Mosaics of Meaning
Full Report
Exploring stigma and discrimination towards mental health problems with black and minority ethnic communities in Glasgow
Glasgow Anti Stigma Partnership
2007
Partners

This research project employed constructivist principles in order to develop shared understandings and insights about mental health and stigma. This required a real team ethos and a diverse community of practice. Accordingly, Lee Knifton and Nuzhat Mirza on behalf of NHS Greater Glasgow & Clyde would like to thank and acknowledge the contribution and commitment of the people and partner organisations involved in shaping and implementing the literature review and community research including:

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This report is jointly published by Glasgow Anti-Stigma Partnership, ‘see me’ and the National Resource Centre for Ethnic Minority Health and we would encourage you to use the findings, references and recommendations as a foundation for your own research, planning and development purposes. Papers are currently being prepared for peer reviewed publication and any citation from this report should be acknowledged. Both the full report and summary report are available at www.seemescotland.org. The project team are currently developing and implementing a range of projects based upon the intervention model developed and we are happy to discuss these further (our details are in the report). This report was designed by Blueline24 and edited by Pauline McLaren.
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Introduction

This report is a summary of work undertaken between 2005 and 2007 to research and address the stigma associated with mental health problems amongst black and minority ethnic (BME) communities in Glasgow.

As well as providing an overview of the work, it also reflects some of the findings of the Mosaics of Meaning report. That report has been the foundation of an innovative programme of social marketing and community interventions. The report, prepared by a partnership of organisations led by NHS Greater Glasgow & Clyde, has two major and complementary sections:

• A report of the findings of community focus groups that were conducted with Pakistani, Indian, Chinese, African and Caribbean communities in Glasgow. This section includes all the work done with local communities in Stage 1 of the project.

• A global literature review of attitudes towards mental well-being and mental health problems in Pakistani, Indian, Chinese, African and Caribbean communities. This section is a literature review which includes evidence from the UK and beyond, including countries of origin of some of the communities, and was undertaken by the Centre for Ethnicity and Health at the University of Central Lancashire.

The full report is available electronically (see the further information section at the end of this summary).

Rather than trying to summarise all of the rich and complex information in the report, this summary instead provides a taster to all the work and an overview of the process and major issues. It is hoped that practitioners and planners who may be considering work with specific BME communities in their areas will make reference to the full report. (Within the report, detail on attitudes within each community is presented separately for ease of reference.) The summary does not cover Stage 2 of the project which is a grassroots campaign of social marketing, providing information and shaping attitudes through direct contact with service users, community groups and mental health professionals.

Contact details for more information and discussion are included at the end of this summary.
Stigma and mental health problems

We know that in Scotland – and indeed throughout the developed world – there are more people recognised as having mental health problems than ever before. There is currently much research looking at the mental health of our population and how it could be improved.

This summary looks at a project with a very specific focus on mental health, namely the stigma associated with mental health problems amongst black and minority ethnic (BME) communities in Glasgow. As such it links strongly to the wider work of the national ‘see me’ campaign in Scotland: ‘see me’ is part of the National Programme for Improving Mental Health and Well-being in Scotland and specifically targets stigma around mental health problems. However, the research explores core beliefs within communities about the relationships between mental health and mental health problems. It therefore has implications for other elements of the National Programme, for example suicide prevention, recovery and positive mental health.

What is stigma and why is it important? One writer defines stigma around mental health problems as follows:

• Stigma refers to a collection of negative attitudes, beliefs, thoughts and behaviours, that influences the individual, or the general public to fear, reject, be prejudiced and discriminate against people with mental disorders. (Gary, 2005)

The World Health Organisation sees it as the result of “a process whereby certain individuals and groups are unjustly rendered shameful, excluded and discriminated against”. (WHO, 2002)

Such shame, exclusion and discrimination can make the person with mental health problems feel miserable and excluded from society, and thereby make the problem or state of mind even worse than it was. Equally important: “It is a barrier to those people who need mental health services, but who are reluctant or refuse to seek help because of the potential for discrimination and rejection by others.” (Gary, 2005) When these misconceptions are reinforced through community-level institutions, we start to see a process of structural discrimination. Difficulty in obtaining support and services makes it even harder for individuals to recover.
Stigma towards mental health problems in BME groups in Glasgow

If we accept that challenging stigma and discrimination around mental health problems is an important issue, why was it decided to have a separate project around stigma for BME groups in Glasgow? The reasons for this initiative were as follows:

• Cultural and religious attitudes to, and understanding of, mental health and mental health problems vary considerably within and across different ethnic groups. We were keen to ensure that we constructed a shared understanding of these beliefs and the nature of associated stigma and discrimination from community perspectives.

• This, together with language and other barriers, meant that some investigation was required to develop a framework to support communities to address mental health stigma. To inform an intervention model, it was important to find out whether the national ‘see me’ campaign, and regional anti-stigma work, was reaching BME communities effectively.

Understanding grew that a different approach would be required to help such communities address stigma around mental health problems.

Therefore, in 2005, funding was obtained for a joint project between ‘see me’ and NHS Greater Glasgow & Clyde to research and then address stigma relating to mental health problems in BME groups in Glasgow. The project was aimed at the four largest BME groups in the city, namely: Pakistani; Chinese; Indian; and African/Caribbean.

This project was intended as a pilot for Scotland as a whole – with the understanding that adaptation and additional research and development will be required according to local conditions and local communities.
What the project did not include

The project was confined to knowledge, beliefs, awareness, perceptions and attitudes towards mental health problems. It did not include patterns of mental health problems in BME communities or other barriers to treatment for such disorders.

The project also confined its scope to the four biggest established BME communities in Glasgow. It did not cover the many cultures and nationalities of the new asylum seekers and refugee communities in Glasgow; Gypsy/Travellers; or new communities of migrant workers from Eastern Europe or elsewhere.

The project did not try to compare stigma in BME communities against stigma in white communities. In reading about the project, it is important to bear in mind that stigma around mental health problems is present in all cultures and communities in Scotland.
Structure of the project

The objective of this project was to create a social marketing programme on mental health stigma for the four largest BME communities in Glasgow. The principles underlying the work were that:

• Cultural background is a key determinant of attitude towards mental health.

• The role of the project partners is to support communities to address stigma rather than to dictate the answers.

• The development of capacity amongst local organisations is a key part of the project.

Stage 1 of the project was about research involving:

• Action research within community settings in Glasgow: capacity was developed across several community BME agencies to undertake focus group research around mental health and stigma within the target communities.

• A literature review of published evidence around attitudes towards mental health within Pakistani, Indian, Chinese and African/Caribbean communities and cultures, whether in the UK or elsewhere in the world.

Each of these studies includes an exploration of approaches that have been used to support BME communities to address stigma, and what communities would like to see happen.

Stage 2 of the project is a grassroots campaign of social marketing, providing information and shaping attitudes through direct contact with service users, community groups and mental health professionals. This ‘community conversation’ about mental health will be delivered by partner organisations in a number of different formats. The work will complement the national ‘see me’ campaign of advertising and media work.
Further information and references

The full *Mosaics of Meaning* report mentioned in the introduction is available on www.seemescotland.org

The project team is also preparing journal articles on the work to be submitted to relevant academic journals.

For further information on the project please contact: NHS Greater Glasgow & Clyde: Lee.Knifton@ggc.scot.nhs.uk 0141 201 4790 or Nuzhat.Mirza@ggc.scot.nhs.uk 0141 201 4973

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To contact the national 'see me' campaign please call 0131 624 8945 or email info@seemescotland.org

References:


Chapter 2 Literature Review

Introduction

The existence of mental health related stigma is widely acknowledged as contributing to the disadvantage and discrimination faced by people experiencing mental health problems, particularly those with a diagnosis of serious mental illness, and as the most significant obstacle in the treatment of mental disorder (US Department of Health and Human Services, 1999). Action to tackle stigma has therefore become an area of concern for governments, professional bodies and national and international NGOs\(^1\). This has led to a call for, and the development of a range of initiatives both internationally (WPA, 1996; WHO, 2001) and within the UK (Shift; MIND, Rethink, Royal College of Psychiatrists, Scottish Executive etc.). However these initiatives have typically targeted efforts at populations rather than specific communities and hence there is little knowledge available to understand the nature of stigma within Black and minority ethnic (BME) communities. Mindful of this, NHS Greater Glasgow is undertaking a project to reduce stigma towards mental health in BME communities in Greater Glasgow.

This project has been developed and implemented under the auspices of “Glasgow Anti Stigma Partnership”, a collaboration of over 30 organisations, under the leadership of NHS Greater Glasgow and Clyde. There are over 15 collaborators supporting this project, including the national “See Me” campaign (itself a collaboration of 5 national mental health organisations), the National Resource Centre for Minority Ethnic Health, through to local area projects such as the Chinese Healthy Living Centre, and youth counselling services. Recent work with community projects in Glasgow, serving areas with higher numbers of Black and minority ethnic people, identified a desire by projects to develop their role in improving mental health (Sherwood 2006).

The Centre for Ethnicity and Health at the University of Central Lancashire was commissioned to support this project by undertaking a brief literature review on the mental health awareness, mental health beliefs and stigma within the four largest Black and minority ethnic communities in Glasgow (Pakistani, Indian, Chinese and African and Caribbean). Alongside this review, research groups, involving community members, are exploring patterns of knowledge and beliefs about mental health problems in the target communities, sources of stigma, and preferred approaches to communicating key messages about mental health. Together the findings of these two elements will provide a foundation of research upon which subsequent project approaches will be developed. These subsequent stages of the project are likely to involve various forms of social marketing (publicity, advertising), and face-to-face work (discussion sessions, training, group-work).

Structure of the report

The report provides an overview of the review. It starts with a definition of the concept of stigma and then sets out the background to the review, with an overview of BME communities in Glasgow and the work that has been undertaken so far that contributes to

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\(^{1}\) Non governmental organisations such as charities
understanding the beliefs, attitudes and experiences of these communities in relation to mental health and illness. This is followed by an overview of the review and how it was conducted – the method; its limitations; the results and difficulties which were encountered. The findings of the review in relation to knowledge and attitudes is summarised in the next section under each of the target communities and includes information drawn from their countries of origin, adopted countries and the UK. The following section summarises studies that have made cross-cultural comparisons enabling the factors that shape beliefs and attitudes to be identified. There is then an overview of stigma in BME communities and initiatives both in the UK and other countries that have been developed to tackle it. The report concludes by drawing out the implications for the development of initiatives to tackle stigma in BME communities in Glasgow.

A full bibliography is provided at the end of the report and includes the references cited in each section of the report. For ease of reference this has been organised into the following sections: general (background and relevant policy documents); sections on the specific communities; cross-cultural studies, and finally a section on stigma.
Background to the review

The concept of stigma

The Oxford English Dictionary defines stigma as “a mark of disgrace or infamy; a sign of condemnation, regarded as impressed upon a person or thing”. To stigmatise is defined as “to set a stigma upon, to mark with a sign of disgrace or infamy, to brand; to characterise by a term implying severe censure or condemnation”.

The concept of stigma is associated with Goffman (1963) who famously referred to stigma as ‘spoiled identity’. There are various definitions of stigma, which capture the concept that stigma, is a social process, which results in exclusion and discrimination by the majority group:

“(Stigma can be seen) as a sign of disgrace or discredit, which sets a person apart from others”

Byrne (2000)

“Stigma results from a process whereby certain individuals and groups are unjustly rendered shameful, excluded and discriminated against”

WHO (2002)

Indeed Goffman (1963) states that someone who is stigmatised ‘is disqualified from full social acceptance’. Fabrega (1990) describes this in relation to mental illness:

“Symptoms of psychiatric ill health have been characterised socially as frightening, shameful, dangerous, imaginary, feigned, fantastic, and incurable… lazy, idle, weak, helpless, unpredictable, unstable, dependent, and irrational. The psychiatrically ill are shunned, less likely to be hired, and less likely to be accepted as neighbours. The legal system is likely to make exceptions for psychiatric ill health, via a dispensation that formally stipulates a diminished social status”.

And as Gary (2005) writes:

“Stigma refers to a collection of negative attitudes, beliefs, thoughts and behaviours, that influence the individual, or the general public to fear, reject, avoid, be prejudiced and discriminate against people with mental disorders. Stigma is manifest in language, disrespect in interpersonal relationships and behaviours. It is a barrier to those people who need mental health services, but who are reluctant or refuse to seek help because of the potential for discrimination and rejection by others”.

Mental illness therefore has a negative social meaning and it is the interaction of thoughts, beliefs, feelings and behaviours that influence individuals, families, communities and the general public (Gary, 2005). The extent to which this is evident in the target communities will be considered in this review.

Stigma operates at different levels – individual, community and society and it can result in discrimination and exclusion from social activities. Stigma arises from attributions,
assumptions and stereotyping of people experiencing mental illness. These stereotypes, assumptions and frank inaccuracies are reinforced by social and cultural institutions. Rusch et al, (2005) describe some core assumptions typical of mental illness related stigma. These are first, that people with a severe mental illness are violent and should be feared and therefore kept out of communities; second, that they are irresponsible, so decisions need to be taken by others and third that people with a severe mental illness are childlike and need to be cared for. It has been suggested that mental illness related stigma is greater for people with a diagnosis of schizophrenia than depression, although people with schizophrenia are less likely to be held responsible for their condition than those with a substance addiction or eating disorder (Rusch et al, 2005). Much attention has focused on the role of the media in perpetuating myths and distorting the experiences and needs of people with mental health problems but this can happen in a range of ways, many of them subtle and covert. For people from Black and minority ethnic communities living in the UK, this is compounded by additional discrimination, stereotyping and racism.

For this review, stigma is being considered as the inter-play of knowledge, attitudes and behaviours that shape the response of individuals, organisations and communities to people with a mental illness. In order to understand stigma in the target communities in Glasgow it is necessary therefore to understand:

Patterns of beliefs and stigma in BME communities;
Knowledge levels and approaches taken to addressing and improving mental health literacy with BME communities;
Behaviors’ towards people with mental health problems within BME communities that may imply either stigmatising or supportive attitudes.

