healthwatch Dorset

MENTAL HEALTH AWARENESS AMONG BLACK MINORITY ETHNIC COMMUNITIES

Healthwatch Dorset CIC is a Community Interest Company limited by guarantee and registered in England & Wales (No.08548235) at 896 Christchurch Road, Bournemouth BH7 6DL

Contents

1. Introduction

1.1. Healthwatch is the national independent consumer champion for health and social care established throughout England in 2013, under the provisions of the Health and Social Care Act 2012 and with statutory powers to ensure the voice of the consumer is strengthened and heard by those who commission, deliver and regulate health and care services.

1.2. Healthwatch Dorset is one of 148 local Healthwatch organisations with a dual role to champion the rights of users of health and social care services and to hold the system to account for how well it engages with the public.

1.3. The following report documents the work undertaken through Healthwatch Dorset's Community Investment scheme by Jessica Akeb Dip. PCT (Person Centred Therapy), a CBT (Cognitive Behaviour Therapy) counsellor who, during work experience with various counselling agencies, found that the number of people from black and minority ethnic communities (BME) accessing mental health services seems to be proportionally lower than for other communities. Jessica carried out some community engagement work to gather the views from BME communities about their experiences of using mental health services, to explore perceptions and misconceptions about mental health in general and to find out what are the factors preventing people from BME communities accessing mental health and/or counselling services.

1.4. We will work with Jessica to bring her work to the attention of local commissioners and service providers and help them to raise their awareness and understanding of how culture and background can affect how people access services.

2. Summary

2.1. Feedback from participants in the interviews suggests that they had minimal understanding of mental illness. Cultural differences, faith and background origins can all play a part. Some African communities believe that mental illness is not a sickness but a curse.

2.2. People often don't feel they have service providers they can relate to in culture, experience or colour. Language barriers can sometimes make it difficult for patients to talk honestly and openly about their problems, especially if they are relying on a family member (for example a spouse or a child) or someone to interpret for them. As a result the patient may not get the right assessment and treatment. People from some communities or faith groups may wish to only see a professional from their ethnic or religious background and some may wish to see a professional of the same gender as themselves.

2.3. Some participants felt that there is an assumption (both within and outside BME communities) that some BME communities are family oriented and that they "look after their own". This can create a situation where people are not encouraged to seek help or access information about the services available.

2.4. Many participants did not know about charities or organisations that offer services such as counselling for free. For example Body Positive for HIV, Dorset Action for Abuse, and some did not know that their GP would be a first point of contact for mental health concerns. People were aware of accessing GP services for physical health concerns but not for psychological issues. This means people are less likely to receive help at an early stage.

2.5. Many mainstream health services are provided by organisations with little or no links with BME communities thus reinforcing the distrust that many BME communities have for statutory organisations. Many participants expressed concern that there are not enough people from BME communities working within the system and certainly not enough at "decision making" level.

3. Findings from interviews and survey

In total 32 participants took part in one-to-one interviews with each interview taking approximately 45-60 minutes. Participants filled in a questionnaire with multiple answers and had a chance to discuss definitions of mental illness while completing the form.

All participants lived in Bournemouth or Poole and were from different African countries and identified their ethnicity as African, Black British, Caribbean or from a Mixed/Dual Heritage.

Nationalities included Ghanaian, Ugandan, British, Rwandan, Jamaican, Tanzanian, Zimbabwean, Nigerian, Kenyan and Portuguese.

(Please note - for this engagement work Jessica focussed on a community with which she had good access and networks so the results cannot be extrapolated across all BME communities such as Asian, Asian British, Arab, Gypsy or Traveller, Hispanic or Latino or any other ethnic background).

Gender:

- 15 were Male
- 11 were Female
- 6 did not state their gender.

Age Group

- 19 were age between 26 – 64
- 4 were age between 18 – 25
- 5 were age under 18
- 4 did not state their age

Religion/Faith

- 24 Christian
- 5 None
- 2 Muslim
- 1 Rastafarian

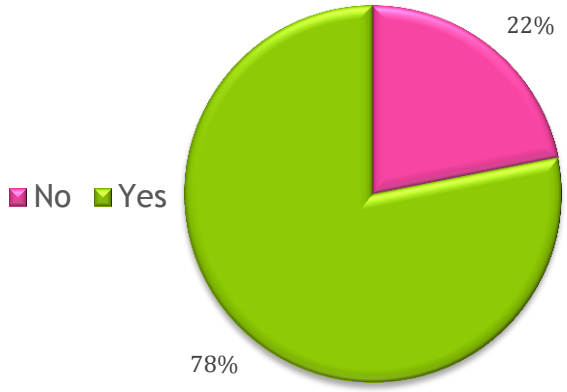
Survey Results

The following are the responses to the survey.

