per cent had a different sexuality and the remainder preferred not to say.



The majority of respondents were young, with 57 per cent aged under 35 years, which partly reflects the Pakistani/Kashmiri age structure and also the online nature of the survey. There was also a good number of respondents in older age groups, with 31 per cent aged 35-54 and 12 per cent aged 55 or more. Significant differences between the responses of younger and older people will be reported.

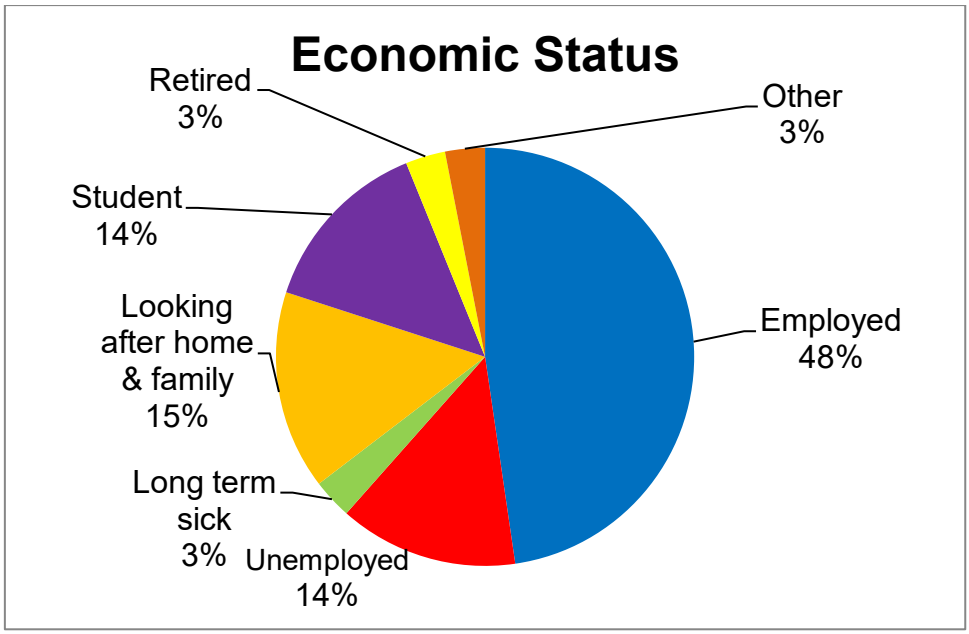


Most respondents were either Pakistani or Kashmiri, comprising 89 per cent of respondents. There were also 11 per cent of respondents from other ethnic groups, mainly White British. Most respondents were Muslims, with 92 per cent of the total whilst White British respondents were either Christian or had no religion.

Just nine per cent of respondents considered themselves to be disabled and 15 per cent had a limiting long-standing illness or disability. In addition, 14 per cent reported that they were unpaid carers, including some of those who were disabled themselves.

Economic and Educational Characteristics

Economic Status



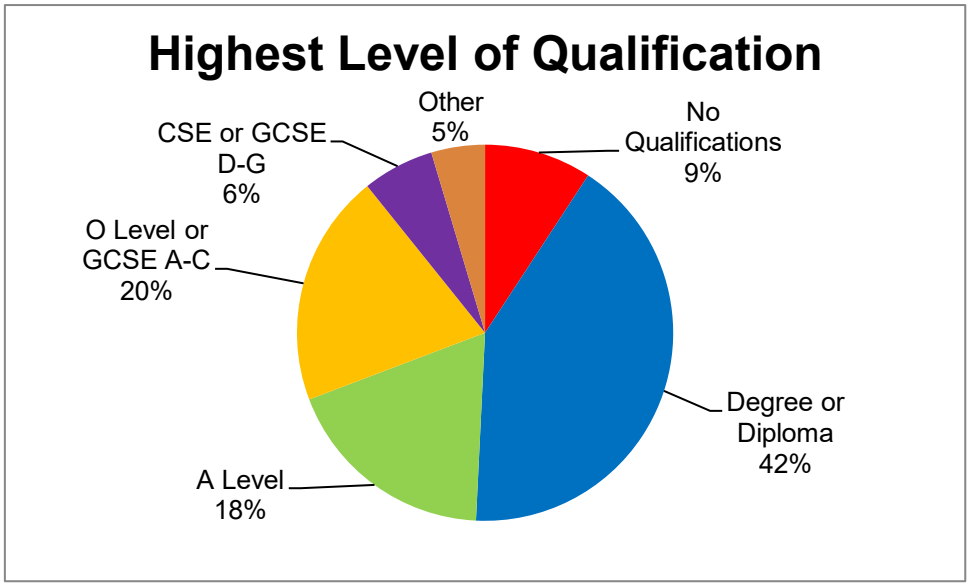
The majority of respondents were economically active, making up 62 per cent of the total. The employment rate was 48 per cent and the unemployment rate was 23 per cent (of those economically active). There were notably few people tong term sick, which partly reflects the age profile although these results suggest that this group is less easy to reach. Of those who were economically inactive, most were either students or looking after their home and family.

81 per cent of employed respondents were women whilst two thirds of those unemployed were men. All of those looking after the home and family were women. There was a much closer gender balance for students.

Women had a higher employment rate (54 per cent) than men but much lower unemployment rate, with those men surveyed being nearly five times more likely to be unemployed. If long term sickness is added to unemployment, men were still nearly three times as likely to be workless than women. Although the male employment rate was lower than for females, economic activity rates were similar for both genders at just over 60 per cent.

In summary, most women were either employed, looking after their home and family or students, whilst most men were either employed, unemployed or students.

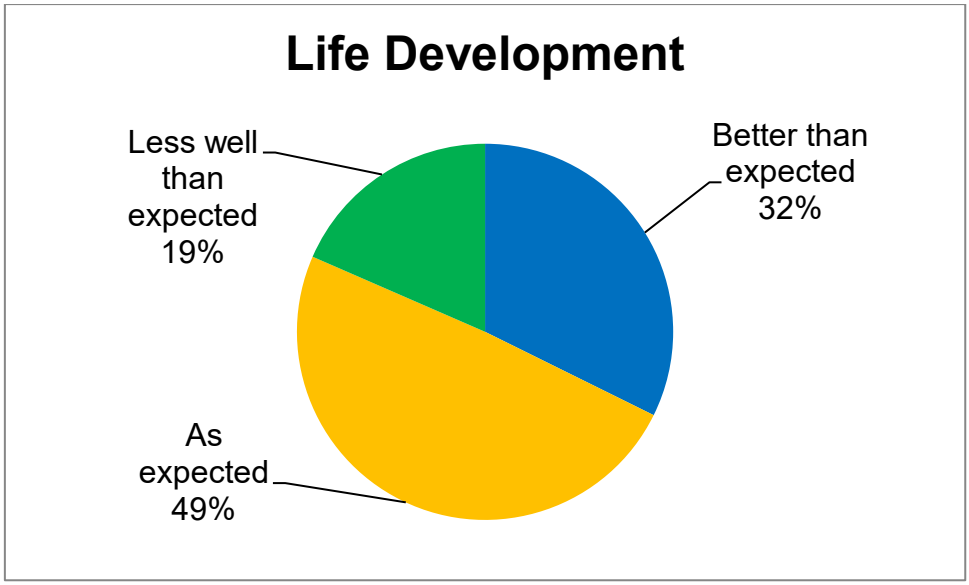
Qualifications



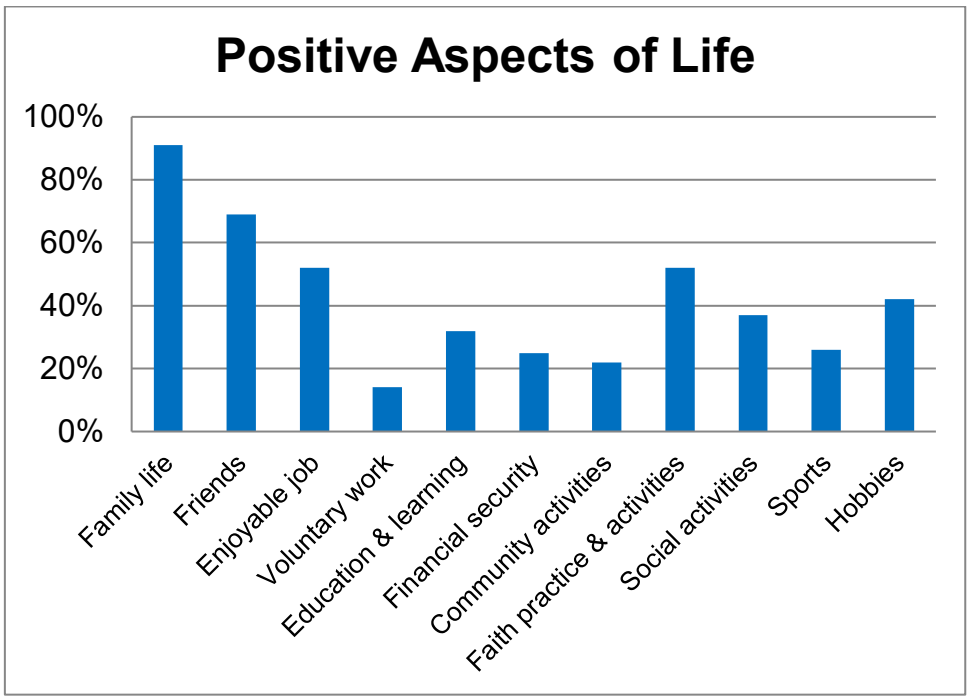
Over 40 per cent of respondents were qualified to at least Degree or Diploma level (NVQ Level 4) and the majority (57 per cent) qualified to at least A Level (NVQ Level 3). However, 9 per cent had no qualifications and in all a fifth had no NVQ Level 2 qualifications.