**Black and minority ethnic communities in Glasgow**

Greater Glasgow has the largest BME community in Scotland with 39,318 people (ie. 4.5% of the population ) recorded as living in the area in the 2001 Census compared with 2% for Scotland overall. Nearly half (45.7%) of the BME community is from Pakistan (45.7% or 17,964 people) with the other major communities being Indian, Chinese, other South Asian and African and Caribbean. A broad comparative analysis of separate health and wellbeing surveys amongst these communities was undertaken by ISM and NHS Greater Glasgow and Clyde during 2005 and published in 2006, building upon an earlier study in 2002. The analysis aimed to compare the health of these communities to that of the overall Glasgow population in order to identify health needs and health improvement opportunities. In four target community groups (Pakistani, Indian, Chinese and African and Caribbean), 1802 interviews were conducted with adults aged over 16 years (67% response rate). In the surveys, the participants had been asked a series of questions about their perceptions of their health and social circumstances. Some of the findings provide an interesting context to the issue of stigma that will be explored.

- Minority ethnic respondents perceptions of their overall health were more positive than those of the general population. Rating of mental health/positive mental well-being was varied. Pakistani, Indian and African/Caribbean communities had better perceptions than Chinese community members.
• Pakistani, Indian and African/Caribbean communities had better perceptions of NHS services than Chinese community members, possibly reflecting greater value being placed upon traditional approaches.

• All communities had experience of racism with higher reporting for African and Caribbean communities, and for younger people generally. Across all groups, older people were more likely to feel Scottish/British and less likely to identify with their ethnic backgrounds than younger members.

• All groups reported feeling more isolated from friends and family than the white community.

This analysis is useful in identifying shared perceptions and experiences, including levels of isolation and racism, as well as important differences in perceptions of mental wellbeing and health services.

Relevant work in Scotland

Within Scotland there has been additional research and survey work that helps to develop a picture of knowledge and beliefs about mental health at a general population level. There are five key reports:

1. The Scottish Public Attitudes Survey on Mental Health 2002 (NOP – Social and Political) and repeated in 2004 (MORI) gives us an indication of patterns of stigma. The study presents some indications of improvements in reported attitudes particularly in relation to perceived dangerousness and public protection. However it is possible that these cognitive changes are not reflected in changes in behaviour towards people with a mental illness and it is also likely that people with more negative attitudes were part of the sample that did not participate. The studies aimed to include a representative proportion of BME community members in the study (2.1%). In 2002 the study was given a booster sample of 51 interviews with individuals from BME communities but this was not repeated in 2004. However this was not a substantial enough sample from which to draw any robust conclusions about potential differences in knowledge and beliefs from the general population (itself not a homogenous group).

2. Equal Services - Report of Race Equality Assessment in Health Boards in Scotland (National Resource Centre for Minority Ethnic Health 2005). Whilst not directly about community stigma, this report includes a set of findings that are relevant for this review. It identifies factors, such as under-representation in services that may imply different patterns of knowledge, beliefs and behaviours towards mental health rather than being an accurate reflection of underlying need. Dual discrimination is identified echoing the findings from the Sainsbury Centre in respect of African and people from Caribbean communities (Keating et al, 2002). Recommendations include: representative staffing; greater BME representation on user groups etc; staff training on different concepts and presentations of mental health and distress within BME communities.
3. **See Me**: the national anti stigma campaign instigated a round table discussion to consider how the campaign could ensure that it was appropriate for Scottish BME communities. The discussion group raised a range of issues and hypotheses including the potential for and risk of faith based approaches and the suggestion that these should be led in conjunction with specific communities within local areas. It also suggested that many messages from the See me campaign would reach the target communities, particularly the younger generation. However the need for distinctly tailored messages and attention to language was raised together with an understanding of the additional discrimination faced by the communities arising from racist or gendered stereotyping.

4. **Glasgow Association for Mental Health Ethnic Minority Project – Promoting Awareness: Perception for Mental Health Needs for Black and Ethnic Minority Communities in Glasgow.** This study explored the views of BME community members who have experienced mental health problems and experienced negative attitudes indicative of stigma. Experiences of mental illness were described by users as frustrating with a lack of understanding by others and loneliness due to isolation in unfamiliar surroundings. Users reported a lack of proper diagnosis, with medication that was too strong and creates its own problems including side effects, weight gain and drowsiness, or with no effect in alleviating the symptoms. Carers were also frustrated, dealing with situations they had no experience of without any help or support from mainstream agencies, which they felt needed to be more appropriate, accessible and offer a range of services to cater for specific needs, along with home help. This demanding situation put the carers’ own mental health under strain.

Language presented difficulties for both carers and users, and was probably the most significant barrier to obtaining the necessary care and treatment necessary for their families or themselves. Causes of mental illness differed between ethnic groups, for example between Chinese and Pakistani/Indian communities. Pakistani and Indian communities expressed difficulties associated with ‘acculturation’ and ‘deculturation’, whereas the Chinese community’s main concern was around long working hours and finances. It cannot be assumed that minority communities share the same experiences and require the same services. Fitting into western culture was difficult for many. The communities knew little about existing mental health services and expressed a preference for voluntary services as they considered them more user friendly. Although the majority agreed mainstream services should become more appropriate, some felt separate service would be best.

Mental illness was described as an embarrassment. Consequently it is hidden and not spoken about, primarily because of the stigma attached to the disclosure of suffering from a mental illness. This can mean that assistance will not be sought readily but when it is, help is sought from a variety of sources particularly the GP but also community and religious sources of support. Mainstream services were considered inappropriate, as they were culturally insensitive, with a lack of appropriate interpreters, and inaccessible, generally because the communities were unaware of their existence and/or role. Those who had used services felt isolated. Communication was the biggest obstacle to accessing proper diagnosis and treatment, demonstrating a lack of cultural
understanding and empathy. This is crucial to understanding the patients’ feelings in context, and more importantly to aid correct diagnosis and treatment.

5. Equal Minds: Addressing mental health inequalities in Scotland. (Scottish Development Centre for Mental Health, 2005). Equal Minds is a ‘scoping’ research report outlining the issues and approaches required to tackle inequalities in mental health in Scotland. Using evidence from across the UK, examples of increased prevalence of certain mental health problems are cited for BME communities, specifically African and Caribbean men and young south Asian women. Factors which contribute to this situation are also reviewed: higher unemployment/poor employment rates, racism and discrimination (multiple stigma), and life events such as migration. Promotion and prevention issues are central to this report and the chapter on BME communities highlights two particular aspects which may be useful in understanding patterns of stigma: The first is the study of resilience strategies including “support from spiritual beliefs” (Wilson 2001) and “developing self healing strategies” (Essien 2003). Only one study could be traced that looked at mental health prevention/promotion specifically in the UK, the Cares of Life project in Southwark, London which aims to build community capacity to assist early intervention and build relationships between the Black community and statutory and non-statutory agencies (Olajide 2004).

Together these reports point to the heterogeneity of Black and minority ethnic communities in Scotland and Glasgow especially in terms of cultural and religious identity; age; experiences of migration and acculturation; experiences of using mental health services; and of racism and discrimination. These factors are likely to have an influence on knowledge and patterns of belief in these diverse communities.
The Review Method

Aim and review question

The aim of this brief review was to consider a diverse range of literature to identify:

- Knowledge and awareness of mental health and illness of Pakistani, Indian, Chinese and African and Caribbean communities living in the UK;
- Attitudes towards mental health and illness of Pakistani, Indian, Chinese and African and Caribbean communities living in the UK;
- Attitudes towards mental health and illness of Pakistani, Indian, Chinese and African and Caribbean communities in their countries of origin;
- Perception of stigma, and factors influencing negative attitudes towards mental health and illness in Pakistani, Indian, Chinese and African and Caribbean communities;
- Approaches to addressing stigma and negative attitudes in Black and minority ethnic communities, specifically Pakistani, Indian, Chinese, African and Caribbean communities.

The focus of the review is on the attitudes of the four largest BME communities in Glasgow (Pakistani, Indian, Chinese and African and Caribbean communities) towards mental health problems. This includes patterns of knowledge, beliefs, awareness, perception and attitudes towards mental illness. The review does not include patterns of mental illness or disorder in BME communities. The particular interest of the overall project is in stigma attached to mental illness and therefore language (i.e. terms used to refer to mental illness and people with mental illness) where available has been identified. The review does not cover the many cultures and nationalities of the new asylum seekers and refugees communities in Glasgow, Gypsy/Travellers or new communities of migrant workers from Eastern Europe or elsewhere.

Review Question

What awareness, knowledge and attitudes do the target communities living in Glasgow have towards mental health and mental illness?

Sub questions:

1. What language do the different communities use to describe mental health and mental illness?
2. Are there important differences between levels of knowledge and attitudes between their target communities living in the UK and their parent countries?
3. What factors influence negative attitudes towards mental health in Pakistani, Indian, Chinese and African and Caribbean communities?
4. What approaches have been used to addressing stigma and negative attitudes towards mental health in Black and minority communities, including Pakistani, Indian, Chinese and African and Caribbean communities?

5. What evidence exists as to the effectiveness of these approaches?

Search strategy

The parameters for the search are described below. The search was restricted to material published in English and from an initial scoping of the literature the date range identified as 1988, as the majority of studies were published after that date, up to 31.3.2006. The focus was adults of working age and although older people were not explicitly excluded, no searching was done in relation to Alzheimer's disease or dementia.

The databases searched were Assia, Central Cambridge Scientific, CINAHL, Cochrane, ERIC, HMIC, IBSS, Ingenta, Jstor, Medline, NICE (incorporating HDA evidence base), NRR, Refer, PsycInfo, Science, PubMEd, Social Care, SOURCE International Information and Support Centre.

As it was anticipated that much of the relevant research would be grey literature, additional strategies were used to identify relevant publications:

- Relevant research reports were sourced from the Department of Health, the Scottish Executive, non-government organisations such as the Scottish Development Centre, Sainsbury Centre for Mental Health, the Mental Health Foundation and the Mental Health Act Commission and Universities known to be undertaking relevant mental health research with BME communities;

- Examination of national databases for Scotland and England, namely the King’s Fund; the Care Services Improvement Partnership, CRER (Centre for Research In Ethnic Relations) and the Joseph Rowntree Foundation

- An internet search for relevant publications and projects was conducted using Google Scholar, BUBL, OMNI and organisations limited to the UK namely CEEHD - UK Centre for Ethnicity, Health and Diversity, Institute of Psychiatry, Diverse Minds, African and Caribbean Mental Health Association, Chinese Mental Health Association and the National Black Mental Health Network;

- Documents resulting from a mail shot/telephone inquiry to relevant organisations.

Search terms

The following key words were used in the search:

- Attitudes, perception, awareness, feeling, emotions, belief, knowledge
- Mental health, mental disorder, mental illness, mental ill health
• Race, ethnicity, black, ethnic minority, black and minority ethnic; BME; African Caribbean, West Indian, African, Caribbean, Pakistani, Indian, Chinese, Asian
• Stigma, anti-stigma, public attitude, public opinion, prejudice
• Advocacy, knowledge, help-seeking behaviour, health knowledge
• Promoting, mental health promotion, tackling stigma

Criteria for inclusion in the review

Inclusion criteria

• English language;
• Papers concerned with knowledge, beliefs, attitudes to mental health and mental health stigma in BME communities, specifically Pakistani, Indian, Chinese and African and Caribbean communities;
• UK and international papers.

Exclusion criteria

• Literature in languages other than English;
• Papers solely concerned with substance abuse, drug misuse and alcohol abuse or learning disabilities;
• Papers solely concerned with patterns of mental illness in BME communities specifically Pakistani, Indian, Chinese and African and Caribbean communities.

Analysis and quality appraisal

Reference manager was used to develop a database of the materials identified, and included in the review. The material was classified by target community. The categories for data extraction under these headings were:

• Language and key terms to describe mental health and ill health
• Knowledge and awareness of mental health
• Attitudes towards mental health
• Nature of stigma in the target communities
• Factors influencing attitudes
• Approaches to addressing stigma

The material was analysed with reference to the review questions and included a limited quality appraisal to identify the strengths and weaknesses of the particular contribution to the review question.

Limitations

The search was necessarily limited by time and resources and this has had the following impact. First, a limited amount of citation tracking was undertaken for all major studies and policy documents but no additional hand searching was undertaken. Relevant information was often buried in literature covering mental health more generally in the BME communities and a wider search may have yielded more results. Further no searching was undertaken on
terms used by the communities to describe mental health and illness such as “Jinni” in Pakistani communities or “Diankuang” in Chinese communities. Literature relating to dual heritage populations was not searched for, although no literature was identified during the course of this review. Finally there was no stakeholder involvement and clearly the review process would have benefited from this expertise and knowledge.

Results

87\(^2\) papers were identified which met the inclusion criteria and have been used in the synthesis. Nearly a fifth of these papers relate to African communities with few papers explicitly considering beliefs and attitudes in Caribbean communities. Nearly a third of all the papers refer to the UK and a notable proportion of these consider South Asian women. A summary is provided in Table 1.

The papers identified were predominantly Journal articles describing primary research. Only two reviews were identified. Other papers, which did not meet the criteria but provided helpful background, were also considered. These included profiles of the countries concerned, approaches to stigma in the general population and to tackling mental illness related stigma and the diagnosis of mental illness and experiences of mental health services of people from BME communities. They are included in the bibliography.

The studies highlight beliefs and attitudes towards mental health and illness and appropriate treatment in the target communities in the UK, their country of origin and other countries notably the USA and Australia. Direct comparisons between the studies are not possible because of the heterogeneity of the communities in terms of religious and cultural differences and the research methods that have been used. Further, differences in beliefs and attitudes may well differ depending on the type of mental health problem and many of the studies did not distinguish between beliefs and attitudes to common mental health problems, such as depression and anxiety, and psychosis.

A thematic analysis has been undertaken and, although it has been possible to identify clear themes, a number of difficulties were encountered in undertaking this review. First, the definition of these communities was often imprecise, conveying an impression of homogeneity and thus masking tremendous diversity. This was particularly evident in the use of the terms ‘Asian’, ‘East Asian’ and ‘South Asian’ and it was not always clear whether Indian, Bangladeshi, Pakistani, Chinese, other Asian or British communities were being referred to. It is difficult in these studies to identify the contribution of religious and traditional beliefs to attitudes to mental health and illness.

