Mental Illness within Black & Minority Ethnic (BME) Groups:
Cultural attitudes to mental illness and barriers to accessing mental
health services:
An outline of good practices within Dudley & Walsall that aim to reduce
stigma and to bring BME communities closer to mental health services.

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Introduction

Dudley & Walsall share a national trend within inpatient statistics. A
disproportionately high number of BME inpatients are detained under the
Mental Health Act (sectioned) and a corresponding low number are admitted
as voluntary (informal) inpatients. Mandy Poonia, Non Executive Director to
the Dudley and Walsall Trust Board expressed concern about this trend.

This statistic has prompted Expert Service Users to consider the possibility
that people from Black and Minority Ethnic communities face barriers when
accessing mental health services.

Expert Service Users and Carers are engaging with BME Community events
and discussing the way in which mental health services can be accessed via
the Stepped Care Model (Appendix 1).

We are working along side Community Development Workers (CDW) who
engage with communities within both Dudley and Walsall. The CDW s are
coordinated by Roy Mc Farlane and managed by Paul Singh, Equality and
Diversity Lead for the Trust.

We attend the Special Interest Group (SIG) meetings, which originated in
Walsall but now also embrace Dudley groups

The focus of all our meetings is to try to understand the attitude of different
cultures to Mental Illness and to accessing Mental Health Services, and to
urge individuals within Black & Minority communities to seek help sooner
rather than later via CDW, GP, social worker or another Gateway Worker.
Mental health problems, if left untreated, can exacerbate into a crisis that may
require detention under the Mental Health Act (sectioning) and hospitalisation.
Detention should be the ‘final resort’ and may be avoided if services are
accessed at the point when the person begins to feel unwell. Individuals need
to become aware of early signs and symptoms of mental illness. This
awareness can be nurtured by education and open communication.

Paul Singh, Lead for Equality & Diversity for the Trust, forwarded a recent
paper ‘Improving In-Patient Health Services for Black and Minority Ethnic
Patients’ Occasional Paper from the Royal College of Psychiatrists 2009. I
have included a brief summary of the paper (Appendix 2). Electronic copy of
the complete paper is available from L Jankowska or Paul Singh.
The paper acknowledges that different cultures perceive mental health problems in different ways and recommends that time, energy, thought and commitment on the part of mental health staff will go towards better understanding of the cultural needs of a diverse group of patients. The population of Dudley and Walsall is suitably diverse.

Cultural attitudes to mental illness and barriers to accessing mental health services.

Pilgrim (2005) describes two approaches to cultural differences that are used.

1. The first assumes that western definitions of mental disorder are valid and can be applied universally. Adopting this orthodox approach needs to be sensitive to cultural differences so that symptoms can be translated into orthodox western psychiatric diagnosis.

2. The second view of cultural differences in mental distress questions the validity of applying ideas, techniques and diagnostic labels from the west to other cultural settings.

Certain illnesses are stigmatised in certain cultures. Consequently, patients may present symptoms that are acceptable to their own cultures. For example, the diagnosis of clinical depression is stigmatised in many Asian cultures and patients with depressive illness may report only physical symptoms such as fatigue and weight loss (Kundhal and Kundhal 2003).

Afro-Caribbean migrants are often associated with higher rates of schizophrenia. Research (Bhugra et al 1996) shows that rates of schizophrenia in the Caribbean are not elevated so a biological cause is unlikely. The stress of migration may be a key trigger factor in the onset of schizophrenia. Ongoing difficulties due to racism, poor social conditions and social exclusion may predispose the second generation to schizophrenia. Social support may be helpful in preventing illness in areas where social identity and low self-esteem are low (Fanon, 1952).

The Irish community in the UK have poorer mental and physical health and higher mortality, which persists into second and subsequent generations. (= NIMHE, 2003).

Recent migrants from Eastern Europe bring with them their own culture. Mental issues may be derived from their culture. Hostility from the majority, discrimination and material deprivation may cause mental illness (Open university, 2008).

The travelling community have their own social codes that differ from the majority. Travellers are resistant to intervention by practitioners who are outside their community.
Often, an individual or the family conceals mental distress because of the stigma associated with mental illness. If that illness spirals out of control, untreated, then detention under the mental health act (sectioning) may follow.

**Barriers**

People from BME groups often find that mental health services are not sympathetic to their individual needs.

**Fear and conflict.**

A report from the Sainsbury Centre (2002) concluded that black people’s experiences of mental health services in the UK are characterised by fear and conflict. Lack of cultural awareness as well as direct and indirect forms of racism, can result in people receiving poor quality treatment from practitioners and institutions. The individual can experience guilt and self-criticism, which can be seen as social failure in some cultures and may be a catalyst for depression.

**Language**

Even when an interpreter is involved, certain meanings of words or phrases get lost in translation and therefore it is more difficult for the doctors and practitioners to get a clear picture of the mental distress being experienced by client.

**Gender**

Within some cultures, free exchange of information between male and female is difficult. Ladies may speak more freely to a lady practitioner. If the practitioner is male then certain taboos or the need for a male relative to be present may complicate communication.

‘The other’

Psychological damage can be the result of being identified as ‘the other’ in society by the majority. Prejudice against a particular race, when habitual, becomes racism which can result in behaviours and decisions leading to racial discrimination.

A black service user said :-

“ The reality is I see myself as ‘normal’ but a lot of people don’t see me as normal. I see other people who have similar experiences as me but they are not seen as mentally ill… I often question if it’s my culture, gender, and/or age that gets a negative reaction.”