There were some similarities by gender with men and women equally likely to have a Degree or Diploma. However, it should be noted that all of those with no qualifications were women, often related to age in the Pakistani community where young women tend to be much better educated than older women. People with a Degree or Diploma had the highest employment rate at 78 per cent and the lowest unemployment rate at just four per cent. Those qualified to A Level were most likely to be students at 50 per cent. Respondents qualified to O Level had the highest unemployment rate at 46 per cent. Those with no qualifications (all women) were most likely to be looking after their home and family.

Experience of Life

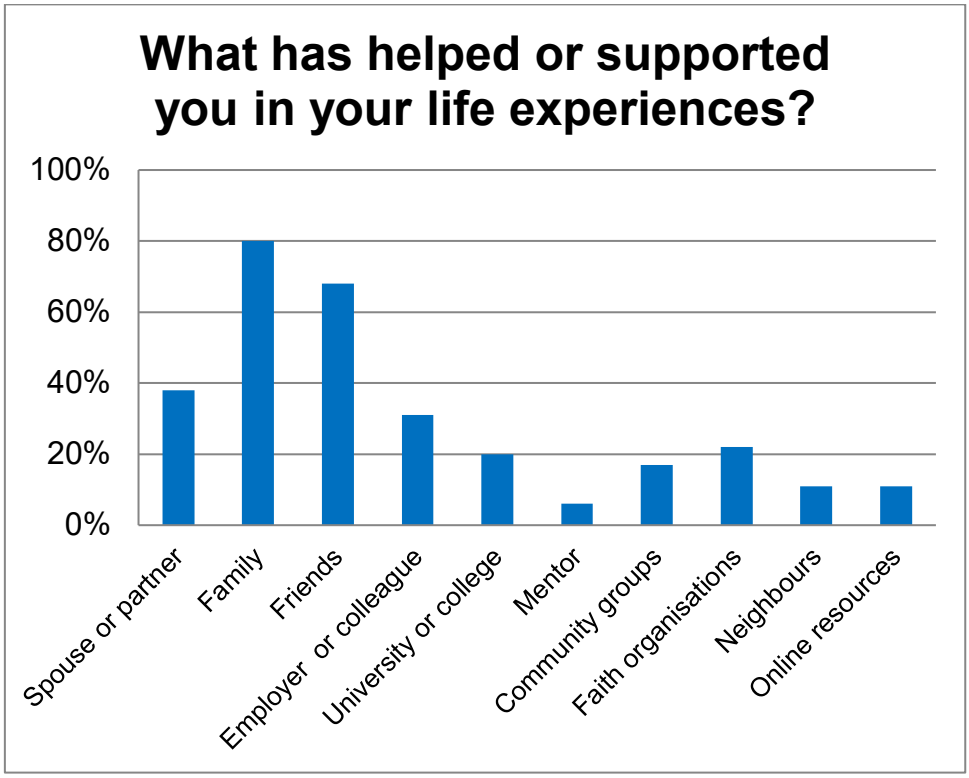


Around half of participants felt that their life experiences had developed as expected with a third feeling that it had developed better than expected and a fifth feeling that it had developed less well than expected. Of those who felt it had developed better, 57 per cent were in employment. Of those who felt it had developed less well, 42 per cent were in employment. Of the latter group, a third were either unemployed or long term sick. Women were more likely than men to feel that that their lives had developed better than expected. Women were also slightly more likely to feel that it had developed less well than expected. These results suggest that men's expectations of life were often met whilst women experienced a greater variety of life outcomes.

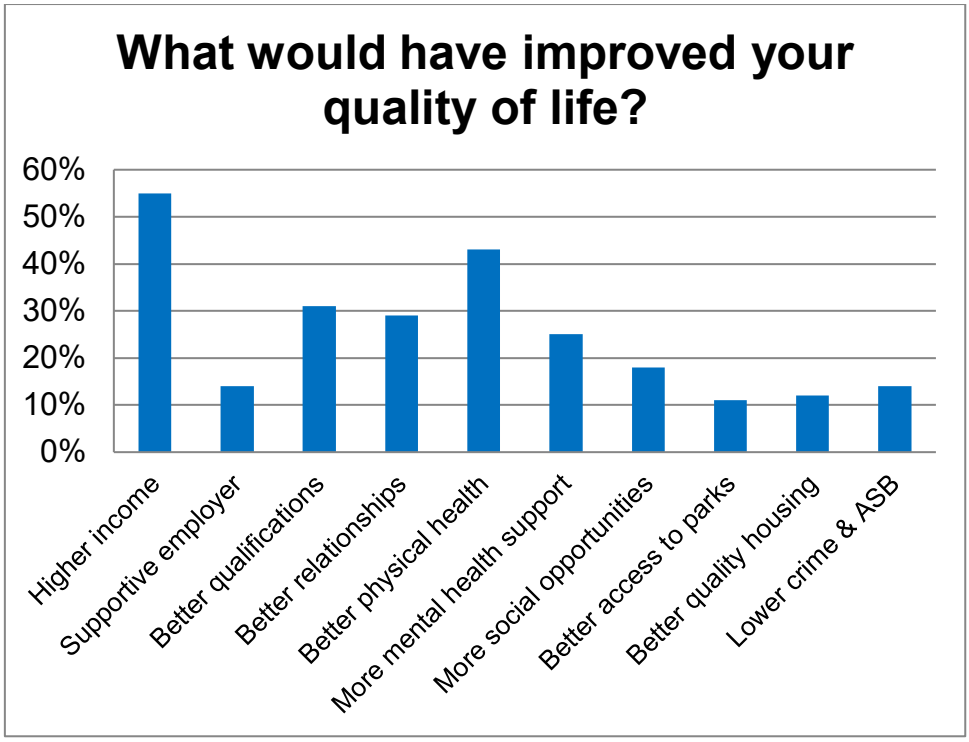


Nearly all respondents (91 per cent) said that family life was one of the most positive aspects of their life, followed by friends at 69 per cent. The other two most often stated positive aspects were an enjoyable job and faith practice and activities, both at 52 per cent. Voluntary work was least mentioned as a positive aspect which may indicate a relatively low level of involvement.

These responses clearly illustrate the foundations of positive life experiences within the Pakistani & Kashmiri community. Family and friends are the dominant positive aspects as a social support network. Beyond these, work and faith related activities are of greatest importance, which will often have a social element.

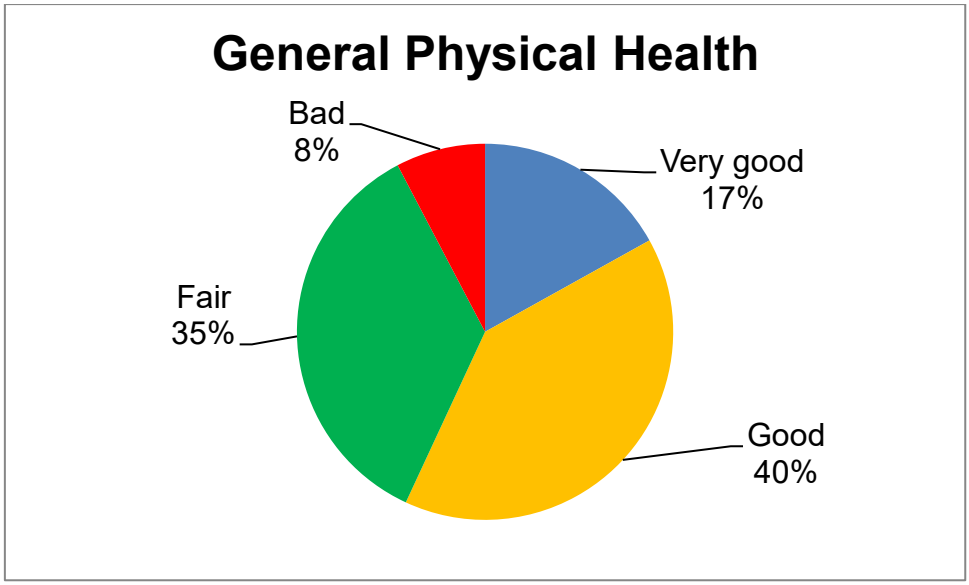


Respondents were asked what had helped or supported them in their life experiences. Reflecting the reported positive aspects of life, family and friends were the main source of help and support, both mentioned by at least two thirds of respondents. Support from a spouse or partner was also significant, especially given that this will only have been relevant to some of the respondents. Beyond these sources, people at work and in faith groups were the other main providers of support. There is clearly a strong link between people and groups who provide help and support, and what people feel are the most positive aspects in their life.

