Mapping the Mental Health Support Needs

of Tamil People in West London

Presented in this short report are the main findings from a mapping exercise looking at some of the barriers and associated interests of Tamil people in relation to their mental health and mental health support. It was not the intention of this mapping to produce an extended report drawing upon extant literature but rather to take a grounded approach in identifying what was pertinent to present and past situations for Tamil people in the aforementioned subject area.

Background

This mapping report contains information gathered from data collection with the Tamil population in Hounslow and Ealing. This work was undertaken following a meeting with ROTA, Tamil Community Centre (TCC) and West London Mental Health Trust (Diversity Unit, Chief Executive and Deputy Head of Partnerships) during August 2013. It was agreed that each organisation would work jointly over a six month period to look at the experiences Tamil people had accessing mental health support and also to think about how services may be shaped differently. At the meeting in August 2013, the possibility of training for Tamil volunteers was discussed based on a model of co-production and positive action in Wandsworth, South West London and this mapping provided a further opportunity to contextualise and further explore some aspects of potential training.

Report Structure

The report has been framed within four main sections: 1. The Role of TCC, 2. Mental Health and Access, 3. Dilemma's and 4. Opportunities and Recommendations. Each of these main sections includes sub-sections drawing more specifically on the topic of the main section.

Section one offers a short insight into the scope and scale of the work of TCC. Section two looks briefly at how Tamil people comprehend mental health before looking at the role of service providers and Tamil Community Centre to supporting mental health as well as a larger focus on unmet needs. Section three describes the main predicaments participants encountered which they felt had a bearing on their overall well-being. Section four posits the different opportunities where future work may be carried out jointly or independently by WLMHT, ROTA and TCC and where such work may lie with other stakeholders.

Methodology

Two focus groups were organised and carried out in Southall and central Hounslow during December 2013. To supplement the focus groups an additional 14 interviews were carried

out with people from the Tamil population and Tamil volunteers as well as analysis of service usage at TCC. ROTA and TCC staff also met with Ealing IAPT (Kiran Sharma), WLMHT second tier (Rod Holland) and primary care plus (Rob White & Helen Potter). Communication has also been established with recovery and assessment teams in Hounslow and Ealing. All participants involved in the mapping at some stage had received support from TCC.

An open ended structure was utilised during focus groups to help encourage discussion and broach a range of issues including arrival and settlement, access to support, experiences of services and the role of TCC. This was carried out to help identify cross-cutting concerns for people pertinent to their well-being whilst also drilling down into some of the complexities surrounding mental health and mental health support. A semi-structured interview design was used for the interviews.

1. The Role of Tamil Community Centre

TCC comes into contact with approximately 4000 people annually through the different activities it provides with the vast majority of these people residing in west London. Many of the obstacles participants had difficulty overcoming were brought to the Tamil Community Centre to be solved. The variability in these difficulties was extreme with some people needing help producing a CV on the one hand to highly complex cases that involve supporting the overall wellbeing of vulnerable clients including liaising with prison estates, legal professionals, mental health services and social care. In some instances people had been attending TCC for multiple reasons since TCC was established 10 years previous.

"I seen TCC's advertisement at the Temple. After attempting suicide I have now been attending TCC since June [2013]*. I tried to kill myself two weeks previous* [date not correct as she now has memory problem has been attending TCC for four months] *with sleeping tablets and now attend TCC for help with getting work"*

"I am homeless. I often sleep on a bus and use No, 10 as an address for any documents. I've been coming to TCC every Wednesday for almost three years. I can eat here and get help with problems".

"I come to TCC to clarify information about filling in forms and to ask for advice. Child tax credit, job seekers allowance. I also come to help myself relax and to speak about country. I will soon start English classes on Friday".

Provided in table 1 is a snapshot of the profile of the needs of service users attending TCC. This table highlights the breadth of some of the work carried out by TCC but also the scale of

TCCs work as this is only a sample of 645 clients from an estimated 4000 per year. The data below does not include new areas of work such as befriending to people in prison. Domestic violence is also expected to be higher as people experiencing domestic violence would not always express this was the reason for attending when the form was completed and often state they were seeking general advice. For similar reasons the number of people requesting support for mental health is also under-reported.