1. **What is mental illness? Participants were asked to choose all that applied from a list of possible definitions.**

Definition	Percentage of participants who ticked each definition
Depression	78%
Psychosis	72%
Post-Traumatic Stress Disorder	66%
Stress	62%
Anxiety	56%
Obsessive Compulsive Disorder	50%
I don't know	9%

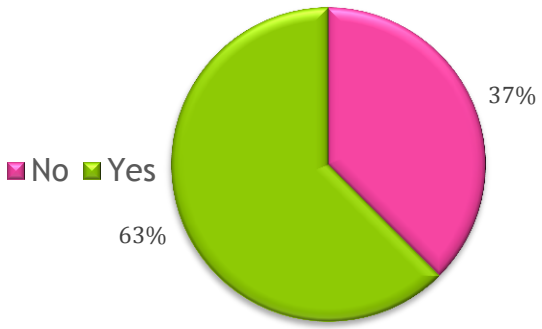
2. **Do you know what causes mental illness?**



If participants answered “Yes” they were then asked to list the possible causes of mental illness:

Possible Causes	Number of participants who listed each cause
Stress	8
Brain/head injury	6
Depression	5
Taking drugs	4
Traumatic experience	4
Family Problems	3
You can be born with it/genetics	3
Loss/bereavement	3
Heavy drinking	2
Low self-esteem	2
Marriage problems	2
Discrimination	2
Life changes	1
Anything can cause it	1
Having no family	1
Lifestyle	1
Failure to cope	1
Financial problems	1
Peer pressure	1
Mental abuse	1
Bullying/harassment	1
Relationships	1
Abuse of any kind	1
Poverty	1
Ill health	1
A chemical imbalance	1
Physical abuse	1
Work/life balance	1

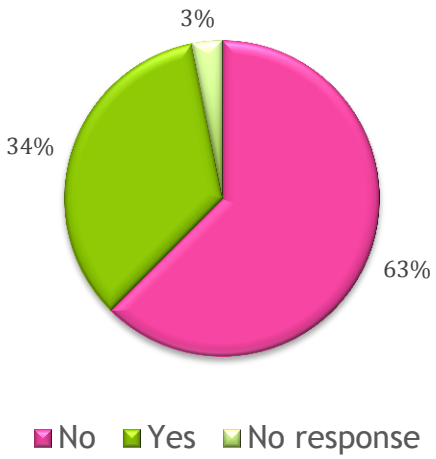
3. Do you know the symptoms of mental illness?



If the participants said “Yes” they were then asked to list the possible symptoms of mental illness:

Possible Symptoms	Number of participants who listed each cause
Behaviour changes	8
Becoming more isolated	5
Insomnia/sleep problems	4
Mood swings	4
Anger/violence	4
Paranoia	3
Amnesia/memory problems	3
Eating problems/reduced appetite	3
Depression	2
Taking to oneself	2
Physical illness	1
Anxiety	1
Stress	1
Hypersensitivity	1
Personal hygiene problems	1
Not talking	1
Psychosis	1
Suicidal thoughts	1
Fear	1
Drinking more alcohol	1
Making mistakes	1
Lack of concentration	1
Lack of self confidence	1

4. Have you suffered from mental illness?



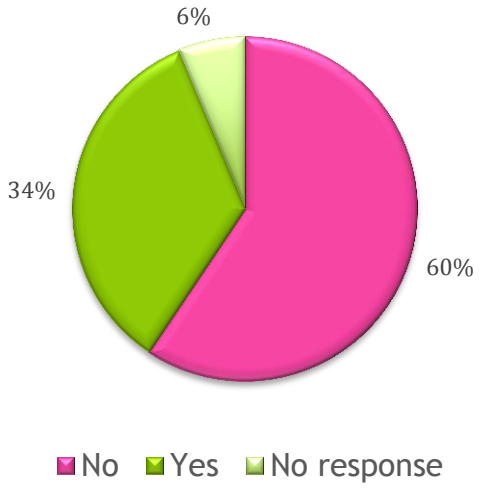
Participants were then asked if they had suffered from mental illness, whether they had received any help. If so, what kind of help, if not what stopped them from receiving/accessing help.