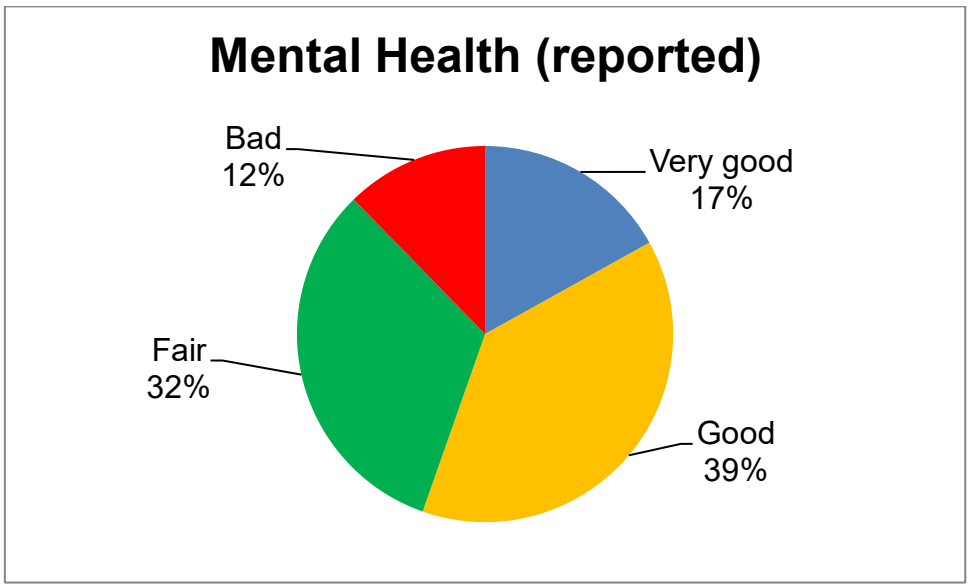


Respondents were then asked what would have improved their quality of life. Not surprisingly, higher income was most frequently mentioned although by no means everyone thought that this was important. Nearly a third thought that better qualifications would have helped which may be linked to the ability to earn more. Better physical health was mentioned by 43 per cent of respondents and more support for mental health conditions by 25 per cent. These results illustrate the importance of good health to quality of life and a significant minority of respondents recognised their own need for mental health support. The need for more mental health support was mentioned by 28 per cent of women compared with 16 per cent of men, which reflects the general prevalence of mental health conditions. The only other factor mentioned by over a quarter of respondents was better relationships.

General Health



The majority of respondents reported that they were in good or very good physical health but 43 per cent reported their health as either fair or bad. All of those with bad physical health were women whilst there was little gender difference for fair health. Men's health was generally better than women's with 26 per cent saying it was very good, double the proportion for women. However, bad health was no barrier to women being employed with 80 per cent of those with bad health being in paid work compared with only half of those with very good health.



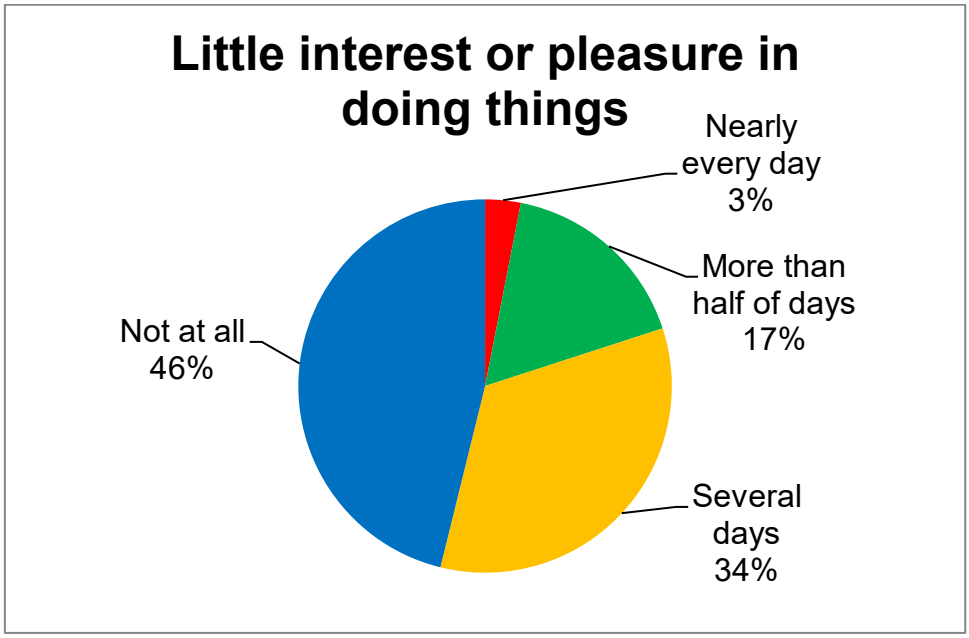
The pattern for mental health was similar to that for physical health. The main difference was a higher proportion with bad mental health. There was similarly higher incidence of bad health reported by women who were three times more likely than men to report their mental health as bad. Those with bad mental health were divided between those with bad physical health and those with fair physical health. Men

were almost three times more likely than women to report very good mental health and almost everyone with very good mental health reported very good physical health.

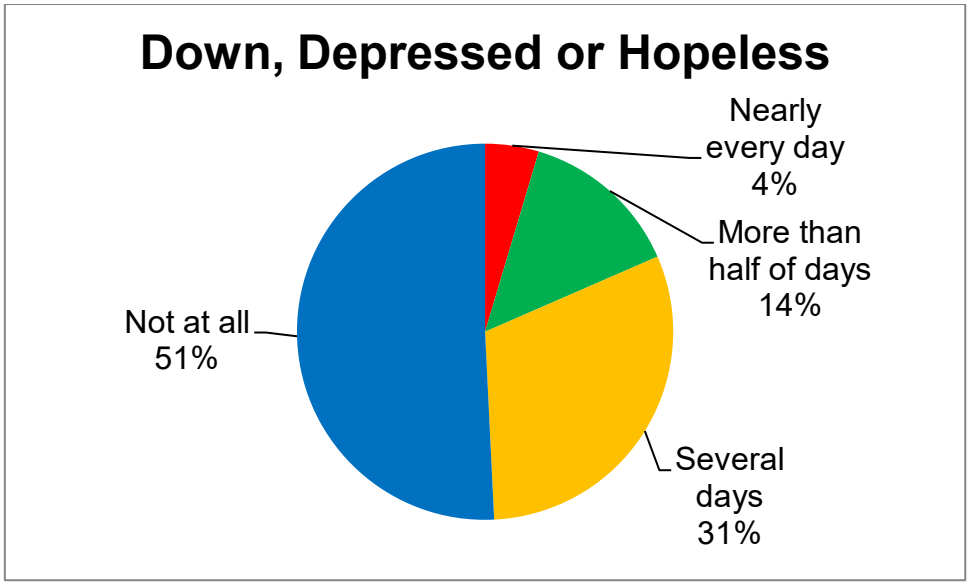
As well as gender, there was a relationship between mental health and age, with 64 per cent of those with very good mental health being under 35 whilst 63 per cent of those with very bad mental health were over 35. The average age of a person with bad mental health was about ten years older than that of a person with very good mental health. There was clearly a strong relationship between mental and physical health which could reflect the influence of poor physical health on life experiences and mental health, although mental health can also affect physical health.

Mental Health Assessment

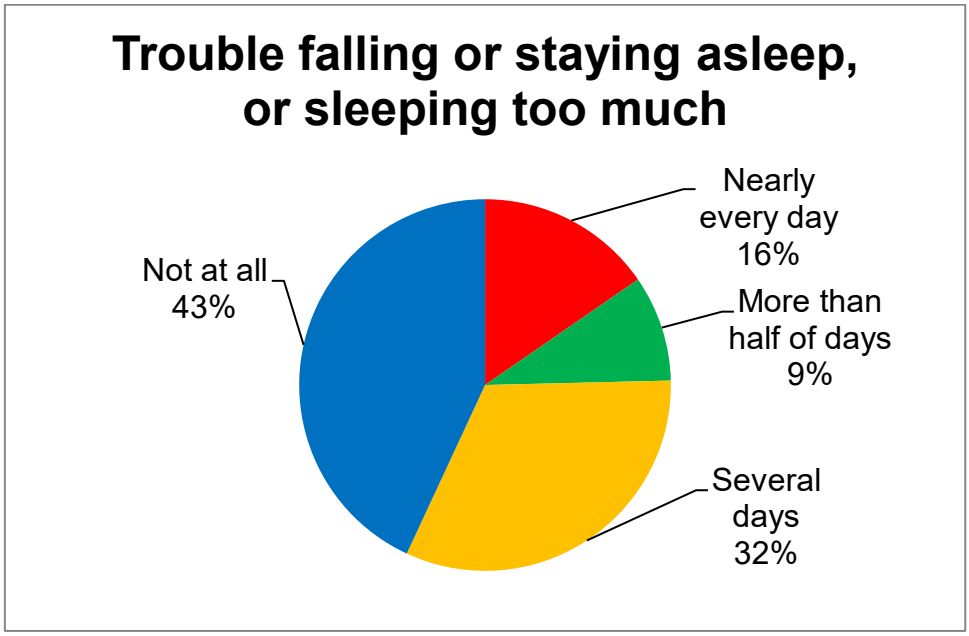
Respondents were asked eleven questions derived from the Patient Health Questionnaire-4 (PHQ-4), developed and validated by Kroenke, Spitzer, Williams, & Löwe, (2009) as screening questions to assess people for anxiety and depression. Each question relates to respondent's experience over the previous two weeks.