Table 1:

Alcohol Counselling	20
Benefits, Housing	40
Domestic Violence	40
English	220
General Advice (letter writing)	100
Immigration	45
Homelessness	15
Mental Health	90
Sewing	75
	645

2. Mental Health and Access

Experiences of mental health needs were discussed in terms of participant's perceptions of the services which had been received at both primary and secondary care whilst there was a larger amount of dialogue focused on unmet needs for those who had not accessed support. Mental health and its impact on an individual's physical health was also noticeable in the discussions with several participants expressing how it became increasingly difficult to get motivated and to participate in activities and ensure their own daily maintenance when feeling down.

Cultural conceptualisation of mental health:

'Padatam' was the name Tamil participants used to describe what is commonly understood in western terms as experiencing a mental health condition. This was also understood as a

whole bodily process rather than something located only in the brain. This was seen in the description of one person who spoke about the high pressure he experienced from 'head-to-toe' following his involvement in the Sri-Lankan civil war and his arrival in the UK.

Unmet/unidentified needs

A range of explanations were offered for reasons to not seek help. Some participants did not want to endure the practicalities of making a booking or go through the hurdles required in obtaining an interpreter. Hence English language presented a significant barrier in a person's reluctance to seek help. The computerised administration of participant's personal information permeated a feeling of being watched. In the circumstance where one has encountered experiences of war and surveilence this would seem a logical fear. Moreover, this is an area which warrants further exploration as it was commented that this hesitation and apprehension to access support could be greater among individuals who have been directly involved in conflict and therefore may create an opportunity for targeted work in this area.

"I now feel stress every day, especially since job loss. I have attended the GP who knows about my history [experience of torture and bodily trauma] *and I have advised GP about stress since ending work…..I didn't get advice from the GP. I would attend IAPTs but would not be content or feel safe entering mental health services"*

Significant discussion in the area of unmet needs revolved around memories of the war including torture and the loss of life which people either directly experienced or witnessed. Across this area, participants who had encountered some form of loss, bereavement or harmful encounter had either not accessed any support or had felt that the support was insufficient or inappropriate. The behaviours and attitudes displayed by participants in relation to their mental health, which were expressed as being a consequence of their experiences, had hitherto been managed differently by participants. In some instances, participants suppressed their feelings without any identifiable conduit to share or discuss their emotions whereas some people delayed seeking any help as they placed greater priority on sorting out basic needs such as their government benefit entitlement.

"My brother and aunty were killed in Jaffna by Sri Lankan army. I experienced bombs and many times had to hide in trenches. My parents were also injured. This was one year of sadness. After that I returned to some normality. But sometimes I remember my brother."

"Always thinking about war and country makes me upset (man starts crying). I have five children and wife in Sri Lana. In 2009 my sister was in a bunker and was murdered. Even if my family here I would still have worries."

"I read in my free time, such as newspaper so I don't have to think about war and family…..The war has ended so I try not to think about it."

Further examples of missed opportunities for support to be provided were described by participants. Many of these examples cited General Practitioners as being fundamental weaknesses in access to care whilst instances where the Home Office had refused access to all health facilities of newly arrived migrants was also posited. In certain situations at primary care level, this was despite obvious wounding from conflict. Much of these pressures were combined with what some participants described as "*a constant tension being able to do anything and a determination in some respects to feel English."* Several occasions were noted were participants or their close friends or family have been in a suicidal mindset and only the passing of time assisted this change in mindset. This was largely attributed to an absence of adequate knowledge or support at community level in dealing with such situations and an identifiable and appropriate care pathway.