Second, linguistic differences presented a difficulty and attention has previously been drawn to the limits on any conclusions being drawn in the absence of linguistic equivalence around terms such as depression (Bhui & Bhugra, 2001). Third, relatively few UK studies were identified and therefore studies from the country of origin and other English speaking countries have been included.

\(^2\) Compared with 17 papers out of 156 which consider these communities in the bibliography to support the WPA programme to tackle stigma and discrimination.
However, to place these in context, a summary of the history and services offered for mental illness in the countries of particular interest to the study, Pakistan, India, China, Africa and the Caribbean is included.

However, probably the greatest difficulty is how differences are constructed between white Europeans, Australian and Americans and people from the BME communities. There is a strong tendency to view the prevailing culture as the norm; differing attitudes and behaviour may be measured against this and judgments made which favour the majority culture (i.e. ethnocentricity). This was evident in some of the papers and a more searching review would need to make this more explicit.

For example the term ‘supernatural’ is rarely defined but frequently used to describe a range of beliefs, including spiritual beliefs. Describing such beliefs as ‘supernatural’ may conjure up an image of irrational superstition rather than a belief in well-established and shared values, which have a long historical and cultural tradition. The term ‘supernatural’ is used within this report and is defined as ‘transcending the powers of the ordinary course of nature’ and includes beliefs in spirits and ancestral powers.

Similarly the concept of ‘somatisation’ has been criticised for implying a less well developed and more ‘primitive’ response to mental illness (Kirmayer & Young, 1998). It rapidly becomes evident from the literature that ‘somatisation’ may be influenced by a complex interplay of factors. In any event the evidence suggests that there is less stigma associated with ‘somatisation’ than with responses which are framed in terms of emotional responses. Caution therefore needs to be exercised if the criticism of cultural imperialism is to be avoided.

_________________________
Table 1: Results of literature search

<table>
<thead>
<tr>
<th>Focus by ethnic group</th>
<th>Number and type of publications</th>
<th>Location</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>UK</td>
<td>Country of origin or other English speaking countries</td>
</tr>
<tr>
<td>Asian</td>
<td>12</td>
<td>7</td>
<td>Includes papers, which refer to Chinese, Indian, Bangladeshi, Pakistani and other Asian populations. 5 papers considered women only.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>including 1 carried out in Glasgow 5</td>
<td></td>
</tr>
<tr>
<td>Chinese</td>
<td>15</td>
<td>4</td>
<td>2 UK papers considered are chapters in a book produced by the Chinese Mental Health Association and one is a training manual.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Indian</td>
<td>9</td>
<td>3</td>
<td>2 papers considered women only.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Pakistani</td>
<td>5</td>
<td>2</td>
<td>2 papers focus on the influence of Islam on beliefs relating to mental health and 1 is the outcome of an RCT of the impact of an intervention to promote mental health.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>African</td>
<td>17</td>
<td>0</td>
<td>The majority of these studies focus on Africans, mainly in African countries but also the US.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>Caribbean</td>
<td>9</td>
<td>3</td>
<td>Only 3 papers specifically looked at beliefs, attitudes or stigma. None of these were from the UK. The UK report and papers are concerned with disproportionate use of services by African and Caribbean men.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Cross cultural</td>
<td>16</td>
<td>9</td>
<td>These studies draw comparisons between attitudes and beliefs in the parent countries and adopted countries</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Stigma</td>
<td>4</td>
<td>1</td>
<td>These papers focus on stigma and do not differentiate between different BME communities and are therefore not included in the specific sections</td>
</tr>
</tbody>
</table>
Beliefs and causal attributions of mental health and illness in diverse communities

Asian Communities

Background

The Asian community is very diverse with many languages, religious beliefs and practices. As such, the causal attributions, attitudes and preferred treatments for mental illness are likely to vary. Cultural and religious beliefs have a profound impact on the perception and treatment of mental illness (Kleinman, 1987; Wynaden et al 2005) and it is commonly assumed that reluctance to access services in the UK reflects these beliefs and cultural traditions despite the lack of substantive evidence for this (Hussain & Cochrane, 2004). This section summarises studies that have not differentiated between different Asian communities.

1. Beliefs about mental health and illness

Belippa (1991) argues that the spectrum of normality and pathology is different for Asian communities and from her survey of 98 people from diverse Asian communities in London, suggests that, as Eastern philosophies do not make a distinction between mind and body, emotional distress is seen as affecting ‘the person’ not ‘the individual’ and thus emotional disturbances are less pathologised than in western societies.

A study in Glasgow of 159 British South Asians, mainly Punjabi, concluded however that there were no consistent differences between them and the general population in the way they described their distress, or in the description of psychosomatic symptoms (Williams & Hunt, 1997). They confirmed that ‘udasi’ and ‘gamgini’ in Hindi function in the same way as ‘sad’ and ‘depressed’ in English. They did find however that the Glasgow South Asian population was experiencing a more extended range of stressful situations and were two and a half times more likely to be distressed. The sources of this stress included absence of parents, stress in work around the house, a low standard of living and experience of being mugged and assaulted – with women showing higher levels of distress on a clinically validated measure.

The study of Asian communities in ‘Milltown’ by Hatfield and colleagues (1996) identified beliefs about mental illness from qualitative interviews with 106 Pakistani, Indian, Bangladeshi or East African Asians. The majority of people were not UK born, this was particularly marked for women, and nearly all were Muslims (100). It was clear from the interviews that most people experienced considerable social disadvantage, including hostility and intolerance from the white community, and this was reflected in the explanation of mental illness. The three factors, which were most commonly identified as causing mental illness, were social stress (87%), family problems (54%) and the will of God (34%). As the authors comment: (Hatfield et al, 1996, p. 331):

“The findings of this survey challenge some common assumptions about how mental health problems might be construed and responded to by people of Asian origin. Expectations that the experience of mental illness may be viewed more holistically, incorporating bodily and
religious/spiritual dimensions, were confirmed by some respondents but were less significant for others. A religious explanation ranked highly by many as a causal factor in mental illness, but more important factors were seen to be stresses in social and family domains. The overall picture is one of a complex and varied range of understandings of mental illness.

This plurality of causal explanations is reflected in studies that have examined what treatments people from Asian communities use during periods of mental illness. Dein (2001) for example examined the use of traditional healing among 25 South Asian psychiatric patients in the London Borough of Waltham Forest. The findings indicated that Asian patients were using a number of treatments concurrently, implying that the plurality of causal attributions is matched by a preference for plurality of interventions for mental distress.

Another UK study considered South Asian women’s accounts of their experiences of depression (Burr and Chapman, 2004). This study found that experiences of depression are grounded in and explained in terms of the subjective experiences and social context of women’s lives. The authors concluded that the women made strategic choices in how they presented their symptoms as legitimate in order to gain access to what they perceived to be appropriate healthcare. They make it clear that the presentation of symptoms is not a culturally specific phenomenon but a feature of all healthcare negotiations.

2. Attitudes to mental health and illness

The following themes were identified and reflect those identified by Wynadem et al (2005) in relation to barriers that prohibit people from Asian communities from accessing mental health services in Australia:

- **Shame and stigma**: Fear of shame is so intense in some communities that family members keep this a secret, and care for the individual in isolation. The community consider those experiencing mental health problems to be different from other community members. Wynadem et al (2005) use the term “hiding up” to describe the situation where information about mental illness is kept secret from the community and treatment is not sought in the, hope that the state of ill health will go away. The value placed on preserving family reputation means that there can be a reluctance to talk about mental illness even to a doctor and the higher the status in society the less likelihood of speaking about it, regardless of educational achievement.

- **Causes of mental illness**: The tendency to attribute mental illness to spiritual reasons varied according to country and age. The knowledge within the community regarding mental illness is dictated by educational achievement, with those with higher educational levels more likely to believe in genetic/hereditary reasons and those with more limited educational experience more likely to hold traditional beliefs.

- **Seeking help**: Various methods are used; the preference is for prayers and visits to temples and churches. In order to keep confidentiality, non-Asian general practitioners will be used; alternatively, general practitioners from the country of origin will be contacted because they are believed to have a better understanding of cultural issues. Using mainstream services is the least favoured option being accessed only when the person is too ill to be looked after.
Indian Communities

1. Background

Since 1500BC in the Atharva Veda, the most authentic Indian medical scripture, insanity – unmada⁴ has existed. It describes conditions similar to schizophrenia and bipolar disorder, and distinguishes physicians and surgeons from doctors practicing magical medicine. The Ramayana and Mahabharata referenced disorders of the mind and how to cope with them (Trivedi, 2000). Three distinct indigenous systems of medicine are practiced in India: Ayurveda, Siddha and Unani all of which predate Western medicine (Thara et al 2004).

The first mental hospital in India was in Calcutta in 1787. General hospital psychiatry services became attached to medical colleges and were developed in the 1930s intensifying in the 1960s. Traditional healers are found mainly in private hospitals and the preference for them is attributed to cultural factors ‘such as explanatory models of ill health and treatment that the patient understands’ (Patel et al, 1997). However both traditional and orthodox healers are used (Trivedi, 2000).

Religious centres are also an important place for treatment as mental illnesses are assigned to ‘divine wrath, curse, black magic or Karma of a previous life’; therefore stigma is not placed on the individual. Treatment includes prayers and ‘bathing in the temple tank’. The first resort for many Indian families is alternative treatment and particularly religious healing.

2. Beliefs about mental health and illness

Joel et al (2002) used the Short Explanatory Model Interview to explore explanatory models of psychosis of community health workers in India. They found a wide variety of beliefs with the majority of the sample attributing problems to economic difficulties. The majority of health workers held at least one non-biomedical belief about psychosis and as well as poverty, these included black magic and evil spirits. The authors conclude that non-biomedical beliefs can delay early recognition and interfere with medication compliance. Indeed a survey of state run general hospital services found that one third of people with schizophrenia did not access these services (Padmavati et al, 1998). It was found that families who cared for relatives as part of the extended family used services less often, the families stating they had got used to their relative’s ill health. Families had to be persuaded to take up these services. The family is an integral part of the process of treatment and is a key influence on the form of treatment the person may have. Further, and regardless of their financial circumstances, families consider it their responsibility to care for their relative. The better prognosis for schizophrenia in India has been attributed to this coping style.

Attitudes to mental health and illness

Raguram et al (1996) examined the role of self-perceived stigma in depression in Bangalore. They found that the greater severity depression was associated with higher stigma scores whilst more somatisation was associated with less stigma (Raguram, 2004). From their qualitative analysis of narratives they also found that patients viewed depression, but not

⁴ Pronounced oon-ma-tha
somatisation, as socially disadvantageous because the latter resembled illnesses that most people could expect to get at some point.

**Pakistani Communities**

**1. Background**

There are four major ethnic groups in Pakistan which has a rich cultural heritage and encompasses many ancient cultures. Islam is the main religion and advocates care of and compassion towards people experiencing mental illness. It is believed that good behaviour will be rewarded in the after life. Religious healers are often the first point of contact for the sick and their families usually detect mental illness early. The number of trained mental health professionals is small and specialist services are virtually non-existent (Karim et al, 2004).

Traditional healers use ancient or herbal medicine, such as ‘khalifs, gadinashins, imams, hakims (Ayurvedic medicine) and others involved in magic and sorcery.’ Also ‘alternative’ healers exist such as homeopaths which are popular often amongst poorer people and are favoured for being more natural and having few, if any, side effects.

**2. Beliefs about mental health and illness**

In Pakistan, religion is one of the primary influences on mental well-being and is regarded as far more important than physical health. Good mental health leading to ideal conduct (as outlined by religion) is considered the best representation of man being “God’s agent on earth” (Karim et al, 2004, p.84). It is widely believed that mental illness is caused by supernatural forces such as spirit possession, jinni, black magic or exaltation, or “testing by God as punishment for one’s sins”.

Hussain (2006) provides a description of the relationship between Muslim beliefs and mental illness. Whilst this is being considered here, clearly Muslims are part of other communities, notably Indian and African communities. Hussain writes that “there is a strong tendency to conceptualise illness as occurring according to the will of God (allag), who is understood to be a higher power that cannot be perceived by the senses”. Human suffering is looked upon as being a means to an end. Sometimes people with an illness are asked to pray for others, as they are regarded to be purer in Allah’s sight. Emotional stresses are typically communicated through somatic or physical complaints with the upper body and mainly heart (ryh, nafs, quib) often identified as the location of the emotional pain. Hussain continues:

“Mental unrest is thought to be the manifestation of an incongruent heart – an unstable soul- that is lost and so has become distant from its ‘creator’, Allah. In this sense, a stable or sound or sound state of mental health is a ‘well’ or ‘true’ or ‘clean’ or ‘guided heart’ that is calm and so is within the sanctions of Islamic teachings. A ‘rusted’ or ‘hard’ heart is a symptom of chronic ill feelings and ultimately God’s displeasure. This state is described as an aching heart, a trembling heart and pressure in the heart”.

26
Other causal beliefs that have been identified include bodily dysfunction (Hussain, 2006), taking Western drugs and stresses associated with deprivation.

A detailed study of knowledge and attitudes to mental health and illness of a Pakistani community in the UK was undertaken by Tabassum et al (2000). Their study focused on two generations of Pakistani women living in a fairly deprived part of Sheffield and their responses were compared to those of Pakistani men on the following items - knowledge of mental illness; help seeking behaviour; families perception of mental illness and the impact of the experience of the mental illness on an individual’s perceived status in the community. They found that responses to the likely causes of mental illness were similar across gender and generations, with stress at home being most frequently identified. Women were more likely than men to identify strained relationships as a cause and 27% of the total sample selected “supernatural causes”. Only second generation women mentioned racism as a possible stressor and the authors concluded that this reflected the circumstances of first generation women who were unlikely to speak English and were relatively isolated from the general population.

3. Attitudes to mental health and illness

Mental illness is stigmatised and is believed to be widely attributed to supernatural causes in Pakistan (Karim et al, 2004). In particular, behaviour that is embarrassing, or draws attention towards the individual or family, is considered unacceptable (WHO, 1999). Mental illness may be discriminated against in education, employment, health care and social opportunity in Pakistan (Karim et al, 2004).