The first question from PHQ-4 asks how many days a person had little interest or pleasure in doing things, which can indicate depression. The scale of low-level negative mental health is illustrated by the fact that over half of respondents reported some lack of interest or pleasure in doing things and a fifth reported that this affected them on the majority of days, although only a couple reported feeling this way nearly every day. There was a smaller gender difference than was the case for self-assessed mental health, with 22 per cent of women and 16 per cent of men reporting little interest for several days or more.

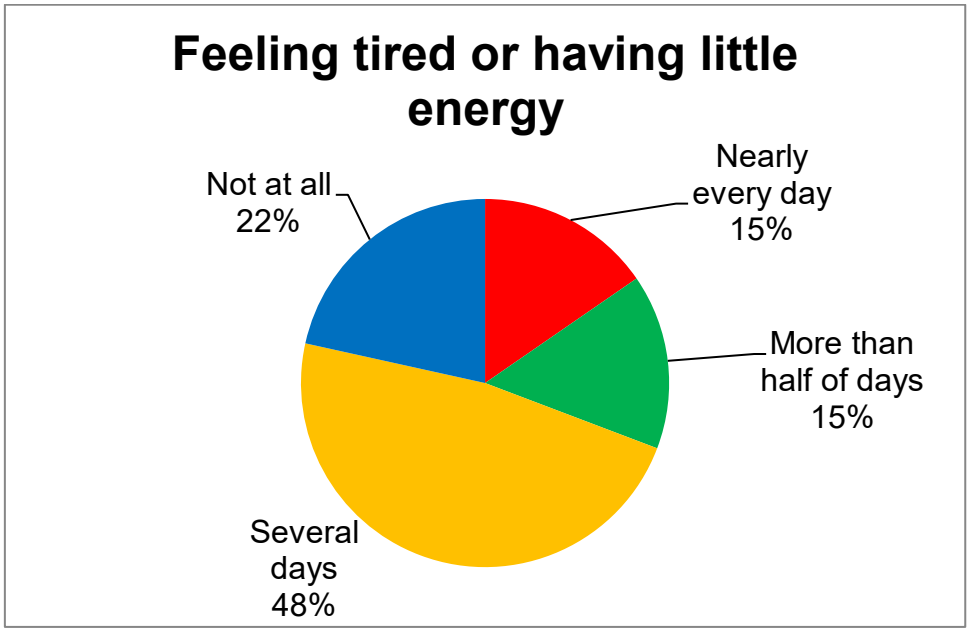


The second question from PHQ-4 asks how often respondents had felt down, depressed or hopeless, which is a more direct indicator of depression. The results were similar to those for the first question, with slightly more respondents saying that they had not felt down, depressed or hopeless but almost half had done so. These feelings were experienced on the majority of days by 18 per cent of respondents, which indicates a significant amount of depressive symptoms. Gender differences were marked with 24 per cent of women and only five per cent of men being affected on the majority of days, and all of those affected nearly every day were women.

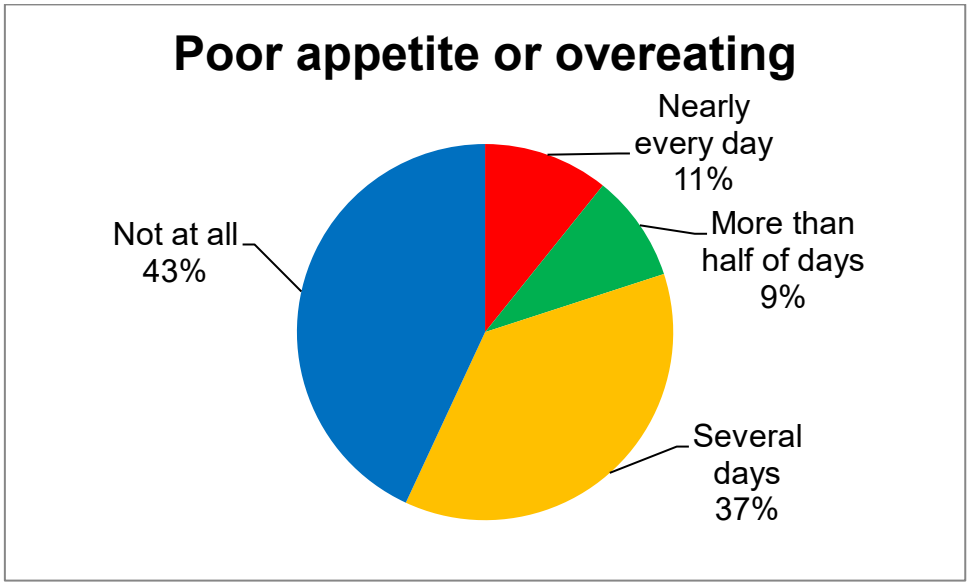


The third question asks how often respondents had trouble falling or staying asleep, or sleeping too much, which can indicate depression. Sleep difficulties affected the majority of respondents with 57 per cent stating that they had sleep problems on at least several days and 16 per cent nearly every day. Whilst there can be many causes of sleep disorders, depression is often a factor. Men were more likely than

women to have sleep disorders, affecting 57 per cent compared with 43 per cent of women. There was also some association with age, with 68 per cent of those with sleeping difficulties being under 35.



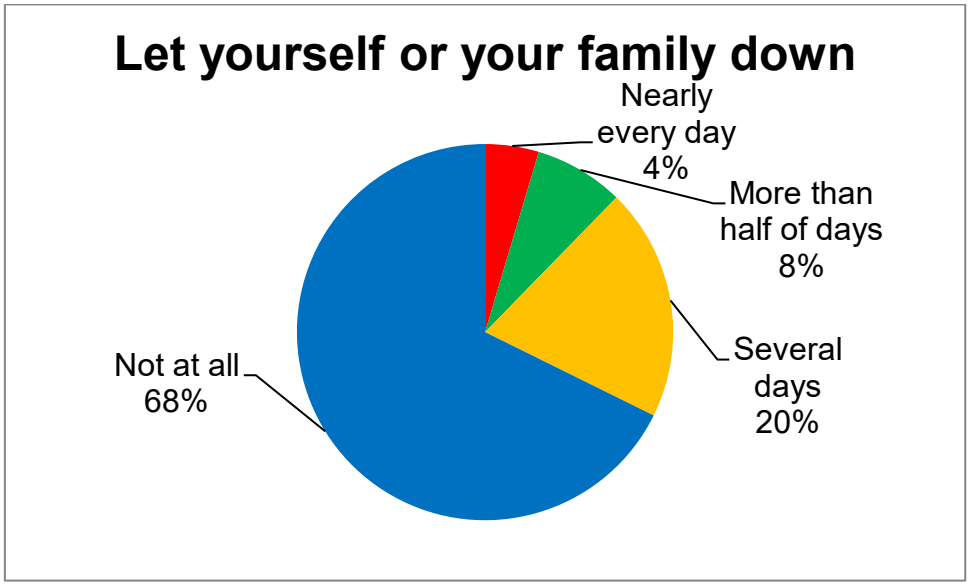
The fourth question asks respondents if they have felt tired or had little energy. Whilst this can have purely physical causes, lack of energy can also be associated with depression. Over three quarters of respondents felt tired or lacked energy on at least several days and 30 per cent were affected on more than half of days. Of those affected nearly every day, 70 per cent were aged under 35.



The fifth question asks respondents how often they had a poor appetite or ate too much, which can be linked to anxiety and/or depression. These eating conditions affected most respondents to some degree with 20 per cent experiencing one or the other on the majority of days. Eating disorders showed a significant gender difference, with 54 per cent of women experiencing these compared with 32 per cent

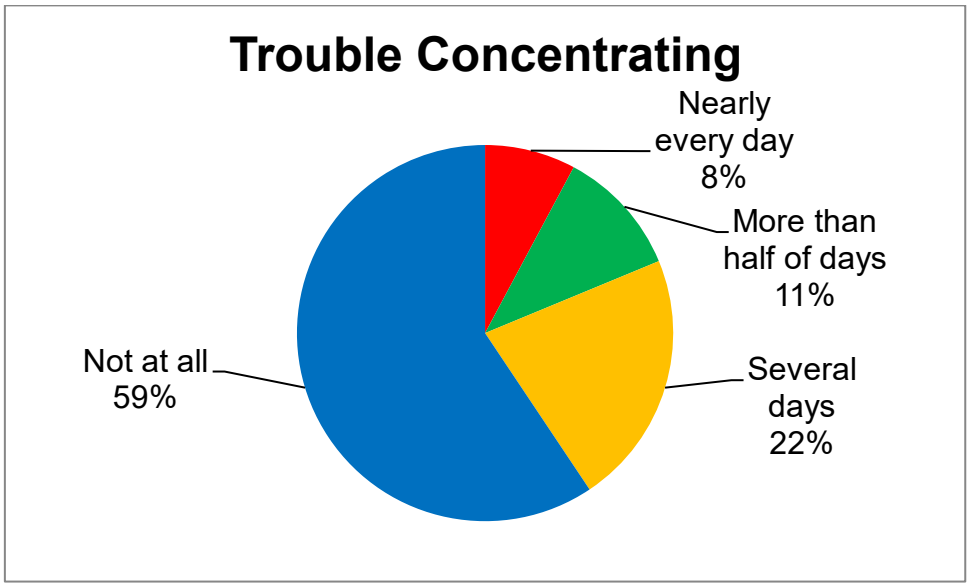
of men, and all of those reporting poor appetite or overeating nearly every day were women.