During both focus groups the majority of participants were women. This meant a greater proportion of discussion was weighted towards some gendered dynamics. Domestic violence and its association with low levels of well-being emerged as a significant area which was highlighted from interviews with TCC volunteers. It was not a topic discussed during participant interviews whilst it was only briefly alluded to during one of the focus groups. Interviews with TCC volunteers evidenced the stresses and physical harm brought about as a consequence of domestic violence where more often overlooked and the reluctance to seek help on this issue was very restricted. It was reported that men would commonly attend the GP surgeries with their partner/wife resulting in women being prevented from explaining the necessary causes of their pain and distress. Additionally, women attending TCC for support would not do so initially to discuss domestic violence but for a different area of need such as a housing application.

Another issue raised by several women attending was the post natal support. These concerns centred on women feeling particularly left alone, especially after giving birth to their second child. Participants registered their disappointment at the lack of information about post natal depression.

<u>General Practitioners</u>

Various issues were discussed relating to General Practitioners (GPs hereafter). At the centre of many frustrations was the sense that many GPs were unaware of the history of events many people had experienced and the respective impact such events had on the present day orientation of participants. It was not always expected that GPs needed lucid familiarity of the situation in Sri-Lanka, but that some understanding was necessary. The barriers placed upon GPs to spending a reasonable amount of time with patients was commonly described as a hurdle. Moreover it was the perception of participants that some GPs did not have any interest that participants felt was of tantamount importance to the limited time patients can spend with a GP.

*"Doctors need familiarity with situation with Sri-Lanka. Need to take time to talk to patient. Doctor has not seen previous reports, (*the GP asked me*) can you breathe, can you eat" he had no interest in wound, no questions about that."*

"I spent about six weeks (10/1/13-29/7/13) at Lakeside. Whilst in hospital my main fear was for my child's welfare. I attended the GP to advise him that I was not sleeping properly for three days. I expressed that I had sleeping problems and sleeping pills were issued. GP did not ask of any other problems I may be experiencing"

Some participants who had changed their GP to one who was Tamil speaking reported better levels of satisfaction. This was a marked improvement in many participant experiences, most notably as the GP identified historical causal factors to their concerns, meanwhile Tamil conversation facilitated better communication exchange. In a small number of instances the use of home medicines before prescribing (western) medicines was thought to be positive.

Different reasons were expressed as to why some participants would or would not go to see a GP. Often after an initial visit several participants were much less likely to make a second visit. On several occasions participants felt their history of torture – which was documented and made aware to the GP – was ignored when dealing with recent issues of stress. The limitations of support at primary care level and what contrastingly appeared to be broadly encompassing support at Tamil Community Centre was a sentiment expressed by many participants.

"GP can't spend longer than 10minutes with me. I have depression for 5-6 months. Did not see GP, I don't know why. My family is in Sri-Lanka and it's difficult to explain experiences to GP. I can make appointment for GP and would expect to wait two days. I would prefer to see Rani instead, then go to see GP. Rani is good for translation".

<u>Second Tier Support</u>:

Five of the participants involved in the data collection acknowledged that they had experience of second tier services. Only two of these had accessed West London Mental Health Trust. Information from participants on their experiences of secondary care services was limited. This may be explained by the focus of the data collection which was centred upon establishing a better understanding of how participants would like services to be delivered. Additionally, it may also be explained by the larger number of participants who seemingly had an unmet or unidentified mental health needs. Since writing this mapping report more contact has been established with Tamil people who have accessed second tier support. This provides an opportunity to expand upon this area of work to explore further the subjective interpretations of Tamil people who have been the recipient of care at this level.

Experiences of second tier services were balanced between areas for improvement and areas that should be commended. One Tamil lady who had attempted suicide was very grateful of the service she received from WLMHT. In particular she cited the quick diagnosis of her worries and more importantly the structured advice and clear guidelines around processes. At the same time participants shared concerns about being discharged and not being provided with a key worker.