In the Tabassum study in Sheffield, participants indicted a general willingness to interact at a superficial level with someone experiencing mental illness but none of the sample would consider marriage; less than a quarter would consider a close relationship and there was a marked reluctance to let children even speak to someone with a mental illness. Further it was clear that hospitalisation for treatment also carried a significant stigma. Indeed Tabassum et al (2000) observed that there was an expectation that families would cope with their own problems and that seeking help outside the family was a last resort. They concluded that there was evidence of prejudicial attitudes towards those suffering from mental illness emphasising the honour of the family and adherence to cultural norms as contributory factors.

**Chinese Communities**

1. Background

As with the other target communities, the Chinese community is highly diverse (Yee and Au, 1997). The Chinese tradition for health care is a holistic approach where mind and body are treated as one, using the “yin-yang” concept of balancing the body, and is based on a strong religious belief. The usual treatment for mental disorders was traditional Chinese medicine before the twentieth century. This system is based on ‘syndromes’ for diagnosis, which is a state of health. Mental illness was diagnosed as part of this ‘wholeness’, and as such symptoms were presented somatically.
2. Beliefs about mental health and illness

The Chinese believe in taking a holistic approach to health treatment where the body and mind are treated as one. This is often contrasted with the Western tradition and mind/body dualism (Shia, 1997) although Western practitioners are now developing a more holistic approach. Traditional Chinese medicine is founded on religious teaching such as, Buddhist philosophy and Confucianism. Key concepts are karma, which refers to every action having a consequence (law of cause and effect), reincarnation and Chin-say, misdeed or having too many desires (Wynaden et al, 2005). Jingshen is used to refer to a person's mental health and is usually translated as “spirit”, “mind” or “consciousness” (Wong & Richman, 2004). Psychological problems are viewed as spiritual in origin. Associated with this are concerns about family reputation; loss of face; shame; guilt and embarrassment.

Confucianism teaches respect for elders and group orientation whilst Taoism stresses the balance of yin and yang. Traditional Chinese cultures also have beliefs associated with animism; supernatural beliefs such as vengeful spirits or possession by evil spirits. These beliefs continue to be important to the Chinese community (Yeung, 2004). Chinese people may also believe that ill health is due to family wrongdoing (Blackwell, 1997) or a mother passing bad blood to her child (Wynaden, 2005).

The Chinese have developed their own diagnostic system, the Chinese Classification of Mental Disorders, which is close to the Western system (Shu et al, 1998) but the old system with somatic complaints is still used in practice. Exposure to Western explanations of mental illness is likely to have an impact on the attributional models. A recent study in Australia (Parker et al, 2005) found that the greater the degree of acculturation, the greater the tendency for reporting persistent and impairing depressive episodes. Whilst this warrants further research investigation it does sound a warning note about the dangers of privileging western explanatory models.

A training manual to improve access to mental health services for Chinese people (Yeung, 2004) describes somatisation as a cultural trait that permeates Chinese society, whether Chinese people are living in predominantly Chinese society or a predominantly white one. Yeung (p. 22, 2004) writes:

“Somatisation offers an effective defense against potential social stigma attached to mental illness. It also offers protection from exposing one’s innermost feelings as the Chinese are very reluctant to express their emotions to a stranger, especially when it is related to negative and sexual feelings”.

Yeung (p.19, 2004) goes on to refer to classical Chinese descriptions of mental illness, which have distinguished two typed of aberrant behaviour. Kuang, or ‘psychosis with excitation’ is similar to descriptions of positive symptoms of schizophrenia and bipolar disorder and is attributed to excessive yang energy. Dian, or ‘psychosis without excitation’, similar to negative symptoms of schizophrenia is due to excessive yin energy. Treatment is therefore aimed at restoring the balance of yin and yang.
3. Attitudes to mental health and illness

In a survey carried out in a US out-patient clinic in Hong Kong, stigma was a common experience for those diagnosed with schizophrenia (Chung and Wong, 2004). In a study drawing on the Chinese community in Manchester, Wong & Richman (2004) explored their understating of the term “Dian Kuang”, which literally translates as “Dian-insane and Kuang-crazy and violent”. They conclude that this term evokes the same stigmatising beliefs as those held in the general population and conjures up images of unpredictability. Over half of the 16 people interviewed said people with Dian Kuang must be isolated and a quarter thought that it should be kept a secret including an eighteen year old British born Chinese person (Yueng, 2004).

Stigma is so deep rooted that those experiencing mental health problems may not tell family members, friends or the community for fear of rejection. Blackwell (1997) identifies one coping strategy is to hide the illness and if necessary avoid treatment for treatable diseases, similar to 'hiding up' described by Wynadem (2000). Shame and guilt are important concepts in understanding attitudes to mental illness with families of people with a mental illness fearful of being exposed to criticism, disgrace and losing face (Yeung, 2004).

The assumption that the extended family is a support network for those experiencing mental illness in the Chinese community may not always be accurate. Indeed Lee (2005) found that the impact of stigma from family members was more ‘hurtful’ than from the general community, as this could be concealed. Users expressed a lack of supportive relationship and blame from some family members. The observed reaction of some families to mental illness has led Li et al (1999) to comment that this “undermines the stereotype of the Chinese family being a consistent resource for ‘looking after their own’.”

A UK study by the Mental Health Foundation (2000), found 56% of those with a mental illness suffered discrimination from within the family, 47% from the workforce, 51% from friends and 44% from general practitioners. Li et al (1999) argue that loneliness, harassment, discrimination and the breakdown of the family unit contributed to poor mental health. In a study comparing diabetes and schizophrenia for stigma, 57.2% of patients’ families thought they were violent and 68% of patients received negative comments from their families.

Chung and Wong (2004) noted that experience of rejection was very low when associated with mental illness from their study in Hong Kong. This could be due to the fact that many use secrecy; avoidance or withdrawal as coping strategies, for reasons noted above. The most common form of rejection experienced was by media portrayal of mental illness, but generally they were treated fairly by others. One participant, however, reported that when he disclosed his mental illness his reaction was ‘I had never imagined my senior to be so supportive! One of my colleagues knew of my mental illness and looked down on me... Not only did my senior accept my ill health, my senior talked with the colleague who looked down on me and asked the colleague not to discriminate against people with mental illness”.

Chung and Chan (2004) conducted a randomized study with school children using vignettes to investigate whether language had an effect on stigma terms included jing-shen-fen-lie-zheng (mind-split-disease) terminology for schizophrenia, si-jue-shi-diao (dys-regulation of
thought perception) symptoms of schizophrenia and labels si-jue-shi-diao, jing-shen-fen-lie-zheng, jing-shen-bing. The findings indicated that changing the language to less pejorative terms did not reduce social stigma.

**African Communities**

1. **Background**

Africa is the second largest continent made up of over 50 countries and has 1,000 cultures. Many African countries acquired mental institutions during colonial rule. Until very recently most have remained as inherited, with Europeans running them. However, indigenous systems of medicine existed in many African countries, with medicine men treating mental illness using certain herbs and psychological techniques.

2. **Beliefs about mental health and illness**

In many African countries causes and treatment of mental illness are influenced by traditional beliefs in the supernatural (Njenga, 2002; Gureje and Alem, 2000). Tanzanians considered mental illness to be an ‘incurable curse’ (Njenga, 2002), whilst in Zambia the reasons given for mental illness include social punishment, spirit possession or witchcraft (Mayeya et al, 2004). Similarly in Kenya, mental illness is viewed as caused by supernatural powers, such as evil spirits, to atone for sins committed by the clan against the ancestors, as a result of being bewitched. The younger generation however, due to acculturation and Western influence, is more likely to consider mental illness alongside physical ill health (Kiima et al, 2004).

In Nigeria, Kabir et al (2004) used a semi-structured questionnaire to elicit beliefs about the causes of mental illness and the respondents identified drug misuse, including misuse of alcohol, street drugs and cannabis, as a major cause of mental illness. God’s will, traumas, accidents and spirit possession were also identified. These findings are confirmed by Gureje et al (2005) who undertook a multistage, clustered sample of household respondents, in three states in the Yoruba-speaking parts of Nigeria. Most respondents thought those with a mental illness were responsible for their ill health, due to substance misuse, possession by evil spirits, or a punishment from God with only a small percentage attributing mental illness to biological factors. In Zimbabwe, people experiencing depression may present with somatic symptoms but attribute these symptoms to “thinking too much” (“kufungisia”) as well as to supernatural causes and social stressors (Patel et al, 2001). It is interesting to note that symptoms can be described in somatic terms, in Gambia often with reference to the brain or heart. Post traumatic stress disorder is described as “Mir Kurando” (the thinking sickness) (Fox, 2003). In Zambia ‘problems of the mind’ are used by women to describe stress and depression. Also in Zambia, in a study of the explanatory models of mental health amongst low-income women (Aidoo & Harpham, 2001), the socio-economic environment (particularly material and relational factors) was identified as being behind the major causal factors for mental illness. These factors included poverty, lack of education, lack of economic opportunities, and relationships within the home, particularly the quality of marital relationships. A minority included a belief that fate or the power of God was the cause and some made vague references to ‘mashabe’ (spirit) as the cause.
In Kenya, the majority of those suffering from mental illness will consult traditional health practitioners, and most have a history of visiting various health facilities prior to consulting a traditional practitioner (Kiima et al, 2004). Faith healing is common for those with a religious persuasion and has been quite effective (Kiima et al, 2004). Traditional healers and religious leaders often administer to those experiencing mental illness (Maveya, 2004) with conventional medicine rarely the first port of call (Alem et al, 1995). In contrast, the treatment preferences identified by the Kibir study in Nigeria (2004) were ‘orthodox medical care’ followed by ‘spiritual healing’ and then ‘traditional herbal medicine’. Gureje and Alem (2002) reported community members believed mental illness was incurable, unresponsive to orthodox medical practice, and that community collaboration was necessary as a valuable resource.

No studies were identified which looked at the knowledge and beliefs of Africans living in the UK and this will reflect, in part, the exclusion of studies considering refugees and asylum seekers. One study was identified which explored meanings of mental distress with African communities in Australia (Tilbury et al, 2004). These communities were Sudanese, Somali, Eritrean and Ethiopian. This study identifies the diversity of perceptions regarding mental health amongst these apparently homogenous communities. The African communities reported the absence of equivalent words for depression in any of the local languages (Amharic, Tigrinya, Sudanese or Arabic dialects). As the authors (Tilbury et al, 2004, p2) comment:

“The closest terms (to depression) were anger, craziness, anxiety, self-pity, constant worry, grief, discomfort, frightened and sadness. Words in these languages denoting emotion-states were not connected with western concepts of normal or abnormal mental states. Rather terms for ‘abnormal mental states’ were translatable simply as ‘madness’ or ‘craziness’ (‘ek’) and referred to more severe psychoses. It is more acceptable for women to express emotions than men, as illustrated in a common Ethiopian idiom: ‘women cry on the outside, men cry on the inside’”.

The participants in this study identify their status as migrants as the most important factor that produced emotional stresses and could lead to depression. Men in particular identified unemployment and working below their capacity as major stresses. Both men and women identified other stresses associated with migration such as accommodation, dealing with new systems, language difficulties, racism and continued responsibilities for families back home. Women also identified the increased workload and a loss of traditional extended networks as key. They also identified changes in relationships with men as a result of migration with a lack of support from men coping with coming to terms with migration.

3. Attitudes to mental health and illness

Adewuya & Makanjuola (2005) observe that although it is widely held that there is less stigmatisation of mental illness in Africa than in other places, the research is not available to confirm this. The findings from the studies cited above suggest that negative attitudes are common. In the study by Gureje and colleagues (2005), respondents considered those with a mental illness to be violent and dangerous and many indicated they would not associate
with them, leading the authors to conclude that negative attitudes are held about mental illness and stigmatisation is widespread within the communities. This is supported by the finding from Kibir et al (2004), which indicated that aggression is believed to be associated with mental illness with female respondents indicating a higher level of fear than men, possibly reflecting cultural norms. Adewuya & Makanjuola (2005) used a modified version of Bogardus Social Distance Scale with university students in Nigeria to assess the degree of social distance towards people with a mental illness. The study found that 65.1% of respondents had a ‘high degree of social distance’ with people with a mental illness and concluded that programmes need to be developed to combat this.

Fear of stigma and anticipation of negative attitudes lead to delay, or indeed unwillingness to access appropriate care often (Gureje, 1996). Education appears to have an influence, with those with higher levels of education displaying more positive feelings towards those with a mental illness.
Caribbean Communities

1. Background

Caribbean people have a different history to that of the other groups in this study, primarily due to slavery and this has had a profound effect on their beliefs, religion and values.

The Caribbean is made up of 7,000 islands, islets and reefs. There are 28 territories including sovereign states most of which were colonised by European countries, resulting in a fusion of cultures reflected in today’s population of Africans, Asians and Europeans (Fryer, 1984). For the purpose of this review, we are concerned with this group commonly referred to in most reports as Afro-Caribbean and African-Caribbean. African descendants are the largest groups on most of the islands and consequently their cultural and religious beliefs have been shaped by their pre-colonial history from Africa.

This community has retained many of the African religions, belief system and values, and have developed the languages of Creole and Patois, as a common language, Patois sometimes being referred to as a dialect. The majority of Caribbean people in the UK are from the former British colonies which are English speaking.

Most of the psychiatric institutions in the Caribbean date back to colonial rule and were established under British rule, with British psychiatrists in charge (Mahy et al, 1999). However, the majority of islands do not operate psychiatric institutions and, in the past, many islands shared facilities.

The over-representation of the African-Caribbean community within mental health services in the UK has been well documented (Health Care Commission 2005; Littlewood, 1996; Thornicroft et al, 1996). The emphasis of these reports has been on the disproportionate rates of admission and detention under the 1983 Mental Health Act and the associated experience of racism and discrimination in mental health services (see for example – Keating et al, 2002; Harding, 1995). This has been an area of major concern within the Caribbean community. Little, however, has been written about the beliefs, understanding and attitudes towards mental health within this community.