The sixth question asks respondents how often they have felt bad about themselves or that they are a failure, which can be linked to anxiety and/or depression. The majority of respondents did not feel this way at all but 21 per cent felt bad about themselves on more than half of days. Although men were more likely to report feeling bad about themselves or a failure at times, most of those who felt this way nearly every day were women.



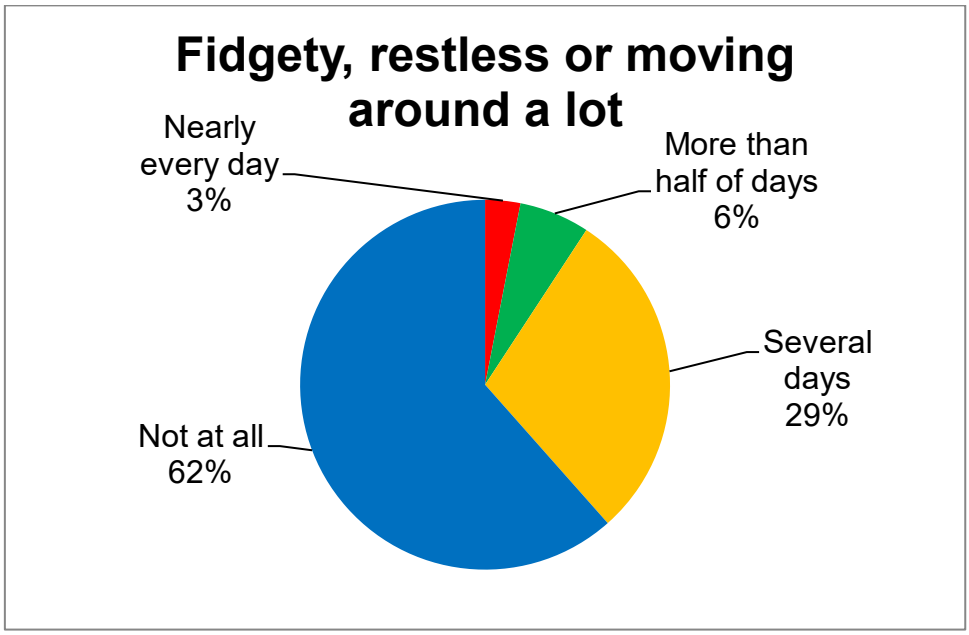
The seventh question asks respondents if they had felt they had let themselves or their family down. Over two thirds of respondents never felt that they had done so but a third did feel this way on at least several days and 12 per cent felt this way on

the majority of days. Men and women were equally likely to feel this way some of the time.



The eighth question asks respondents if they had trouble concentrating on things such as TV or reading, which can be linked to anxiety and/or depression. Although most people had no trouble concentrating, 42 per cent reported some difficulty, with 19 per cent having trouble concentrating on the majority of days. Women were twice as likely to have trouble concentrating on most days than men.

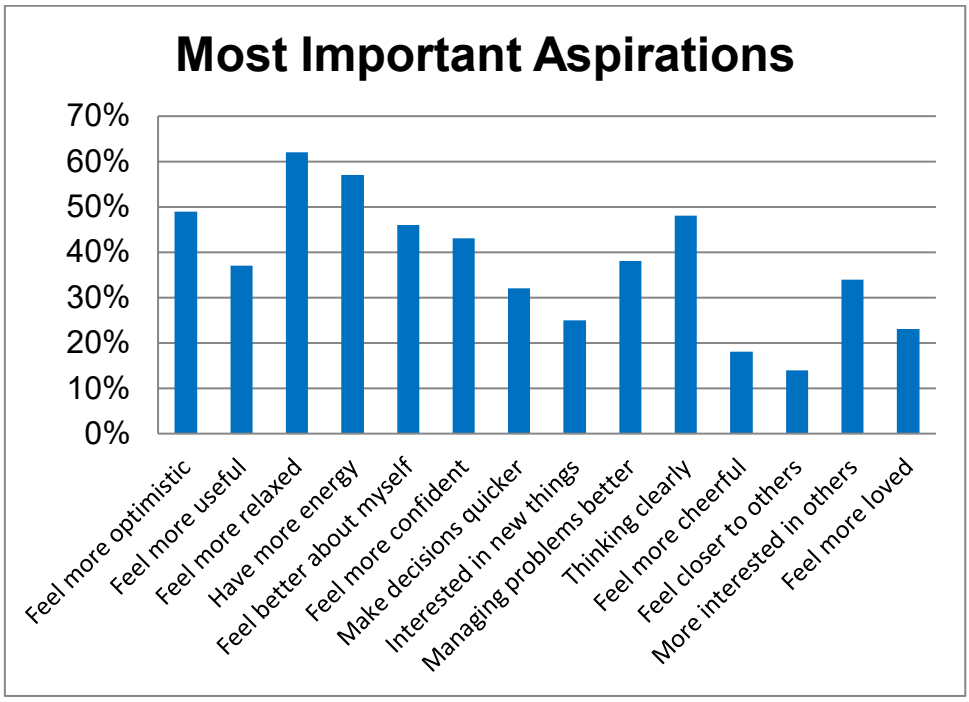
The ninth question (not graphed) asks respondents if they have moved or spoken very slowly and 80 per cent answered not at all with just a fifth saying this happened on at least several days, although very few people were affected on the majority of days. This was most likely to affect men to some degree, at 37 per cent compared with 13 per cent of women.



The tenth question asks respondents if they have been fidgety, restless or moved around a lot, which can indicate anxiety. The majority had not experienced any of these but over a third reported being fidgety, restless or moving around a lot for several days or more, although there were few cases where this happened on most days. Men were more likely to report these on at least several days, at 47 per cent compared with 35 per cent of women.

The final question from PHQ-4 (not graphed) asks respondents if they had suicidal thoughts or wanted to hurt themselves. The vast majority of respondents did not have such thoughts but 11 per cent did so, almost all on several days rather than more often. Men were three times more likely to have suicidal or self-harming thoughts than women and all of those affected were under 35. Given that most respondents were Muslims, the fact that suicide is a grave sin and forbidden in Islam might reduce suicidal thoughts or their acknowledgement.

Well-Being Aspirations

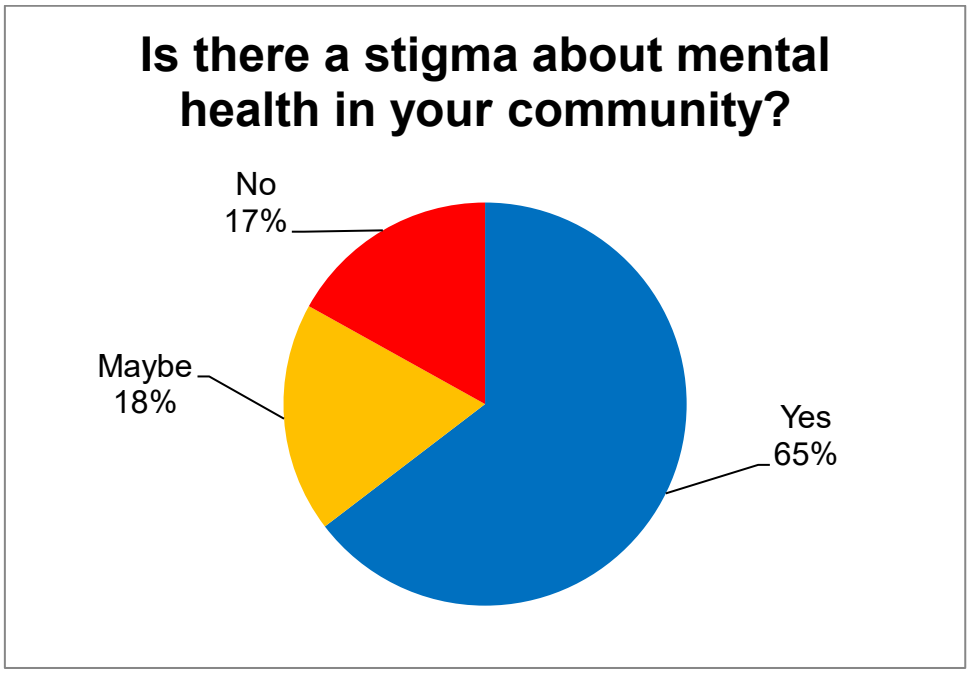


Respondents were asked about what well-being aspirations were most important to them. There was a wide variety of responses which together indicate a high level of aspiration for better well-being. The most frequently aspiration was to feel more relaxed which may indicate that many people have busy lives which might be stressful and don't include much time to switch off. The only other aspiration quoted by the majority of respondents was to have more energy to do things, which suggests they find their lives to be tiring. This is the most common aspiration for those with the poorest reported mental health. Other main aspirations of those with poor mental health are the feel more useful, more relaxed, more confident and better about themselves, also managing problems better. Almost half of respondents would