TCC and Mental Health

TCC was seen as a valuable and more importantly safe point of entry to receive direct support and to be referred to other services. The services provided by TCC to support a person's mental health condition are not intentionally designed around any psychiatric, sociological or psychological methodology. However in many circumstances the effectiveness of TCC's work is seemingly positive with regards to self perceived outcomes and also the potential for supported work to operate at this level. The importance of functional social dialogue more generally was thought to be of high importance as was dialogue around specific issues such as domestic violence and community needs. Additionally, the patchwork of activities where people, in particular women, could interact meaningfully was thought to be integral to wellbeing. This includes Family Group sessions, English language, Yoga, PC training, sewing, benefit support and alternative therapies (meditation, massage).

"I have two people, one facing suiciude but eventiually found work with support from TCC and another individual who felt they were suffering from depression was support by a GP via TCC"

"I find TCC helpful for support. They have help find my support, such as getting a walking stick, has been useful. Translation support to Ealing hospital and TCC's understanding of my background is my need."

"I arrived in August 2011, then in 2012 I came to TCC, I then went to English classes for 1 year, sewing for three month and also to childcare. Because of going to TCC and the support I then went to Western College, Isleworth and did ESOL entry level 2."

TCC was viewed as a place where the 'mind can relax' being able to talk to somebody who understands what has taken place hitherto. The notion of understanding and trust is one that came across overwhelming strong and was articulated as the basis of many of the users attending TCC.

Although TCC is a place where an array of vital services are offered free of charge there were acknowledged limitations in the support that could be provided to individuals. This was especially the situation for people who were experiencing the difficulties associated

with various mental health conditions or alcohol/drug abuse. Several situations were highlighted were TCC staff expressed a desire to have greater skills in knowing what step to take next when supporting people.

3. Dilemmas

This section draws attention to a wide range of cross cutting issues, which although not directly linked to the provision of mental health services, were brought up by participants as interests and concerns that had relevance to their well-being.

English language:

Challenges associated with communicating in English came across as a significant issue in people's past and present situations. The impact this had more broadly was noticeable in encounters such as having a conversation with the school about the welfare of a parent's child. Although not directly associated with the delivery of mental health services participants articulated the pressure this placed on parents and the worries they experienced.

The inability to communicate in English and its effect on mental health was raised by all participants as being substantial. Discussion often centred on the barriers of how the basic practicalities of life were made challenging and difficulties in gaining access to interpreters was a common factor across all health services. Importantly participants commonly expressed that English language ability remains a significant factor in a person's reluctance to seek help or not.

"You don't understood – simple tasks like the practicalities of going to hospital"

"Having a little bit of Tamil language capability helps when visiting the GP but English language creates huge barriers".

Despite a strong desire to learn English it was clear limitations were placed on acquiring this skill due to financial costs and family commitments. This resulted in a number of participants dropping out of some courses.

Lawyers:

The role of legal professionals, and in particular lawyers, was highlighted as both an area where interventions can take place and one that brought about immense levels of distress.

Participants enunciated their challenges in paying for lawyers upon arrival in the UK to assist with their immigration. It was discussed how this financial outlay often assumed precedence over other areas of financial commitment and placed people in predicaments of hardship. It was expressed how paying fees was an ultimate concern for some participants which at

points resulted in people not partaking in their typical routine of attending church or temple.

Housing:

Although home was identified as the place where any individual should be able to relax, a number of participants did not have a place of residence. This meant some participants had to find some form of abode in a shed, garage, on a friends couch and in some instances on a bus. Participants who were found experiencing these situations also communicated the regular occurrence of nightmares resonating with the Sri-Lankan war.

For those with a home which constituted a physical building that was most often rented accommodation, overcrowding was a common factor and sometimes seen as a necessity. In more extreme cases people cited the pressures of living with five other people in one room. Combined with the pressures of overcrowding the quality of housing stock was specified as an aspect of concern and the burdensome processes to be undertaken when attempting to arrange repairs.

"I've been coming to TCC taking advice from Sister (Rani), initially legal advice to assist with housing association not carrying out repairs. I've attended to see Rani three times to solve repair……now I'm trying to solve my housing benefit….reduced by £30 per week from November."