2. Beliefs about mental health and illness

Religion is a very important aspect of Caribbean tradition, and many religions are rooted in African or Christian belief systems - these include, Rastafari, Spiritual Baptists, Christian and Catholicism (Swatos, 2006), with Christianity being the most common in the English speaking Caribbean (Mahy, 1999). Faith for many Caribbean people is the norm (Raji, 2004), an important reference point in times of crisis and is used as a coping mechanism (Social Policy Research, 1997); However, this has often been misinterpreted by the medical profession and viewed as symptomatic of mental disorder (Morrison and Thornton, 1999). Black Minority Churches play an active role in ministering to people with a mental illness through counseling (MacAttram, 2006) and spiritual healing (Mahy et al, 1999). This is confirmed by other studies that have highlighted the importance of God and the Devil, magico-mystical beliefs (Kiev, 1963; in Mahy, 1999), reincarnation and spiritual healing (Mahy et al, 1999). Hallucinations are widely accepted, particularly amongst Black Baptist,
Black Methodists and Church of God members, and are positively valued. However their associations with mental illness make it difficult to report in early illness as they are likely to be viewed as symptoms of mental disorder rather than valued experiences. Consequently, the necessity for clinicians to be able to distinguish between cultural hallucination and mental illness has been identified (Al-issa, 1995).

De Toledo & Blay (2004) undertook a literature review to identify public perceptions of mental disorders in Latin American and Caribbean countries. They identified 10 papers published between 1980 and 2001 but only one focused on a Caribbean community (Kohn, 2000). This study found that community leaders recognised the presence of the experience of mental illness less than did the community with psychosis most commonly recognised as mental illness. Most of the participants indicated that they would seek help from a physician for mental illness. This is consistent with the overall findings from de Toledo and Blay’s (2004) study which found that despite regional variations Latin American and Caribbean countries generally share the beliefs associated with the Western medical model. However, they make the point that these beliefs co-exist with other beliefs and practices particularly the greater importance of family and social networks in mental health care and the importance of religious or spiritual resources in the understanding and treatment of mental disorders (p. 956).

Those studies that have considered the experience of African and Caribbean communities of mental health services in the UK have identified racism and discrimination both as a source of mental distress and of stigma (Fernando, 1990; Keating et al, 2002; Mahy 1999; Agbolegbe, 1991). The survey by Sashidharan and Walls (2003) reported a lack of culturally sensitive staff; failure to understand religion, over-medication; lack of counseling and appropriate aftercare; lack of information; coercive treatment and general neglect. The medical model of care was strongly criticised for not addressing the social and cultural context of mental illness leading to a failure to diagnose correctly (Shashidharan and Walls, 2003).

3. Attitudes to mental health and illness

Stigmatisation around mental illness has received little attention within the Caribbean context. The major source of stigma appears to be related to mental health services as noted above. From these studies, a lack of trust and fear is associated with mental health services as Keating et al, (2002) comment:

“Black people see using mental health services as a degrading and alienating experience: the last resort. They perceive that the way services respond to them mirrors the controlling and oppressive dimensions of other institutions in their lives e.g. exclusion from schools, contact with police and the criminal justice system. There is a perception that mental health services replicate the experiences of racism and discrimination of Black people in wider society, particularly instances where individuals have experienced the more controlling and restrictive aspects of treatment.”
One study has also identified stigma associated with depression. In this study of West Indian Canadians, the women believed their strength would enable them to overcome their depression (Schreiber et al, 1998).

**A Mosaic of Meaning**

Across these diverse communities it is evident that they share a conception of mental health as a sense of harmony; of being in balance and of peace. This is underpinned by a concept of community harmony and belonging. This holistic concept of mental health and emotional well-being embraces a diverse range of causal explanations for mental illness. In other words, mental illness is attributed to different causes by different individuals in different communities thus creating a mosaic of meaning\(^5\). The causal beliefs, which have been identified by this review, are:

- Mental illness as a consequence of stress
- Mental illness as a consequence of social deprivation; living in poverty, poor accommodation and unemployment
- Mental illness as a consequence of migration; loss of status, associated socio-economic deprivation and changes in family relationships
- Mental illness as shameful and bringing the family and community into disrepute
- Mental illness as a consequence of difficulties in relationships; problems and worry with children, quality of marital relationships
- Mental illness as punishment for wrong-doings
- Mental illness as God’s will
- Mental illness as possession by spirits or demons
- Mental illness as illness
- Mental illness as a consequence of misusing drugs

The factors which shape these beliefs and the stigma associated with mental illness are considered in the next section.

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Factors influencing knowledge and attitudes to mental health and illness

Those studies that have compared attitudes and beliefs across different cultures provide an insight into the factors that influence attitudes. A synthesis of the key themes is provided in Table 2.

Weiss et al (2001) used the Explanatory Model Interview Catalogue (EMIC) for studying illness-related experience, and user narrative accounts to compare the nature of stigma in a white British population in London and amongst Hindus and Muslims in Bangalore, India. In Bangalore, the narrative accounts highlighted the importance of good standing within the community, self-respect, self-esteem, and being well connected socially. Fulfilling family obligations is important: for men this means taking care of the family and for women it means being acceptable for marriage. Ill health is sometimes viewed as a sign of weakness and providing an opportunity for others to take advantage. Even though there were recognised benefits to be gained from disclosure, many users did not even tell family members, principally because of concerns that it would cause pain and suffering to other family members. Men however, were less concerned about social disapproval, and more concerned about their inability to provide for their family. Social stigma for women was more difficult because of the implications for arranged marriages. In London, interviewees identified stigma by name and spoke of being a burden, of weakness and loss of friends. They described how assertive behaviour could be mistaken for aggression or inappropriate behaviour. People in both countries revealed how stigma affects their everyday life, although the nature of the concerns was different across cultures.

Cultural differences in beliefs were confirmed by Sheikh and Furnham’s (2000) study of 287 adults belonging to three groups (British Asian, Western European and Pakistanis) also using the EMIC and the Orientations to Seeking Professional Help (Fischer and Turner 1970) and a demographic data sheet. The results indicated that positive attitudes toward seeking professional help for psychological distress were similar for all three groups but that there were significant differences between the three groups in the causal attributions of mental distress. On the other hand, culture, as a variable, was not a significant barrier to seeking help for the British Asian and the Pakistani groups.

Another UK study (Pote & Orrell, 2002) explored lay perceptions of mental health problems, particularly schizophrenia, across different ethnic populations living in Britain and the influence of ethnicity in relation to other variables such as age, gender, religion and contact with people with mental health problems. Using the Perceptions of Mental Health Problems Questionnaire, 190 participants from five broad ethnic groups (African and Caribbean, Bangladeshi, Indian, Sub-Saharan African and White British) reported their perceptions of schizophrenia symptoms. In comparison with the White British group, Bangladeshi participants were less likely to view suspiciousness or hallucinatory behaviour as indicative of mental health problems, and African Caribbean participants were less likely to view unusual thought content as a symptom. Although differences in perceptions were also associated with religion, education, gender and contact with people with mental health problems, the authors concluded that ethnicity was the best predictor of perceptions of schizophrenia symptoms.
Studies from other countries found that people from minority ethnic communities are less likely to endorse aetiologies consistent with biopsychosocial beliefs about mental illness than the indigenous populations of the host country. The findings regarding belief in supernatural causes are less consistent. In a US study, Yeh et al. (2004) found parents of African American, Asian/Pacific Islander American, and Latino youths were generally less likely than parents of non-Hispanic Whites to support a biological explanation but there were no differences evident for sociological, spiritual or nature disharmony aetiologies. Analyses controlling for factors including child symptomatology produced fewer significant racial/ethnic differences but a similar pattern of results.

Whilst these studies have primarily sought to explore whether there are differences in beliefs, common themes are also evident. In particular, several studies have identified the stresses associated with migration as a significant cause (Tilbury et al., 2004, Taha & Cherti, 2005, Rooney, 2005). In a recent consultation exercise involving 20 consultations with more than 35 community groups in Kensington, Chelsea and Westminster, participants defined mental well-being as “having peace of mind”, “being balanced mentally”, “not having extreme emotions” and “coping with day to day activities and events with peace” (Taha & Cherti, 2005, p. 11). These communities involved participants from Africa, the Caribbean and Morocco as well as refugees and asylum seekers from the Middle East, Africa and South Asia. Many of these participants identified poor mental health as a part of their life in the UK as a minority or as refugees or asylum seekers. The majority of participants indicated that they would not tell their friends, relatives or neighbours about their mental health problems for fear of being labelled, isolated or alienated by their friends, community or in some cases their families. They also shared a perception that people with a mental illness are violent, out of control and that there is a stigma associated with accessing mental health services.
Table 2: Factors influencing beliefs and attitudes towards mental health and illness within the target communities

<table>
<thead>
<tr>
<th>Sphere of influence</th>
<th>Nature of the influence</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Culture based role expectations e.g. men’s role to provide for the family compared with expectation that female will secure a good marriage. Women more likely to identify relationship difficulties as a potential cause. First generation women may be more isolated than men or subsequent generation because of language and cultural practices.</td>
<td>May influence willingness to disclose experience of mental illness. May reflect underlying social issues. Will need to influence strategies to address knowledge and stigma – use of English language media may be inappropriate.</td>
</tr>
<tr>
<td>Age</td>
<td>Belief in ‘supernatural’ causes. Results conflicting with Sheikh and Furnham study finding those under 35 had a greater belief in ‘supernatural’ causes whilst Dein (2001) found older people more likely to use traditional healers. Tabassum et al (2000) did not identify a difference between two generations of Pakistani women.</td>
<td>May influence treatment preference.</td>
</tr>
<tr>
<td>Level of education</td>
<td>Higher educational levels associated with stronger beliefs in biological causes in some Asian communities but the willingness to disclose the experience of mental illness is inhibited by concerns about shame, for example in the Chinese community, regardless of educational levels. De Toledo et al found an association between positive attitudes and higher levels of education.</td>
<td>May influence treatment preference.</td>
</tr>
<tr>
<td>Religion</td>
<td>Belief in higher authority</td>
<td>Prayer and spiritual healing.</td>
</tr>
<tr>
<td>Family</td>
<td>Fulfilling family obligations Not wanting to harm family or bring family into disrepute</td>
<td>Concerns for privacy and to not disclose mental health problems.</td>
</tr>
<tr>
<td>Community</td>
<td>Importance of maintaining a good image Avoidance of shame which is built on a concept of communal harmony The understanding and role of community leaders in acknowledging mental illness</td>
<td>Compromising arranged marriages Keeping ill health to oneself or to one’s family Minimisation of experience of mental illness to safeguard community image</td>
</tr>
<tr>
<td>Sphere of influence</td>
<td>Nature of the influence</td>
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<td>-----------------------------------------</td>
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</tbody>
</table>
| Cultural construction of mental health and ill health | Mind and body in balance  
Plurality of causes  
Definition of thoughts and behaviours | Holistic approach to treatment  
Reluctance to access UK psychiatric services  
Acceptance of thoughts and behaviours construed as symptoms by Western medicine |
| Migration                               | Exposure to Western model of mental illness  
Association between traditional beliefs and attitudes to mental illness become eroded  
Exposure to Western media and images of dangerousness.  
Experience of stresses, particularly racism and socio-economic deprivation arising as a consequence of migration | Increased reporting of persistent and impairing episodes of mental illness  
Perception that people with a mental illness are dangerous and out of control  
Stigma becomes associated with accessing mental health services  
Mental health problems such as depression attributed to experience of these stresses |
| Additional discrimination (i.e. racism) | Racism can be a source of additional discrimination and can shape service delivery and interactions with mental health professionals | Lack of trust and confidence in statutory services  
Stigma becomes associated with those services |
| Socio-economic deprivation              | Poverty  
Poor housing  
Unemployment | Likely to be identified as a major source of stress and cause of mental health problems. |
Stigma and the target communities

*Does stigma exist in Black and minority ethnic communities?*

The studies cited above indicate some positive but mainly negative attitudes towards mental illness resulting in shame and anticipation of rejection within the target communities. The issue of whether stigma exists within BME communities has attracted some attention. Fabrega (1991) in a review of the literature concluded that mental health related stigma is variable in ‘elementary’ societies, for example in Papua New Guinea but that it is present in India and China and that studies suggest that it is less prevalent in Islamic societies. Belippa (1991) has questioned the assumption that there is a greater stigma in Asian cultures and suggests that such findings reflected poor research methodology and culturally insensitive data collection. Stigma in Asian communities has been used to explain low uptake of services but this has been recently questioned by Hussain & Cochrane (2004) who point to research that implies that it is not the stigma associated with mental illness itself but its impact on other life expectations that is responsible. Fabrega (1991) has also pointed to the difficulties associated with the concept of mental health related stigma in non-Western cultures as it has grown out of a tradition of understanding stigma and prejudice in relation to Western psychiatry. Fabrega comments (p. 535): “In reviewing the topic of psychiatric stigma in non-Western societies, one is forced to keep in mind the Western ethnocentric bias”. This will be particularly evident in studies which have developed or used questionnaires, or other measures, to evaluate stigma which were originally developed on Western populations. The papers which have been reviewed generally provide little information about their methodologies and it has therefore been difficult to develop a critical commentary on this.

From the studies reviewed, and given the caveat above, the conclusion that mental health-related stigma exists in the target communities appears inescapable. The experience of isolation and limited social opportunities as a consequence are also evident. Phillips et al (2002), for example, defined four experiences of stigma related by patients and their families from interviews in three psychiatric hospitals in China:

- The frequency and intensity of devaluing statements and behaviors by others;
- The degree of unjustified external restrictions (as judged by the respondent) on activities;
- The level of self-restriction of activities;
- The intensity of patients’ and family members’ emotional reactions to actual or feared stigma and discrimination.

The nature of stigma in BME communities

There are four ways in which mental health related stigma effect people from the target communities:
- **Self stigma:** Stigma leads to low self-esteem, loss of confidence, lack of self worth, and lack of self-respect resulting in the individual avoiding, withdrawing or placing limits on activities (Corrigan & Watson, 2004);

- **Family stigma:** The sense of shame and stigma is shared by the family who fear reprisal from their community (Kramer, 2004) and/or fear losing face or status in their communities (Fan & Wally, 2000; Boufous et al, 2005);

- **Community stigma:** The community’s shared fear of being scorned, humiliated, being condemned, being treated differently which may influence how the community acknowledges mental illness to the external world (Mayeya et al, 2004). This is likely to be particularly marked in adopted countries where the target communities are a minority.