4 participants had received help and 7 had not.

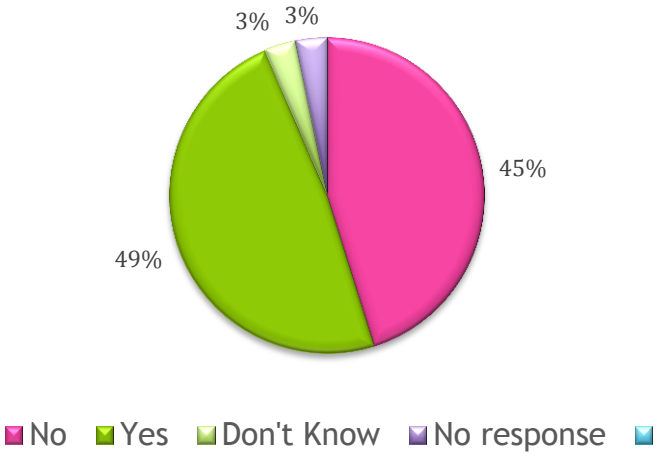
Type of help received	Number of participants
Counselling	3
Advice from GP	1

Reason for not receiving/accessing help	Number of participants
Not enough information about what to do	2
Fear of being judged	1
Ashamed	1
Felt would be seen as not capable	1
Didn't think needed help	1

5. Have you been to counselling before?



6. **Do you think health services (including mental health services) are accessible to people from ethnic backgrounds?**



7. **What can be done to improve those services for people from ethnic backgrounds?**

Ideas for improvement	Number of participants who listed idea
Better information/awareness/education for people about mental health and where to go for help	13
Better use of influential people in the community (e.g. church leaders, community leaders) to make people aware of services and encourage people to use them	4
Improve GP access to community groups	3
Create DVDs and adverts to be shown in "African" churches. Highlight cases of ethnic minority people who have been through mental illness to encourage others to seek help	3
Approach young people in school assemblies to educate them	1
Employ counsellors who are knowledgeable of that culture	1

8. Any other comments:

"People aren't willing to seek help".

"We need more communication, follow up and socialisation events".

"Fund the churches so they will help the black minority because most of them are Christians and they believe in getting help from church".

"Services for physical issues are there but for not for psychological issues. Awareness of these services is not given adequately to people from ethnic backgrounds. Sometimes people feel alienated by the clinical/western culture based approach of people here".

"Need familiar faces in treatment" (e.g. people from various backgrounds, cultures, ethnicities etc.)

4. Conclusions

4.1 Information gathered through the interviews and conclusions made:
As reported by the Mental Health Foundation (2015), in general, people from black and minority ethnic groups living in the UK are:

- more likely to be diagnosed with mental health problems
- more likely to be diagnosed and admitted to hospital
- more likely to experience a poor outcome from treatment
- more likely to disengage from mainstream mental health services, leading to social exclusion and a deterioration in their mental health.

They go on to say that "these differences may be explained by a number of factors, including poverty and racism. They may also be because mainstream mental health services often fail to understand or provide services that are acceptable and accessible to non-white British communities and meet their particular cultural and other needs. It is likely that mental health problems go unreported and untreated because people in some ethnic minority groups are reluctant to engage with mainstream health services. It is also likely that mental health problems are over-diagnosed in people whose first language is not English".

4.2 Feedback from participants in the interviews suggests that they had minimal understanding of mental illness. Cultural differences, faith and background origins can all play a part. Some African communities believe that mental illness is not a sickness but a curse. Some of the feedback received:

"Mental illness is a big word. It means that you're mad, if someone told me that because am depressed I have mental illness I would feel bad it would imply that I throw stones at people and walk naked."

"If I seek help for depression and I get diagnosed with mental illness it means that I am going to lose my job and I will not be able to financially help my family in Africa and also pay my bills."

"Mental illness is associated with witchcraft"

"A lot of people from African backgrounds do not believe that mental illness is a sickness and get help, they believe in being bewitched or cursed".