"I want to have my own place. I live with my friend and need to leave at 9(am) everyday. The situation gives me tension and stress".

Support:

Different types of support were noted as being key to assisting the overall well-being of Tamil people upon arriving in the UK. Friends and family were the obvious avenues of support. Meanwhile the support and direction offered by legal professionals was also deemed to be helpful, especially as a point of contact during early settlement. For those who were able to depend on such levels of support and overcome initial language barriers, we found that life, once acquiring a skill, improved dramatically and was a point very salient. The role of voluntary organisations elsewhere was alluded to as participants referred to similar groups they were able to access upon arriving. Similarly the presence of Tamil societies operating within and from churches or temples proved to be well placed in meeting some needs.

"Arrived 1991 and joined group similar to Rani's in Brixton, travelled there whilst living in East Ham. Most Sri-Lankans joined there and received training in administration and English. Job was found from this".

The process of sorting out benefits was one that highlighted major flaws across different public services available to people experiencing a mental health condition. This was raised as a dilemma for individuals experiencing a wide range of mental health conditions with several examples of benefit cases appearing highly complex to resolve. Two participants felt strongly about the gaps in support they had received. This involved key workers not arriving at their house, not providing attention to the needs of the individual and not providing clear guidelines where support would/would not be provided. TCC is often overwhelmed by the number of people seeking help relating to welfare support. It is not uncommon for TCC to receive requests for support from as far as Norway where people need help with negotiating their welfare system, obtaining support whilst experiencing emotional distress.

"I had nightmares about previous country, extreme anger, anxiousness, extreme headaches. Unable to be certain about things. Upon arriving I felt 'pressure on my head'. The struggle come to a head. I had to make the journey from Southampton for support [at TCC]. *I had big problems accessing counselling but sorting about benefits comes first."*

4. Opportunities & Recommendations

This section provides an account of possible enablers to identifying unmet mental health needs and also the possibilities thereafter for supporting the mental health of Tamil people.

<u>TCC engagement, Brokerage and Support with WLMHT</u>

Against the background of participant feedback emphasising an almost overall reluctance of Tamil people involved in this mapping to either want to access support via TCC or not access any support at all for their mental health, there appears to be a functional role for TCC. This may involve identifying specific mental health needs and/or in some circumstances supporting those said needs in addition to continuing to provide activities around social interaction. In all instances, TCC was viewed as a fulcrum that should be central to facilitation of such work. This to some extent is supported by several participants who stressed that mental health and the processes of some enduring problems where viewed as being a need whereby solutions lie in the community rather than individually or institutionally focused.

"The opportunities that TCC could open up for those who have suppressed"

"Support provided by TCC is there, a place to come together as has happened today [at focus group]*, and sort out problems collectively, possibly in the presence of GPs and experts"*

Notwithstanding, suggestions were made about bringing in health professionals/experts who can provide specialist support to meet Tamil people as part of group and in one-to one sessions. Interestingly, and paradoxically, although some participants proposed the use of group discussions and/or one-to one support as an opportunity to talk about the war and

the impact it has had on how people feel at present, there were mixed feelings with regards to encroaching the subject directly as a mental health issue. Moreover not everyone was content with any single approach being the only approach with some people encouraged by the possibility of group dialogue and others feeling other arrangements located within TCC being feasible.

"I still worry about family members, sister in law. Talking makes me upset. I lost family members. I have only ever spoken to family and friends about atrocities. I wouldn't want to speak with a health professional. Coming to TCC with friends with similar experiences that could help. I attend a temple but would not want to talk about it there. A temple is for pray AND ONLY PRAY"

"Important to discuss it with professional and not always in a group as people have their own expressions of trauma and focus can be lost"

Service Location

The possibility of providing mental health support outside of a statutory institution and in a place where Tamil people were thought to be more comfortable visiting was an area considered by participants. During focus groups and interviews participants initially highlighted places such as those used for religious activities to be most commonly attended. Nevertheless, a high degree of caution and resistance was expressed by participants when offering consideration to places such as temples and churches as places where mental health support in some form could be provided. The main opposition to this set up was the openness to the public and therefore the lack of privacy that would be afforded in contrast to an operation that would be available at TCC which was perceived as being local, small and where there is a broader comprehension of historical suffering and individual family dynamics. Some participants were also cautious that hidden hierarchical structures would inhibit the possibility of placing mental health support in temples and in some Gudwara's.