Joseph Rowntree Foundation, 2002

**Institutional racism**

Racial prejudice may be embedded in the structures and institutions of society. It is defined as :-
"The collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin." (Home Office, 1999)

The way it manifests itself is through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping leading to disadvantage amongst ethnic minorities.

**Double stigma**

Being a member of a minority group makes a person vulnerable to the effects of stigma. If that person finds themselves with a label of 'mentally ill' then they are vulnerable and open to more discrimination and stigma. It is therefore understandable that some people from BME communities are wary of approaching practitioners with mental health concerns.

**Looking Ahead**

Melba Wilson, National Programme Lead for Mental Health Equalities at the National Mental Health Development Unit, looks forward to challenges and priorities over the next 25 years (Looking Ahead, Sainsbury Centre for Mental Health, 2010)

She claims that the emphasis should be about accurately understanding and reflecting the needs and aspirations of individuals and communities of diversity. ‘Communities of Diversity’. This is a more useful description of BME communities.

“Ultimately, success is about developing and building good relationships in a range of contexts and environments. It involves having a keen ability to make connections and an ability and awareness to address visible as well as invisible barriers to change. It is quite literally, about improving the quality of conversations in a range of spheres.”

(Melba Wilson, 2010)

**Outline of good practice in Dudley & Walsall**

**Special Interest Group (SIG) meetings.**

These began in Walsall, instigated by Dr Afghan, some time ago. Now the meetings are for both Dudley and Walsall Groups and are concerned about mental health within BME communities and other minority groups eg a Lesbian Gay Bisexual and Transgender Group. The meetings are chaired by Paul Singh (Equality & Diversity Lead for the Trust ) and Roy Mc Farlane (CDW Coordinator) . From these meetings we have learned about :-}
• Support for young Asian women. Depression and anxiety has been recognised amongst young Asian women in the Lye & Wollescote area. Humaara is a group that is working with these young ladies. There is a Ladies’ Support Group at St Thomas’s Network, Dudley.

• Support for older Asian women. Older Asian ladies who have lost family support though bereavement or when children leave home need support to gain coping skills. Also social peer support is facilitated. The Saqoon group in the Lye has been providing this support for a few years.

• An Nisa. This group is campaigning to raise the self-esteem of women from South East Asia who wear the Hijab (scarf). It aims to combat discrimination. Emphasis is about the worth and dignity of women and in communicating the positive aspects of Islam to a wider audience. Its launch was in May 2010.

• A DVD about Dementia, aimed at the Asian Community and facilitated by Dr Tabassan and Tony Hipwell, Bloxwich Hospital isl to be launched in October. Depression DVD for Asian community is also in the pipeline.

• The work of the Community Development Workers (CDWs) across Dudley and Walsall. An outline of their work is summarized below.

Community Development Workers. Summary of Action and Progress.

• CDWs are working across Dudley & Walsall with the Community Mental Health Teams (CMHT) and are beginning to link with the Psychiatric hospitals within Dudley and Walsall, adult and older adult wards.
• ‘Drop in sessions’ are taking place to promote mental health awareness at Dudley, Stourbridge and Netherton Libraries. The project will be extended to Walsall libraries in the near future.
• Development of a Mental Health Training Package for faith leaders.
• Working with Walsall asylum seekers, refugees and migrants (WARMA).
• Work with the Yemini. Tracy Cross (CDW) has worked extensively with the Yemini community (men and women) of Halesowen to address issues of housing, education and health. This community has specific needs due to their strict code of behaviour regarding gender. Tracy organised a Ladies’ Day for the Yemini women inviting the ladies to fill in questionnaires about health, physical and mental. The results of the questionnaire will be distributed at a subsequent SIG meeting.
• The second Mental Health First Aid Course to take place in July.
• Men’s mental health and well being programmes are taking place in the Aisha Mosque and Muslim and Gujarati Association in the Lye.
• Work with teenage girls who have a tendency to self-harm. ALGEE training for CDWs (about assessing risk, recognising and dealing with signs of self harm and suicide)
• Awareness days in local High Schools
• Fun days – Refugee food at Walsall Art Gallery- Hawaiian Day Netherton
• Supporting Black Sisters Walsall, Black Voices at the Poplars and an African Caribbean Carers’ Group.
• A CDW, Michelle, works with children, young carers, victims of domestic abuse and in the promotion of sexual health and transgender issues.

CfEd are providing the CDWs with information and training for building partnerships, staying safe and the prevention of violent extremism. Kenneth Rodney works with and mentors the CDWs.

An aim for the future involvement of CDWs is to work with Primary Care and to promote the use of preventative measures that will halt the escalation of mental illness to a point where it requires specialist, secondary provision.

**Equality, Diversity and Human Rights Working Group**

Paul Singh (Equality and Diversity Lead) chairs this group for the Trust.. Current legislation, e.g Equalities Act 2010, is examined to best understand how it affects public sector employees and the wider public. The group is planning to promote ‘Equality and Diversity’ during Mental Health week in October, working in partnership with Kieran Larkin, Communications. An aim is to raise the awareness of mental health services that are available to BME communities.

**Bridging the Gap**

Paul Singh (Equality & Diversity Lead), Roy McFarlane (CDW Coordinator) and Expert Service Users and Carer are in a good position to bridge the gap between BME communities and the Trust, by liaising and linking BME groups and trust personnel.

Expert Service Users are urging members of the SIG group to become involved with the expanding Service user and Carer Reference Group.

**Finally**

“The progression within mental health policy shows a positive understanding of the effects of an untreated mental health condition. However, it is necessary to remember the inequality still present in the provision of services and actively to promote challenges to this.”