4.3 People often don't feel they have service providers they can relate to in culture, experience or colour. Language barriers can sometimes make it difficult for patients to talk honestly and openly about their problems, especially if they are relying on a family member (for example a spouse or a child) or someone to interpret for them. As a result the patient may not get the right assessment and treatment. People from some communities or faith groups may wish to only see a professional from their ethnic or religious background and some may wish to see a professional of the same gender as themselves. Feedback from the interviews:

"There was a woman from Rwanda who was on a ward. She had a specified need for an interpreter who was a woman from the same religious background. But the interpreter who was provided was a man from a different racial and religious background and she refused to speak with him."

"A wife was sectioned [under the Mental Health Act]. She hasn't got a serious mental health issue as to be sectioned but the husband had made those difficulties so huge because he doesn't get on with the wife. When she comes into the hospital staff say she is fine. But the husband terms her mad and paints the happenings at home in such a way that the clinicians then take his side. And she doesn't speak English so she can't represent herself."

4.4 Some participants felt that there is an assumption (both within and outside BME communities) that some BME communities are family oriented and that they "look after their own". This can create a situation where people are not encouraged to seek help or access information about the services available.

"Coming from a black ethnic background I kind of felt I could manage on my own because most people from my social group who are black as well were able to manage so it is my belief that if I got help I might come across as a failure. There is a need to decrease the high levels of ignorance people have from these groups".

4.5 Many participants did not know about charities or organisations that offer services such as counselling for free. For example Body Positive for HIV, Dorset Action for Abuse, and some did not know that their GP would be a first point of contact for mental health concerns. People were aware of accessing GP services for physical

health concerns but not for psychological issues. This means people are less likely to receive help at an early stage.

4.6 Many mainstream health services are provided by organisations with little or no links with BME communities thus reinforcing the distrust that many BME communities have for statutory organisations. Many participants expressed concern that there are not enough people from BME communities working within the system and certainly not enough at "decision making" level. Feedback received:

"Services are available but I don't have the confidence to approach them, not knowing the confidentiality, talking to someone I can't relate to worries me that I will be misunderstood."

"Why would I tell a stranger my problems because they don't understand our culture they don't believe us". Note – this participant then talked about his experience with immigration services when he first came to the UK stating that he was not believed and now feels that no one believes him so why seek help when all organisations will be the same.

5. Recommendations

5.1 Service providers should consider locating some services in places that offer some form of anonymity. This would help to engage people who fear the perceived stigma of having mental health problems or who feel anxious of using statutory services.

5.2 Local service providers should have a better understanding of the needs of different communities to ensure services are developed in a way that is suitable for all BME groups, with high quality cultural responsiveness and language, delivered in accessible locations. This will help to remove barriers to access.

5.3 Service providers should work more closely in partnership with voluntary and community organisations to develop mental health programmes for community leaders i.e. pastors, women's associations, football team leaders, mothers' groups to increase awareness of services in the local area and improve and encourage engagement. Also to encourage development of community groups involving parents, young people, elders and community leaders to help raise awareness of services and provide education to people.

5.4 Mental health service staff working among BME communities should be provided with more training and development to enable them to understand and address the issues raised in this report.

5.5 Local services could develop case studies, DVDs and adverts focussing on mental health using people from ethnic minority backgrounds. This may go some way to reducing the stigma and discrimination experienced by being able to relate to other people from similar cultures, giving people the sense that they are not alone and that people are supporting them.

5.6 Helplines specifically aimed at BME communities should be developed.

In conclusion, most people had some knowledge about what is meant by mental illness, its symptoms and causes but some of their definitions reflected differences in culture and background.

Commissioners and service providers need to be more aware that mental illness may be understood and viewed differently by people from different cultures. There needs to be more practical and accessible information to raise awareness about mental health, the available services and the causes and consequences of not seeking help or leaving it until it is too late. This cannot be done in isolation i.e. a one-day conference but should become part of the “toolkit” that professionals and communities can access as and when needed.

References

- Mental Health Foundation. (2015) Black and Minority Ethnic Communities [Online] Available from: http://www.mentalhealth.org.uk/help-information/mental-health-a-z/b/bme-communities [Accessed: 17th February 2015]

Other formats, easy read etc. available upon request. Report will be published on the www.healthwatchdorset.co.uk website.

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