Even in situations where TCC volunteers would need to be highly skilled to be able to provide the necessary support to any particular individual, the mechanisms for building trust between any individual experiencing a mental health problem, the TCC and a specialist worker need to be established. This bridging of support appears absolutely essential across the care pathway, in particular prior to access and after discharge. The opportunity for WLMHT services to be located at TCC is a possibility and has been offered. Nevertheless capacity issues would appear to be a barrier to this.

Skill Provision

It seems possible that the right type of training to Tamil volunteers could yield meaningful benefits across the Tamil population and to health services. Part of the data gathering involved speaking to volunteers after they had provided support to service users to better

understand where they felt they did not have the right skill set or limited knowledge to be able to provide the support they may otherwise have the capacity to do so. From this volunteers expressed a need to be able to talk through different situations with service users and to possess an understanding of different techniques which are likely to assist such a talking process. In some instances, due to the ambiguities around what actually constitutes mental health largely associated with differing cultural interpretations and through fear of unnecessarily stigmatising individuals, there was a desire for training to avoid being focused on symptomising the way people do present, but rather concentrating on the support needs of each service user.

Further exploration:

This short mapping offered an insight, albeit glancing, into some of the dilemmas faced by Tamil people across a number of areas. Many of the topics did only brush over areas that were meaningful with respective implications for mental health provision but could not be afforded adequate time. Areas that were touched upon that warrant further exploration include looking at the experiences of childhood, sexual exploitation, war alongside different experiences of trauma (financial loss, migration journey). More specific areas would include looking into the relationship between seeking help and experiences of torture. Also, opportunities are possible for ROTA and TCC to work with WLMHT to look in more detail at the experience of Tamil people in relation to second tier services.

Starting April 2014, ROTA and TCC will commence targeted work with Tamil men in a looking at areas of support and experiences related to the Sir-Lankan war.

Earlier intervention

Various junctures were identified where an intervention can take place comprised of different forms and requiring different types of expertise. This included information at law firms specialising in immigration, Tamil videos in GP surgery's and Tamil media, home visiting, targeted gendered work as well as increased skill provision at community level alongside the positioning of psychological expertise at community level.

Some of the opportunities for earlier intervention have been addressed under the sub-heading looking at 'service location' and skill provision. Meanwhile, TCC and ROTA have already commenced specific work with Tamil women around motivational skills and handling hostile domestic situations.

Recommendations.

1. A model of mental health provision that would address 'Padatam' should include; provision of psychological support alongside support with social issues such as housing, immigration and financial concerns. Provision of psychological support

should be based at a venue locally where TCC can operate. Other places that offer support where awareness raising could take place include frequently used solicitor's offices, housing offices and local Tamil GP surgeries.

2. Joint funding between TCC and WLMHT to support the holistic work carried out at TCC combining advocacy support and specialist work by WLMHT and/or the provision of training support for Tamil volunteers to support people coming into contact with TCC services.

3. Language is a main barrier to accessing and receiving appropriate mental health services. Greater knowledge/awareness of services could be achieved through translated information sheets about services, and clarity about the process of having an interpreter for both the community and service providers. This is particularly pertinent for GP surgeries.

4. For those receiving services at WLMHT, there should be more advocacy services (Tamil language speakers) in place and increased awareness/acknowledgement of the context of Tamil people.

5. Provision of information about postnatal depression and support systems for the local community.

6. Further research into the mental health needs of Tamil men and further more in-depth research looking at the Tamil population across mental health services.