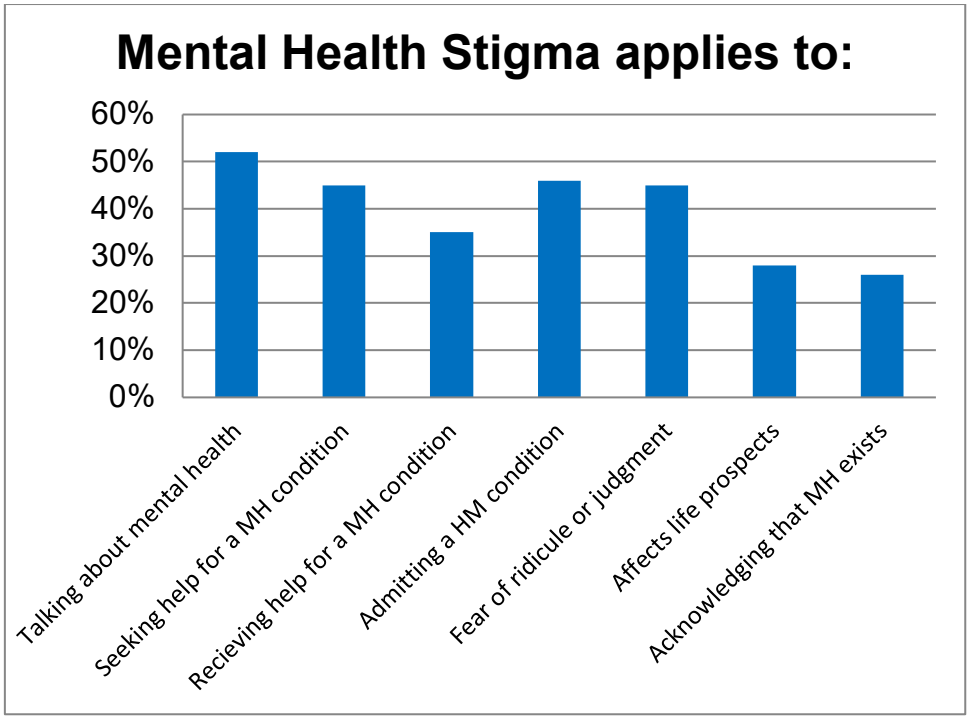
like to feel more optimistic about the future which suggests a high degree of pessimism at present. Thinking clearly is another common aspiration.

Some of the less often reported aspirations indicate significant issues affecting a minority of people, such as the 23 per cent who want to feel more loved.

Mental Health Stigma in the Community

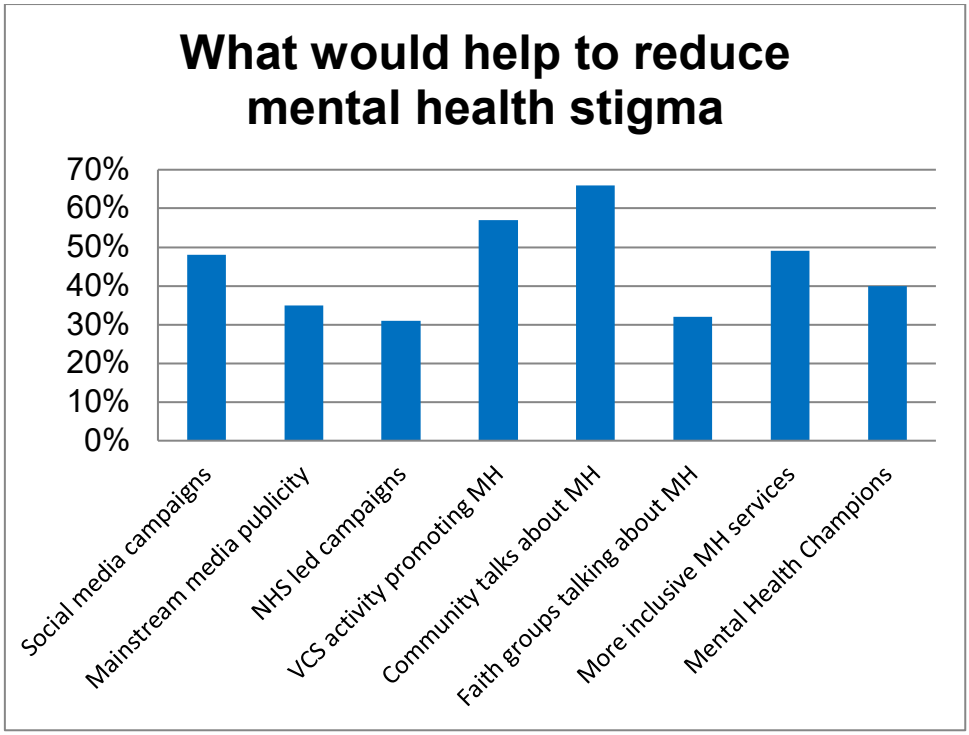


Respondents were asked if they thought there was a stigma in their community about discussion of mental health or having a mental health condition. There was a clear answer from two thirds of respondents who thought that there was still a stigma, with only 17 per cent thinking there was not. Older people were most likely to think there was a stigma, the view of 71 per cent of those aged over 35, compared with 59 per cent of younger people. This probably reflects changing social attitudes with younger people becoming more open to discussion about mental health. Women were somewhat more likely to think there was a stigma, with 67 per cent saying there was, compared with 58 per cent of men. Men were twice as likely as women to think there was not a stigma. This may reflect the earlier findings that women were more likely to have experience of poor mental health.



According to the respondents, mental health stigma applies to a range of circumstances related to mental health. Over half of respondents said that a stigma applied to talking about mental health, which makes other aspects problematic. Admitting that you or a family member has a mental health condition carries a stigma according to 46 per cent of respondents and the situation is almost the same for seeking help for such a condition. Fear of ridicule or being judged by others is another aspect of stigma, felt by 45 per cent of respondents. This is likely to be linked to over a quarter of respondents who felt a mental health condition would affect future life prospects.

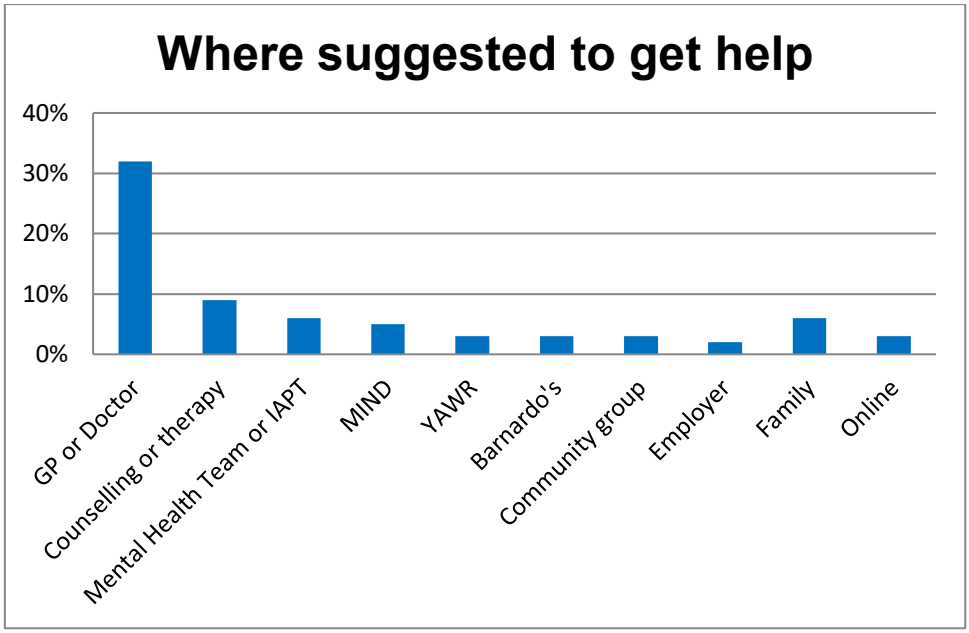
Over a quarter of respondents felt there was a stigma in acknowledging the existence of mental health. These findings illustrate the challenge of addressing mental health in the community where the issue is often hidden despite the wide prevalence of mental health conditions.



Respondents were asked what would reduce the stigma of mental health and there was significant support for a variety of methods. The most popular was community talks to raise awareness of mental health, supported by two thirds of respondents. Who would give such talks and in what venues would have to be worked out but people clearly liked the idea. The desire for community based solutions was reflected in the only other option supported by the majority of respondents, charity and community group activities promoting mental health. Community based campaigns were clearly favoured over NHS led campaigns. Community mental health champions were favoured by 40 per cent of respondents despite these being unfamiliar to people. Faith groups talking to their congregations about mental health, despite being familiar to most people, were only favoured by a third of respondents.