- **Public stigma:** The public stigmatisation of mental illness and BME communities through images of dangerousness and violence, incompetence and responsibility for one’s own mental illness leading to restriction of opportunities to fully participate as a productive member of society (Gary, 2005).

The anticipation of negative responses from families, the community and society at large has been identified as significant barriers for BME communities in accessing mental health services (Weiss et al 2001; Gary, 2005). The additional discrimination and racism experienced by BME communities when they are in the minority interacts with the stigma related to mental health both as a factor which increases vulnerability to mental health problems and as a deterrent to seeking help and disclosing experiences even to close family members.

**Double stigma**

It is evident from the review that people from the target communities living in adopted countries face discrimination and racism and associated social disadvantage. Several studies have identified this (e.g. Hatfield, 1996; Rooney, 2006). Gary (2005) coins the term “double stigma” to describe this. This refers to mental health-related stigma combined with the stigma of minority ethnic group membership. Describing the situation in the US, she writes (p. 982) “numerous factors interact to produce and sustain stigma related to mental disorders among ethnic minority groups”. Gary refers to self-stigma and public stigma as above, both of which are fuelled by stereotypes, prejudice and discrimination. In addition double stigma among ethnic minority groups compounds stigma through misdiagnosis and maltreatment resulting in lowered self-esteem and mistrust of the system. She identifies the contribution of mental health services, which magnify stigma through inadequate cultural competence, communication failures, conscious and unconscious stereotyping, thereby limiting access to services for people from BME communities.

This indicates that strategies to tackle stigma in BME communities need to be two pronged – tackling mental–health related stigma and racism and discrimination concurrently.


**Practical strategies for reducing stigma**

There are various ways of dealing with stigma and the nature of the intervention will depend on the target audience, and needs of that specific community. The following strategies are identified in the literature:

1. Information, which is targeted at specific communities, needs to be widely disseminated. This information needs to be translated appropriately and key messages identified as in examples of the initiatives above. Writing about Asian communities, Wynaden et al (2005) suggest the following messages are promoted:
   - Early intervention will facilitate better management
   - Health professionals will maintain confidentiality
   - There is no shame attached

2. Information needs to be developed in different formats and disseminated through different routes. This could include leaflets in churches, temples, community associations as well as seminars for community groups and using BME radio stations (Wynaden, 2005).

3. Changing the portrayal of mental illness in the media, including that targeted at BME communities (Weiss et al 2001, Chung 2004).

4. Focus on family and family members and encourage externalisation of stigma and address the sense of shame.

5. The development of early interventions for people experiencing mental health issues to enable them to develop their resilience.

6. Training for clinicians to understand the range of mental health beliefs and to recognise how they may contribute to stigmatising mental illness (Phillips et al 2002; Tsang, 2004; Chem, 2004; Kramer, 2004). Mental health professionals can help by encouragement, giving advice and coping strategies for dealing with self-stigma and social stigma (Dickenson, 1998; Holmes and River, 1998).

7. Work on expressed emotion has shown that high and low expressed emotion has an effect on the family and the individual. Those with high expressed emotions view stigma in a much more threatening way than those families who encounter low expressed emotions (Leff et al, 1983; Koenigsburg and Handley, 1986; Kavanagh, 1992). Thus interventions aimed at reducing expressed emotions would not only influence relapse rates but also reduce stigma and improve treatment outcomes.

Finally it is clear from the literature that initiatives to tackle stigma need to be located as part of a comprehensive response to improve mental health provision for BME communities. The stigma associated with mental health services in UK emerged as a major theme and there is a clear need to think about their design and delivery for people in the context of beliefs about mental health and illness identified here. This will need to be grounded in respect for and understanding of religious practices; an understanding of the socio-economic deprivation and...
stressors experienced by people from BME communities; an understanding of discrimination and racism and the way they operate, including shaping knowledge and research and partnerships with community groups and the Black voluntary sector. A strategy for improving mental health provision to BME in England has been developed and is currently being implemented through a range of initiatives based on the principles and method of community engagement. (Department of Health, 2005).

**Examples of initiatives to tackle stigma**

**Non UK examples**

Tanzania and Kenya have introduced new legislation for mental health: included in this are laws concerned with destigmatising, decriminalizing and demystifying mental illness (Njenga, 2002). Initiatives which are being developed include a weekly radio programme, where consumers, mental health patients and families discuss their experiences. This has proven a very popular method of destigmatising mental illness, as Kenyans see, at first hand, persons with suicidal depression and/or psychosis discuss without fear their route to recovery. The new message for Kenyans is that patients can recover from mental illness, look ‘normal’ and have no shame about the problems they may have encountered, and the ways they dealt with them (Njenga, 2002).

Gureje (2000) believes that education should be the priority for the development of mental services in Africa, as such services depend heavily on the local communities involvement, and this involvement is necessary in order to decrease stigma (Giel et al 1983).

The only systematic evaluation of an intervention to tackle stigma within the target communities comes from Pakistan. The Gurjakhan demonstration project was a mass educational campaign, which aimed to reduce stigma and educate families on how best to protect their mental health (Patel et al, 2001). The focus of the programme was engaging with the schools, training the teachers and reinforcement through visits to the schools and development of the programme through slogans and contests involving parent teacher associations. Slogans included:

"Mental illnesses are not due to possession by evil spirits but are, like any other bodily disease, treatable."

"People are different and some of them have disabilities. Do not laugh at others’ disabilities but help them."

A randomized controlled trial demonstrated that the impact of such a programme on knowledge and attitudes is not restricted to school children, but cascades out to their parents, neighbours and friends not attending school (Rahman et al, 1998).

As faith healers were often the first port of call for those with a mental illness in Pakistan their cooperation was sought. Engaging with those people who are trusted by the community has enabled people to access health facilities via faith healers (Saeed et al, 2001). This model has been rolled out to the Eastern Mediterranean and it has been observed that local participation and engagement is a fundamental requisite for the success of such programmes (Patel et al, 2001).
Carter (2003) (citing Athar, 1993) identified statements from the Qu’ran and Sunnah that could be used as tools by psychotherapists to strengthen a psychotherapeutic approach and which may have relevance to mental health promotion:

“An ounce of prevention is worth a ton of treatment”

“The body is a gift from God, you have to look after it: you can’t ignore it and you can’t abuse it”

The study cited earlier by Tilbury et al. (2004) on East African communities in Australia concluded that existing mental health promotion initiatives were inappropriate for these communities. They recommended: the development of materials in the appropriate languages; the value of word of mouth to spread information, and the need to understand that in some communities providing information to men is more culturally appropriate. As a response to the research, a number of activities were initiated which included seminars and a series of community consultations to bring together practitioners, service providers and communities to discuss mental health issues; a radio series on ‘ethnic’ radio covering mental health issues; facilitating access to health services; providing information about the different communities to the health services and developing plans for submission to government departments which outline the mental health consequences of current policies for these communities. They also recommended the need to recognise the value of traditional and religious forms of healing and the development of ethnocentric mental health services.

**Initiatives in the UK**

In addition to recent work in Scotland, initiatives aimed at raising awareness and tackling stigma in BME communities in the UK were sought. However, a search solely for anti-stigma campaigns in these communities yields few results. The reason is that approaches to addressing stigma are nested within community organisations, which are providing a range of services and support to the local community. This would appear to be a similar situation to that which has been identified for mental health advocacy (Rae-Atkins et al, 2002). This is exemplified by Rethink Sahayak (which means helpful in Hindi) in Kent, cited as good practice in the report of a national conference in England (Rethink, 2003). The description of this service makes it clear that tackling stigma is a key function sitting alongside providing a telephone health helpline and information about services. The organisation has strong links with other key stakeholder groups include faith and community groups:

“What has made Sahayak a success is that from day one the service has had community involvement, whereby the history of the service name ‘Sahayak’ was selected by community volunteers in 1996. Mental health awareness delivered appropriately to meet cultural and linguistic needs assist with having an impact of raising the profile of mental health within the community. Working also at a preventative stage before a diagnosis is given allows access to a service for support to assist reduction in hospitalization.”

(Rethink, 2003, p. 29)
Similarly Antenna in London provides an outreach service to African and Caribbean people aged 16-25. The project visits schools, churches and mosques, youth and educational services to raise awareness about mental health issues. A community event attracting 500 people is held annually to help raise awareness about mental health in the community (DH, 2004). Information about a further 30 initiatives in England is available in Celebrating our Culture-mental health promotion with Black and minority communities (see www.nimhe.org.uk).

The Department of Health (2004) has suggested pointers for engaging with African and Caribbean mental health communities in mental health promotion. These are summarised in Box 1 and provide general strategies for working with BME communities reflecting themes that emerge from the literature (see Rooney, 2004 for example).

**Box 1: Mental health promotion and African and Caribbean communities (from DH, 2004)**

- Consult and work in partnership to plan, implement, deliver and evaluate mental health promotion with individuals, carers and community organisations
- Build partnerships between the voluntary sector and the statutory sector and identify sustained funding for local groups to facilitate involvement
- Raise awareness of mental health issues and services by developing mental health promotion specifically designed for the African and Caribbean population and working with African and Caribbean organisations to provide mental health promotion interventions within accessible community venues
- Challenge racism and discriminatory stereotypes and promote employment opportunities for those who do and do not currently use services
- Train staff in both anti-discriminatory and cultural awareness, including the important role of spiritual and religious beliefs, and provide support and training for carers and families to increase their knowledge
- Promote mental health within services by developing culturally accessible services
- Ensure there is information, choice and a range of therapeutic approaches including complementary therapies and attention to physical health needs
Conclusions

The review has indicated the diverse conceptual and theoretical approaches to mental health and mental illness in the target communities. Any initiative to tackle stigma and change attitudes needs to be developed in the context of these concepts and beliefs. However the reduction of these concepts to single causes must be avoided as it is evident that in all the target communities there is a plurality of beliefs which is matched by wanting access to different types of support – faith based, community based, traditional medicine and mainstream services.

General principles

From the literature review it is possible to draw general conclusions about the principles that should underpin the development of initiatives to address stigma in BME communities in Glasgow:

- The diversity of minority ethnic communities is clear and needs to be taken into account in initiatives to tackle stigma (see also DH, 2004). The variables which have been identified as influencing beliefs, and which therefore need to be considered, are age, gender, educational level, language, ethnic identity and religious affiliation.

- Anti-stigma programmes should include a cross section of individuals and groups including community groups, health care professionals, carers as well as service users. These programmes should be conducted within and across cultures and the diversity of the communities needs to be matched by a diversity of approaches (Weiss and Ramakrishna, 2006; Lang 1991; Kleinman, 1995).

- Initiatives must reach into and engage the target communities as a priority if attempts to tackle negative attitudes and promote awareness are to be successful (King’s Fund 2003; Wynaden et al, 2005). This should include making contact with spiritual/religious leaders as places of worship have an important role in determining health beliefs.

- Assumptions about the nature of beliefs and attitudes need to be avoided and the plurality of explanatory models understood. Whilst sensitivity to the factors that influence attitudes will be helpful, dialogue with target communities about the relative importance of these in the local context will be key to shaping appropriate interventions.

- The mental health related belief systems of the target communities are based on a holistic view of the emotional, physical and spiritual aspects of living. This is in stark contrast to Western explanatory modes that are predominantly pathological and are grounded in a mind-body dualism. Successful community engagement will ensure that these beliefs are reflected within initiatives to tackle stigma. It is unlikely that campaigns which promote mental illness solely as ill health that will respond to effective treatment will be successful in addressing attitudes within BME communities.
• Programmes need to recognise, understand and address the nature of shame and the potential for family stigma within BME communities, particularly Asian communities.

• There are extensive resources within BME communities and initiatives to address stigma should aim to build capacity in service user, family and community groups.

• Initiatives to tackle stigma need to be part of a comprehensive response to improve the response to people from BME communities experiencing mental illness and to tackle the discrimination and marginalisation they experience in the UK as a whole.

Future research

Further research is clearly needed to understand the nature and impact of mental health related stigma on BME communities living in Britain. As has been made clear by Weiss and Ramakrishna (2006), this research needs to explore and document the burden of stigma for different BME communities; compare stigma for different health problems and different settings; identify determinants of stigma and its effect on illness experience and behaviour; and evaluate changes in stigma over time in response to interventions to tackle it. This research needs to be shaped by and actively involve BME communities in determining its direction.
Chapter 3 Community research approach

This chapter introduces some of the principles, aims and methods used in the community research and is organised into 3 sections

3.1 Background to the community research
3.2 Research aims and objectives
3.3 Method
3.1 Background to the research

Improving the mental health and well-being of Scotland’s population is a national priority for the Scottish Executive. Through the National Programme to Improve Mental Health and Well-being they have established ‘see me’, an alliance of 5 mental health organisations that lead a national awareness campaign. At a regional level, NHS Greater Glasgow and Clyde have an established programme of work aimed at tackling the stigma and discrimination associated with mental health problems. To take this work forward in Glasgow City, NHS Greater Glasgow and Clyde have established ‘Glasgow Anti-Stigma Partnership (GASP), a collaboration of almost 40 organisations that have different skills and work at national, regional and local community levels. The partners instigated and now manage a range of programmes that aim to tackle stigma in a variety of settings across Glasgow, such as schools and workplaces, employing a number of differing approaches. A key principle underpinning all health improvement work is the reduction of inequalities, and this collaborative partnership is keen to ensure that the anti stigma programme meets the needs of the whole community.

Patterns of stigma associated with mental health problems are well-documented; however, mental health stigma that may result from belonging to a minority ethnic community is less clear. To explore such issues, we established a project to oversee a staged process of research and implementation aimed at supporting Black and Minority Ethnic (BME) communities to develop evidence-based approaches to tackling stigma associated with mental health problems. The whole project is overseen by a steering group, drawn from national and local organisations. The findings of this research, in tandem with a specially commissioned literature review will be utilised to inform an on-going programme of community work and a future public awareness and social marketing programme. It will also inform work undertaken at a national level in partnership with ‘see me’ and The National Resource Centre for Ethnic Minority Health.

The project uses constructivist principles to develop shared understandings about the issues and potential solutions. This required a real team ethos and diverse community of practice. Accordingly, Lee Knifton and Nuzhat Mirza on behalf of NHS Greater Glasgow & Clyde would like to thank and acknowledge the contribution and commitment of the people and partner organisations involved in shaping and implementing the community research stages including:

- Christopher Homfray, Dale Meller and Dr Sandra Grant (National Resource Centre for Ethnic Minority Health, Health Scotland)
- Lesley Sherwood (Independent researcher in health and social issues)
- Linda Dunion and Johannes Parkkonen (‘see me’ campaign)
- Pratima Pershad (Glasgow Association for Mental Health)
- Hina Sheik (NHS Lanarkshire)
- Tina Yu (Mental Health Foundation)
- Florence Dioka and Iffat Bhatti (Meridian, Black and Ethnic Minority Women’s Resource Centre)
- Patricia Rodger and Andy McArthur (IAS Smarts, Edinburgh)
- Ravina Naroo and Amna Qureshi (Youth Counselling Services Agency)
- Safia Ali (Pollokshields Development Agency)
3.2 Research aims and objectives

The stated aims of the community research stage were:

- to support community projects in Glasgow to undertake research exploring patterns of stigma associated with mental health problems in partnership with Black and minority ethnic communities and to use the emerging issues and proposed solutions, alongside other linked research, in order to develop an evidence based social marketing campaign with community partners

- to develop and document an innovative research approach that may have wider utility and application in health contexts that necessitate us to more fully engage with and understand the perceptions and needs of a range of minority communities.

The following project objectives were agreed in order to fulfil this aim:

- agree the different BME communities to be involved in the focus group research
- identify suitable organisations and facilitators within those communities to develop, host, arrange and run focus groups.
- identify an experienced researcher to work flexibly to attend each focus group, support the facilitators, record key themes, analyse the data and prepare the final report.
- Host a training day for the focus group facilitators
- Develop a flexible and appropriate pro-forma for the focus groups
- oversee the development of the final report, with recommendations, which presents:
  - key themes about participant perceptions of knowledge, attitudes and behaviour
  - an outline of ideas to address issues of stigma as presented by participants
  - feedback on the ‘see me’ campaign materials with particular reference to their appropriateness for BME communities.
3.3 Method

The primary method of information collection for this project was focus group research, which was carried out with a number of different established BME communities in Greater Glasgow. The main aspects of the method are presented below:

3.1 Planning and managing the research

A steering group was established to develop the research design and to oversee the implementation of the focus groups research.

A freelance researcher\(^6\) was then commissioned to:

- consult on input on the final design of the research tool and finalisation of the questions for the focus groups and written guidance for facilitators
- attend each focus group to support the facilitators and record the discussion
- prepare individual reports for the ten focus groups, help synthesise and analyse the data across the BME communities and by theme
- draft the community report with recommendations

3.2 Identifying and Supporting Facilitators

Six community projects that work with BME communities across Glasgow were identified through local knowledge and agreed to participate in research skills training and then to recruit, host and facilitate a 90-minute focus group to explore stigma and issues of mental health. The IAS SMARTS Research and Planning ran a focus group skills training workshop for participating BME community project workers prior to the start of the research.

Following the workshop, an IAS SMARTS\(^7\) led the development of the focus group questions and written guidance for facilitators and submitted this draft pro forma to the steering groups and independent researcher for comments and input. (see Appendix A for final agreed pro forma).

3.3 Focus group composition

Table 1 (below) shows a summary of the focus groups by BME community and numbers of participants. Full details of the number, age, language and gender breakdown for each focus group, may be found in Appendix B.

<table>
<thead>
<tr>
<th>BME Community</th>
<th>No. of Groups</th>
<th>Gender / age group</th>
<th>No. of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Muslim</td>
<td>5</td>
<td>2 x women only</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 x men only</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 x young people (mixed gender)</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Total number of Muslim participants</strong></td>
<td><strong>39</strong></td>
</tr>
</tbody>
</table>

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\(^6\) Lesley Sherwood, freelance consultant in public health and social issues.

\(^7\) Patricia Rodger, researcher and strategic planner with IAS SMARTS.
3.4 Incentives
A budget was given to each host organisation to be used at their discretion as an incentive for people to attend the focus groups. The community workers facilitating the groups used this money to provide lunch, travel and other expenses.

3.5 Data Collection and Analysis
Ten focus groups took place during 2006. The independent researcher recorded (by taking notes) each focus group discussion (with ‘interpreter’ support, if the group was not conducted in English). The independent researcher worked with the facilitator for each group to check on various emerging views and themes. A brief report was written for each of the ten groups. The data was synthesised for each of the five BME groupings and subsequently analysed by theme. A further level of comparative analysis was carried out through the identification and exploration of emerging themes across the five BME groups. This resulting final research report aims to provide an overview of the key themes and solutions, highlighting differences and similarities amongst the different BME groups and across different age groups, where comparative data was available.

The initial research findings and recommendations were explored with all of the participating community projects at a validations session. The session assessed accuracy of recording and validity of recommendations. A further session developed the proposed model of intervention more fully.

3.6 Dissemination:
A commitment was made to provide each participating organisation with a summary of the research report so that the results can be disseminated to the focus group participants. The findings of the combined reports will also be disseminated through conferences, publications, partner websites and organisational meetings.

3.7 Reflective process
This was the first time that NHS Greater Glasgow and Clyde had worked in partnership with some of these organisations, facilitators and BME communities in order to undertake community based research about mental health and stigma. It was, therefore, important to try to reflect on the process of setting up and running the focus groups in order to be able to inform similar processes in the future. Comments and recommendations for future work of a similar nature about the process of running the focus groups with the different BME communities are presented in Appendix C.
Chapter 4 Community Research Findings

The findings are set out to reflect the different phases of each of the focus groups.

4.1 Beliefs and attitudes around mental health and stigma in BME communities
   4.1.1 Words or phrases associated with mental health issues
   4.1.2 Beliefs, attitudes and reactions to mental health problems
   4.1.3 Treatment issues
   4.1.4 Religious and spiritual influences on attitudes to mental health

RECOMMENDATIONS (SECTION 4.1)

4.2 Challenging stigma: channels of communication and possible solutions
   4.2.1 Television
   4.2.2 Radio
   4.2.3 Newspapers and magazines
   4.2.4 Using media and other mechanisms to influence beliefs and attitudes to mental health
   4.2.5 Attitudes to change and sources of support

RECOMMENDATIONS (SECTION 4.2)

4.3 Feedback on the existing ‘see me’ campaign materials

RECOMMENDATIONS (SECTION 4.3)

The findings in each of these sub-sections have been organised into key themes and, where possible, comparisons have been made between the different BME groups, identifying both correspondence and disparity. This constitutes a further level of analysis from of the original data that was analysed primarily by BME group. Full group findings can be accessed in Appendix D. ‘Quotations’ are provided to give appropriate illustrations of key points. Tentative recommendations are also proposed at the end of each section, to be considered in conjunction with the literature review.
4.1 Beliefs and attitudes around mental health and stigma in BME communities

This sub-section presents the findings in relation to words or phrases used when referring to mental health issues. Beliefs, attitudes and reactions to mental illness are also covered. Treatment issues are reported, as are the influences of religion/spirituality on perceptions of mental health.

- More detailed findings, as reported by each participating BME community, are available in appendix D.

4.1.1 Words or phrases associated with mental health issues

Focus group participants were asked to say the first word or phrase that comes to mind when they hear the phrase ‘mental health or mental health issues’. Key themes emerging from this introductory question were:

Key themes:

- the first words/phrases offered by the Muslim and African/Caribbean focus group participants were at the severe end of the spectrum. English-language terms were often derogatory and in colloquial language e.g. ‘schizo’, ‘nutter’. The most common non-English-language word used by the Muslim groups was ‘paghul’, which equates to ‘mad’ or ‘crazy’ and, as with these English-language equivalents, can be employed and/or interpreted in various ways depending on the context in which it is used.

- the initial reaction of the Hindu, Sikh and Chinese communities was to use less extreme terms and they referred to more common and (usually) milder forms of mental health problems such as depression, stress and family worries. The Muslim and African/Caribbean communities also mentioned these milder problems but only after their initial response in more extreme words/phrases.

- both groups of young Muslim people used phrases relating to learning disabilities, such as ‘retarded’ or ‘brain damaged’. The African / Caribbean group was the only other group to briefly refer to this or use this terminology.

- the Hindu group was the only one to mention any physical symptoms of mental ill-health such as nausea, palpitations.

- phobias were referred to infrequently and only by participants in the Hindu group and by Chinese young people.

There were few, if any, generational differences observed in the Muslim and Chinese communities regarding words or phrases associated with mental health issues. (NB: these were the only two communities that had focus groups from different generations.)
4.1.2 Beliefs, Attitudes and Reactions to Mental Health Problems

Participants from each focus group were invited to give their views on what they felt their community’s common beliefs and attitudes were towards mental health problems and typical reactions their community would have towards a person experiencing a mental health problem.

There were considerable similarities in the beliefs, attitudes, reactions and emerging themes among participants in all the BME communities. Some significant differences between the BME communities did emerge, however, in terms of consistency or strength of views held.

There were some generational differences among participants from the Muslim and Chinese communities, differences that are indicated in the findings as they were expressed in the groups. It is significant that there was consistency in what the older generation perceived the younger people would think and what they actually thought, and vice versa.

Key themes:

- Shame and secrecy: a strong sense of shame and the need for secrecy regarding mental health problems were the most commonly expressed reactions by participants from all the BME groups (although the Sikh community expressed less concern in this area). Fear of gossip and lack of trust in small, close-knit communities provided a strong drive for secrecy.

  Although the Muslim and Chinese young people still referred to shame and the need for concealment, they expressed a willingness to be more open, understanding and tolerant of mental health problems. They would confide in friends more than they would with family.

- Causes of mental ill-health: the belief that mental health problems ‘are not an illness’ was strongly held by participants from the Muslim, Hindu and, again to a lesser extent, from the Sikh community. Perceived causes of mental health problems were:
  - ‘Black magic’ (or a curse) – Muslim, Hindu, Sikh
    - possession by spirits (or Jinn/Djinn) – Muslim, Sikh (this was not explored in the focus group with the Hindu community)
  - punishment from God - Muslim
    - inheritability – Muslim, Hindu, Sikh, African/Caribbean (but not mentioned by participants from the Chinese community)
    - stress/family worries/difficult living environment – especially the Sikh and Chinese communities, although there was also some acknowledgment of this by the Muslim and Hindu communities too.

The young Muslim and Chinese participants expressed some belief in spirits and ‘Black magic’, however, these beliefs are not held as strongly as by participants from the older generations.
African/Caribbean participants expressed a notion that ‘people never really get cured’.

- Mental ill-health as a single illness at the severe end of the spectrum: participants from the Muslim and Chinese communities expressed the idea that mental health problems are homogeneous (or a single all-encompassing condition rather than a range of illnesses with different symptoms and levels of severity). This perception seems to be linked to the response that unless a condition is very severe, then it should be ignored (because ‘it does not really exist’) and is supported by the words and phrases to which people referred (in 4.1.1) that mostly described conditions at the severe end of the spectrum. This view of homogeneity may also be held by the other BME communities but it was neither expressed nor investigated during other focus groups.

Participants from the African/Caribbean community felt that milder forms of mental illness such as stress and depression are a ‘Western issue’ that only become a problem in their community here due to the pressure of immigration. They feel that stress and depression ‘wouldn’t really be an issue back home’.

- Avoidance vs. Sympathy: avoidance was a common and strong reaction expressed by the Muslim, Hindu, and African/Caribbean focus groups. There was an indication that people would keep their family away from the affected person (and that person’s family) due to notions of contagiousness or beliefs that it may be a ‘cursed family’. Participants from the Muslim community (although not the young people) also expressed concerns about ‘dangerousness’ – that, potentially, they might be killed or attacked by someone with a mental health condition - a fear that might also lead to avoidance behaviour. In contrast, participants from the Chinese and Sikh communities expressed higher levels of sympathy and the need for people and their families to be supported.

- Marriage: the belief that the marriage prospects of people with mental health problems would be profoundly affected was strongly expressed by participants from the Muslim, Hindu, Sikh and African/Caribbean communities. This appears to be related to notion of ‘inheritability’ or ‘being passed on in the blood’ (although this belief appeared to be less clear cut among the Hindu community). Many participants suggested that this provides a strong drive for families to keep mental health problems a secret within the family, ‘The main reason is to keep it a secret until they get married because the main thing is to get married’ (Sikh community participant).

Participants from the Hindu community also expressed the belief that mental health problems will affect marriage prospects but for this particular group, their concerns were mainly related to education. There was consensus amongst the group that mental health problems result in low educational achievement - with educational achievement relating to future prospects, both of which were identified as important within the Hindu community.
4.1.3 Treatment Issues

Participants were asked whether beliefs and attitudes to mental health problems affect the kind of treatment people from their community might seek or be offered.

Some common themes about treatment emerged from each of the BME community discussions and are explored below:

**Key themes:**

- **Deciding who to approach for treatment/help:** there appear to be three main factors that influence the type of treatment or support people would seek for mental health problems:
  - **Perceived causes**
    participants across the focus groups had a variety of perceptions of the causes of mental health problems – for example, many Muslim participants said that ‘bad spirits’ caused the mental health problem, which means that many people from this community would seek help from religious leaders first and foremost.
  - **Confidence in speaking English**
    participants believed that if people were not confident in speaking English, they would seek help from religious leaders, as respected members of their community with whom they can communicate easily rather than seeking help outside the community.
  - **Levels of awareness and education**
    participants who were comparatively aware of mental health issues, such as young people raised in the UK and those who participants described as more ‘educated’ would generally seek help from their GP first. They are less likely to believe in spirits and more likely to view a mental health problem as an illness. It is also less likely that they would have language issues if/when engaging with health professionals or comprehending written materials.