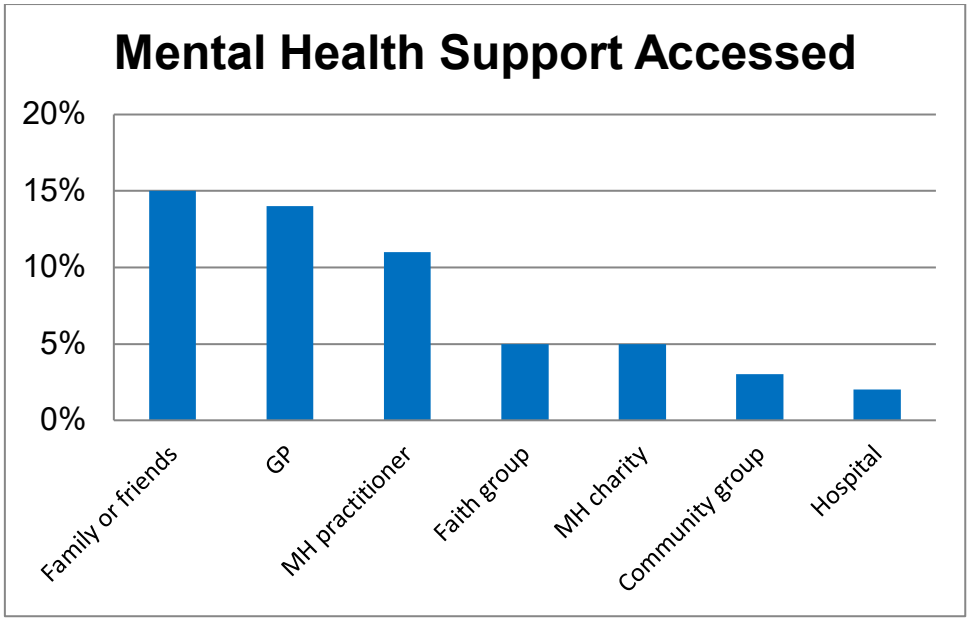
Almost half of respondents favoured more inclusive mental health services, suggesting that improvements are needed in these to better meet the needs of people from BAME communities. Social media campaigns were favoured over mainstream media, possibly because many people in BAME communities do not follow mainstream media.

Accessing Mental Health Support



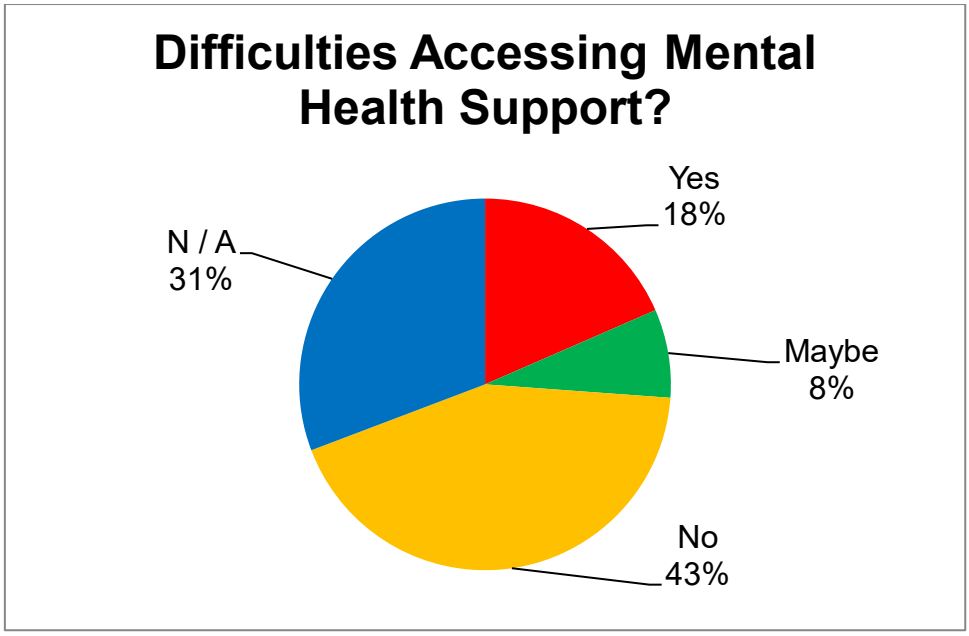
Respondents were asked if they or a loved one was experiencing mental health difficulties, would they know how to get help? People were almost equally divided between the 52 per cent who said they would and the 48 per cent who said they would not know how to get help. Younger people were least likely to know, with 71 per cent being under 35 compared with 57 per cent for the overall sample profile. Those with the worst self-assessed mental health (bad or very bad) were least likely to know how to get help, with only 38 per cent being aware. There was an inverse relationship between the need for help and awareness of how to get help.

Of those who said they would know how to get help for mental health difficulties, 82 per cent actually suggested where they would advise someone to find help. Of those who suggested a source of help, three quarters said that a GP should be approached. A small number of respondents suggested getting help from mental health services directly, getting help from a VCS group or from family members. Whilst these might be valid in some cases, the most appropriate response would be to start with a GP who could refer their patient to the relevant service such as IAPT or counselling if needed. The fact that only a third of those surveyed suggested help from a GP shows that awareness about accessing mental health support is low. Women were more than twice as likely to suggest help from a GP as were men, 39 per cent of women compared with just 16 per cent of men.

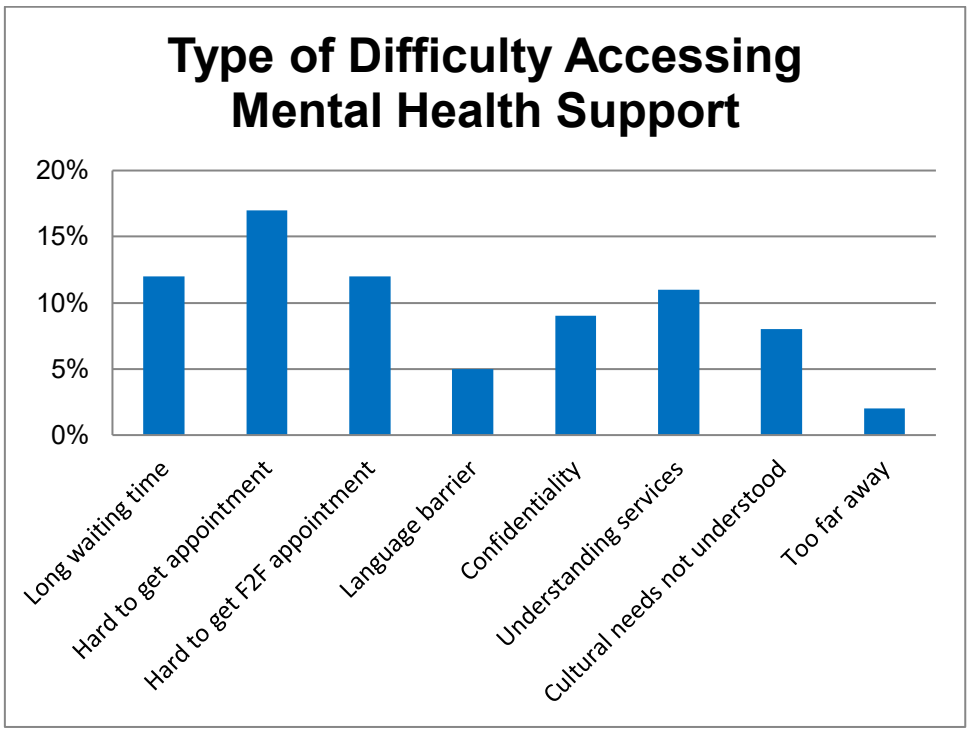


Respondents were asked if they had accessed mental health support and 45 per cent had done so. A third of these had turned to family or friends for informal support. Almost another third had accessed GP support although in some cases this will be for a referral to other services. Some people had also accessed mental health practitioners directly. A few people had accessed support from faith or VCS organisations.

Respondents who had accessed support for their mental health were further asked which types had been most useful. Most people said that the support they had accessed was useful although in the case of mental health practitioners and mental health charities, these were not felt to be useful. This finding suggests that more informal and generalist support was felt to be more useful than specialist services. This may reflect respondents feeling more comfortable sharing their vulnerability with people and organisations they know and who also understand their circumstances and backgrounds. Furthermore, specialist services may not understand the religious and cultural needs of many BAME patients and not respond to their mental health needs appropriately in this context.

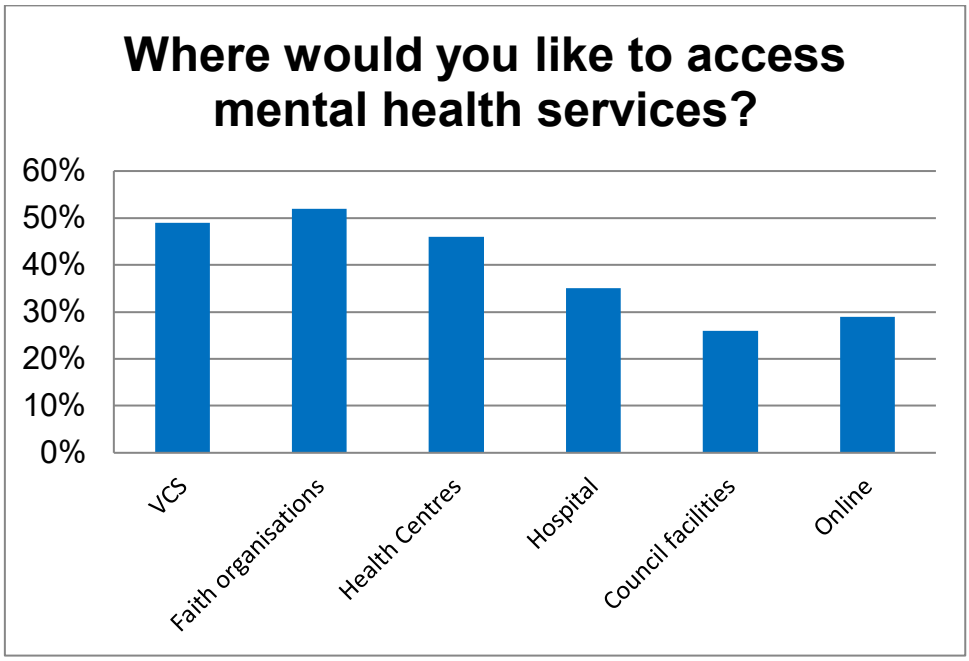


Respondents were asked if they had experienced any difficulties in accessing support for their mental health. A quarter of respondents said they had or might have, with 18 per cent reporting difficulties. It is not clear whether those who said they had no difficulty had accessed support without difficulty or had no need, which was more clearly the case for those saying it was not applicable.



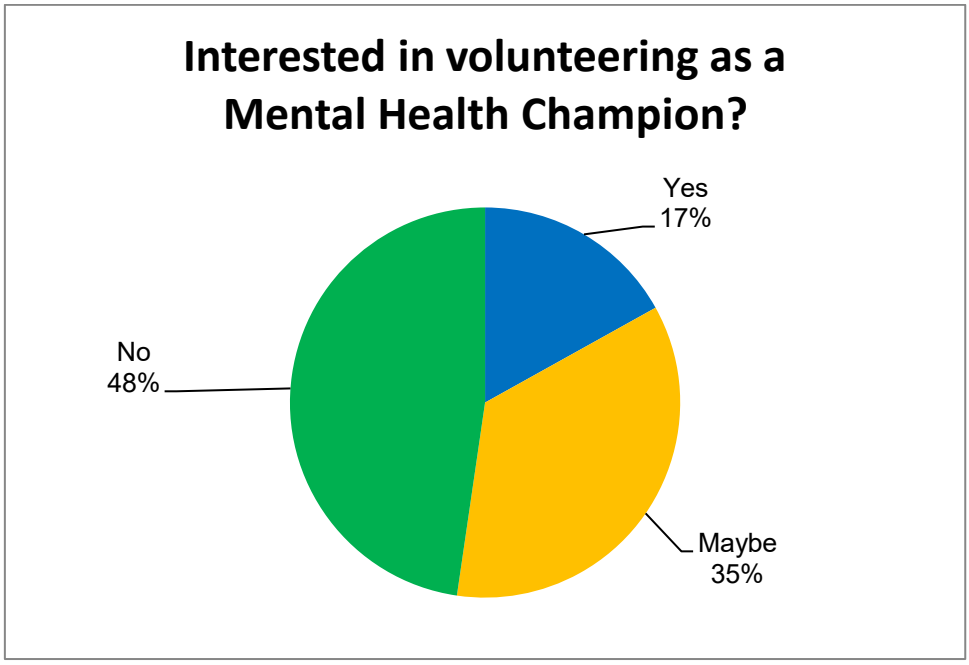
Respondents were asked what difficulties they had experienced in accessing mental health services. The most common difficulty was getting an appointment, mentioned by 17 per cent of respondents, almost all of those who had experienced difficulties. Face to face appointments were difficult to get. Also evident from the responses

were long waiting times, lack of confidentiality and lack of understanding between patients and services, with services not understanding cultural and religious needs.



Respondents were asked where they would prefer to access mental health services, if needed. Preferences were varied with no one setting being dominant. However, there was a preference for faith, voluntary and community settings. Health centres are also popular, more so than hospital and Council settings.

Interest in Volunteering as a Mental Health Champion



The penultimate question in YAWR's survey asked respondents if they would be interested in volunteering as a Mental Health Champion for their community. A brief

summary of the role of such a champion was provided as this would be a novel concept to the respondents. Just over half of respondents said that they might be interested in volunteering although in most cases this was a ‘maybe’, perhaps because they were unsure about the role, their suitability for it or how much time it would take up.

Of the 17 per cent who would definitely be interested in volunteering, the majority were women although relative to the sample sizes of each gender, men were more likely to say ‘yes’ at 21 per cent compared with 15 per cent of women. Almost all of those who might be interested were women and overall 63 per cent of women were willing to consider being champions compared with 26 per cent of men. There was a good spread of age groups amongst those showing some interest, with similar proportions aged above and below 35 years evident in those responding both ‘yes’ and ‘maybe’. Most of those definitely interested reported good mental health, half were in employment and half had a degree or diploma.

Other Comments

Respondents were invited to add anything further at the end of the questionnaire. There were a variety of comments which echoed some of the survey findings. Some people said that mental illness was hidden, not recognised or accepted. Personal resilience and self help with support was suggested to deal with problems. Public services for mental health were described as terrible and volunteers were needed to address the scale of need. A couple of respondents said that practitioners who spoke Urdu or Punjabi would help them.

1. Conclusions and Recommendations

Conclusions from YAWR’s Feasibility Study and Survey

This study has demonstrated the importance of mental health to both individuals and communities, and widespread nature of mental health conditions, which are often undiagnosed. Whilst many people enjoy good mental health, a large minority experience a wide range of problems and conditions which are often hidden from others. There are a wide range of mental health conditions and degrees of severity in each case. Most people affected have mild or moderate mental health difficulties on either a long term or short term basis, which are easy to disguise and rarely recognised. Mental health problems affect people from all ethnic groups, but how different communities respond to them varies. The recent Covid-19 pandemic and its associated lockdowns and other restrictions, has had a significant adverse impact on the mental health of many people. This is likely to persist long after the pandemic itself has faded from the news headlines.

YAWR’s survey of 65 adults has provided a valuable insight into the characteristics, experiences, mental health and related views of Rotherham’s Pakistani & Kashmiri

community. Those of people from other minority ethnic groups might be different which could relate to how well established they are. The majority of respondents were women, who the survey confirms are more likely to have mental health problems, and significant gender differences are reported in the analysis.

The survey has shown that mental health varies considerably in the community and is often linked to physical health. Both have a large influence of people's quality of life and one in eight reported that their mental health was bad. Women were significantly more likely than men to have poor mental health, with three times the rate of reported bad mental health, although some conditions affected men more. Family and friends were of crucial importance to positive life experiences and in providing help and support, both in general and for mental health.

The survey results confirm that there is a stigma about mental health in the community, which limits talking about mental health, admitting a condition or seeking help. There is a real fear of ridicule and being judged by others which leads people to hide any mental health issues. In the survey, people favoured community based solutions to address this stigma and favoured community based mental health services, which nearly half had accessed at some point. Half of respondents would not know how to get help, more so those with the poorest mental health. Only a third of respondents knew to consult their GP about it. It is important to note that people found that the support of family and community organisations was more useful than support from mental health services and practitioners.

The survey has illustrated that whilst a high proportion of people have some degree of mental health problem, many don't know how to get help and even if they do, face community stigma in trying to do so. Respondents found informal support more useful than mental health services so trained volunteer champions within the community offer good potential to be effective. People already rely on family and friends, and this can include informal community contacts who already provide advice about a range of issues. Having someone to talk to and listen is important for anyone with mental health concerns.

The concept of Community Mental Health Champions was reasonably well supported by two fifths of respondents, quite high considering that it was unfamiliar. One in six respondents was interested in volunteering for the role and twice that proportion would also consider doing so. Given the interest in accessing mental health support in community based settings, mental health champions would be best hosted within the voluntary, community and faith sectors.

Recommendations

1. **Rotherham Health and Wellbeing partners note the importance of mental health conditions in BAME communities and how these present themselves differently**
   Existing strategies for mental health need to take account the additional stigma and other challenges faced by people from BAME communities..

2. **Develop a Partnership for BAME Mental Health Support**
   Create a funded partnership between YAWR, VAR, and possibly other VCS or NHS organisations) to devise a community based approach to raise awareness of mental health, reduce stigma, provide advice and signpost people for mental health conditions.

3. **Establish and recruit Community Mental Health Champions**
   Identify an appropriate number of Mental Health Champion volunteer roles for people from BAME communities or a pilot for the Pakistani/Kashmiri community, with suitable gender balance. Invite applications for the roles of Community Mental Health Champions and interview anyone shortlisted. Some people may already be informal champions who need to be encouraged. Consider the possibility of recruiting Ambassadors to promote BAME mental health at a more strategic level.

4. **Support Community Health Champions**
   Provide appropriate training in mental health first aid, and facilitate personal development and team building for Community Health Champions and support them in their role over a sustained period. Allow champions to claim any reasonable expenses and consider paying small allowances, given the challenges faced by many during the cost of living crisis.

Appendix 1: Survey Questionnaire

Appendix 2: References

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