- **Medical services:**
  - participants from the Muslim and Chinese communities thought that seeking help from their GP would be the first approach of young people and those who participants described as more ‘educated’ people.
  - participants from the African/Caribbean community also thought that people from their community would approach their GP but most said that they would prefer the doctor to be from the African/Caribbean community. (Participants also thought that people from this community would readily seek help from their church - mostly the Pentecostal Church - but the reasons for this were not explored during the focus group).
Avoiding mainstream medical services: participants across the focus groups expressed a variety of reasons why they felt people in their communities would avoid seeking help from mainstream medical services.

Reasons cited include:
- “It will not work”: participants from the Muslim, Hindu and Sikh communities talked about a community belief that mental ill-health is not an illness - but rather is caused by inheritance, ‘Black magic’ or spirits; as a result, they feel that medical intervention / medication will not help. For example, participants made comments like “Medication will not work” and “Drugs only sedate the person, there is no cure.” Although not explored to the same extent in all focus groups, participants from the African/Caribbean community also expressed concern about potential addiction to medication.
- “There is no cure”: some participants in the focus groups with Muslim and African/Caribbean communities felt their mental illness is permanent and untreatable: “People never really get cured”.
- “It will resolve itself”: a number of participants across the focus groups expressed the belief that people experiencing mental ill-health “Will get over it” or that “Lots of love will solve it”.
- Language: participants from both the Muslim and Chinese communities felt that if people have difficulty in speaking English, they would avoid going to the doctor.

Although interpreters are used readily by the Chinese community, there are perceived issues of confidentiality and a sense that it is difficult to convey feelings accurately through an interpreter.
- Lack of trust: participants from the Muslim community expressed a fear of being asked “too many questions” either by the doctor or by others in the waiting room; they also expressed a lack of trust in things being kept confidential. Participants from both the Hindu and African/Caribbean communities expressed general distrust of doctors and social workers. (It was not possible to fully explore this issue).
- Fear of extreme measures being taken: this fear was expressed by participants from the Muslim community, who expressed concerns about “ending up in an asylum”; these concerns were not mentioned in focus groups with other BME communities.

Traditional remedies
- participants in the Chinese young people’s group referred to traditional remedies such as feng shui but this area was not explored further.
- participants from the African/Caribbean community said that herbalism, spiritual healing would be used in Africa but less so here.
4.1.4 Religious and Spiritual Influences on Attitudes to Mental Health

Focus group participants were asked if they felt that religion played a part in their community’s attitudes to mental health; any connections between perceptions of mental ill-health and ‘spirits’ or ‘karma’ were also explored.

**NOTE ON SOME RELIGIOUS /SPIRITUAL CONCEPTS:** a number of complex ideas and issues were raised during this part of the focus groups. These often needed to be clarified by the researcher with the focus group facilitator after the end of the focus groups. It is worthwhile providing a ‘community definition’ of some of these ideas here, to provide some context for the focus group findings.

Spirits / Jinn/Djinn: some communities believe that mental illness can be caused by possession by spirits or ‘Jinn’ (or ‘Djinn’); this belief centers on the idea that spirits of the dead are all around us - some good, some bad - and that these spirits can ‘take possession’ of the living.

‘Black magic’: a belief that mental illness can be caused by the placing of a curse on a person (or family) as retribution for a (perceived) wrong done or similar; Muslim, Sikh, Hindu and African/Caribbean community focus groups all mentioned belief in ‘Black magic’.

Karma: a belief, originating in Hinduism & Buddhism, that states that a person's actions and conduct during the successive phases of their existence determine that person's destiny – in other words, a person’s actions will have consequences on what happens to them in this life (and any future incarnations)

The majority of the participants made reference to religious/spiritual issues throughout their focus groups, for example whilst talking about ‘reactions’ or ‘treatment issues’ which highlights the significance of religious/spiritual beliefs and practices for these BME communities. As a result, religious/spiritual issues are also referred to in other parts of this report. Key themes are summarised.

**Key themes:**

- the influence of religion and religious leaders over people’s beliefs, attitudes, reactions and treatment of mental health issues was most strongly stated by the Muslim community.

- all the focus groups reported that their own community had some degree of belief in ‘Black magic’ or spirits, there was a broad consensus that these beliefs were strongest in older people and those who are thought to be ‘less educated’.

- as the origins of the concept lie in Hindu-ism and Buddhism, Karma was only raised within the Hindu and Chinese communities.
RECOMMENDATIONS: (SECTION 4.1: Beliefs, Attitudes, Reactions, Treatment)

1. General awareness raising and education:
   There is a need to create a dialogue about concept of ‘mental health’ and also to
   raise awareness of mental health problems - for example: how common mental
   health issues are; how anyone can be susceptible; what form mental-health related
   stigma takes; what people can do to help themselves and others etc.

2. Range of mental health issues:
   In addressing the issue of awareness of the range of mental health issues, areas to
   highlight include: less severe problems and how people recover; how common it is
   for people to experience mental health problems – participants expressed opinions
   indicating that the use of facts and figures would be popular; put the more severe
   forms of mental ill-health in context (thus helping to tackle fears of being attacked
   and of asylums).

3. Causes of mental health problems:
   There is also a need to raise awareness about the causes of mental health problems
   - issues of contagion and inheritability were highlighted as being of particular
   concern; there is also a very specific need to explore perceptions of
   religious/spiritual ‘causes’ of mental ill-health (see below).

4. Religious/Spiritual influences:
   Ways to address the influence of religious/spiritual beliefs on stigma and mental
   health issues need to be very carefully considered - a universal approach across all
   BME communities may not be appropriate as beliefs vary depending on culture and
   religion. There should be sensitive consultation with each BME community including
   community groups and religious/spiritual leaders. For the Muslim community, in
   particular, the religious leaders (Imams) may be key figures through which to raise
   awareness of mental health issues.

5. Getting help:
   There is a need to target the different BME communities with information about
   mental health and well-being, what sort of help is available to anyone with a mental
   health problem and how to access that help.

6. Language issues:
   Issues of language are twofold: first, there is a particular issue for older people and
   others who are not confident in communicating in English; continuing efforts should
   be made to ensure that services, information and all sources of help are sensitive to
   the language needs of BME communities; interpreters should receive good training
   regarding confidentiality and taking a professional approach; second, there are
   issues around the lack of non-stigmatising terminology in languages other than
   English, something that community workers need to be aware of when undertaking
   discussions around mental health with their community groups.
7. **Cultural awareness:**
   There is a need to build up levels of understanding and trust between mental health practitioners and policy-makers and BME communities.

8. **Lack of trust:**
   There is a need to consider how to tackle the lack of trust in mental health services that was expressed by some of the groups.
4.2 Challenging Stigma: Possible Solutions and Channels of Communication

This subsection reports on the potential influence of broadcast (TV, radio) and print (newspapers, magazines) media on perceptions of mental health issues; other channels of communication are also covered and it is worth noting that ‘new media’ was only briefly raised in focus groups. Attitudes to change and potential barriers and opportunities for challenging attitudes are also explored before addressing potential sources of support.

4.2.1 Television

Participants in the various focus groups were asked if they watched any TV stations or programmes specific / related to their community and, if so, how this compared to their consumption of mainstream English-speaking channels. Key themes are summarised below:

**Key themes:**

- participants in the Muslim, Hindu and Sikh focus groups felt that many people within their communities would watch Zee TV and Star Plus. Participants in the Muslim focus groups said some additional channels were watched by people in their community.

- Zee TV and Star Plus (plus other channels mentioned) were preferred predominantly by older people, mainly because of issues of language comprehension. There is some indication that this may be the case for women in particular as men are often more confident in their use and understanding of the English language as they may work in an environment where English is used all or part of the time.

- young people in the Muslim and Chinese focus groups said they sometimes watched these channels but did so mostly because their parents watch them. These younger people expressed a preference for mainstream English channels.

- the African/Caribbean community focus group was the only one to express a clear preference for mainstream English TV.

4.2.2 Radio

Participants in the various focus groups were asked if they listen to any radio stations or programmes specific / related to their community and, if so, how this compared to their consumption of mainstream English-speaking radio. Key themes are summarised below:
Key themes:

- participants thought that both Radio Awaz and Radio Ramadan (although it is only available for one month of the year) are popular with most of the Muslim community, including young people.
- Radio Awaz is also popular within the Hindu community.
- it is difficult to draw clear conclusions about the popularity of these stations compared to mainstream English-speaking radio.
- participants from the Chinese community and the African/Caribbean community did not mention any specific radio stations that cater specifically to them.

4.2.3 Newspapers and magazines

Participants in the various focus groups were asked if they read any newspapers or magazines programmes specific / related to their community, and if so, how this compared to their consumption of mainstream English language papers/magazines. Key themes are summarised below:

Key themes:

- participants indicated that the Muslim community enjoys easy access to a wide variety press - newspapers and magazines - in Urdu; these publications are particularly popular with those who are not confident in reading / comprehending English.
- mainstream English-language free newspapers (e.g. Metro, Glaswegian) are also popular with the Muslim community.
- the young people from the Muslim and Chinese communities who took part in the research reported a preference for English language papers.
- participants noted that while there is some press aimed at the Sikh Community, there is no evidence of any print media specific to the Hindu community; both these BME groups mostly read English-language press.
- there is a Chinese language newspaper available and free papers like Metro are popular with this community too.
- African/Caribbean participants did not mention any newspapers or magazines specifically for their community.
- There is some indication that people (especially young people) may seek access to newspapers specific for their BME community via the internet.
4.2.4 Using the media and other mechanisms to influence beliefs and attitudes to mental health

Participants were asked to what extent they felt that TV, radio and newspapers could influence their community’s awareness and attitudes towards mental health. This was followed by discussion around any other possible means of communication that is / could be significant in shaping people’s views and attitudes on mental health, such as religious groups, schools and discussion groups. Key themes are summarised below:

**Key themes:**

- **Media influence:** all BME focus groups felt that TV would be the strongest potential influence on their beliefs and attitudes to mental health issues. Most groups agreed, however, that an approach using all three primary media (TV, radio and newspapers) would be the most effective way to reach the majority of BME communities including women, young people, older people and those who work.

- **Other approaches:** the Muslim and Chinese young people highlighted the importance of targeting children and young people, through school and the internet.

  The workplace was also felt to be an important setting in which to raise issues of mental health and well-being. Other suggestions by participants from the Muslim community included doctor’s surgeries, local shops and bill posters.

  Chinese focus group participants said that community-based Chinese projects would provide effective fora for communication of mental health issues, as would places significant to the community such as Chinese supermarkets, Chinese restaurants and the Chinese weekend schools.

- **Religious, cultural and community gatherings and festivals:** participants from the Muslim community reported that religious gatherings and festivals would potentially provide good opportunities to raise awareness and issues of mental health. This reinforces the earlier findings that religious leaders would have influence over the views of this particular community.

  The Chinese community reported that large group events are popular with their community and would provide an opportunity to raise awareness and issues of mental health.

- **Discussion groups:** All participating BME communities talked positively about discussion groups as a means to challenging people’s views on mental health issues. The Hindu focus group seemed slightly less enthusiastic about discussion groups, however, but as this group was small, this view would have to be checked with others from the community. There was a suggestion that it would be important for people to be able to talk in their own language,
especially when it comes to emotional issues. Discussion groups would need to be flexible in terms of time and venue, and confidentiality would have to be assured. Young people may require an incentive to attend and, in general, attendance would be encouraged if refreshments were on offer.

4.2.5 Attitudes to Change and Sources of Support

Participants were asked how easy or difficult they felt it would be to change negative attitudes towards mental health issues in their community. Each focus group then explored potential problems and opportunities in doing this before giving their views on whether they felt someone from within their community who was experiencing mental health problems would seek advice and support from inside or outside their community. Key points are summarised below.

Key themes:

- **Easy/Difficult:** there was consensus across all BME groups consulted that it would be very difficult to change the negative attitudes to mental health issues; it should be noted, however, that both the young Muslim and Chinese groups felt that it would be easier to change young people’s attitudes than those of the older generations.

- **Barriers to change:** there was consensus across all BME groups consulted (that discussed this issue) that the main barriers to changing negative attitudes would be fixed views, lack of interest, lack of understanding. Language was a key issue, especially for engaging with older people.

- **Opportunities:** again there was broad agreement across all the BME groups about the opportunities for changing negative attitudes. Ideas included making use of existing community centres that people visit frequently; using mental health professionals from BME backgrounds to talk to people in their own language; using a multi-media approach; and using incentives to encourage people to become involved. The Muslim community focus groups, in particular, felt that involving religious institutions (and leaders) would be useful.

- **Support and advice from inside or outside community:**
  - most participants expressed a preference for going outside their community for help and support, mainly for reasons of confidentiality but also in cases where a mental health problem had become ‘out of control’.
  - help and support from within the community would be sought by those who are not confident in speaking English - primarily older people. Also ‘inside’ help from religious leaders would be sought by the Muslim community in some cases.
  - those issues aside, participants from the Muslim and Chinese communities expressed an ultimate preference for help and support from a professional friend or relative from within the community who could both be trusted and
understand the language and cultural issues.

- both the Muslim and Chinese young people expressed a strong preference for going outside the community for help and support, this course of action would be easier for young people as language is not an issue.

- both the Muslim and African/Caribbean focus groups felt that it was important that members of their communities knew how and where to seek help for mental health problems e.g. counselling.

- African/Caribbean participants were the only ones that expressed a clear preference for seeking help from professionals within / from their community; participants also stated, however, that there seems to a lack of African/Caribbean people within the mental health related professions locally.
RECOMMENDATIONS (SECTION 4.2: Channels of Communication & Possible Solutions).

NOTE: All BME communities consulted felt that it would be difficult to change existing negative perceptions of and attitudes towards mental health issues, especially in older generations. An approach that uses all types of media and channels of communication available was perceived to be the best way to reach everyone.

1. Television
Zee TV and Star Plus would offer strong opportunities to inform and influence the attitudes of Muslim, Hindu and Sikh communities. This would be especially true for older people - and perhaps those women who spend more time at home - who tend to watch channels in their own language rather than mainstream English-speaking channels. One approach might be to try to influence the storylines of TV dramas to cover mental health issues in order to raise awareness and demystify some of the current perceptions of mental health.

2. Radio
Radio Awaz and Radio Ramadan are potential sources of influence and information for the Muslim Community – and to some extent, Radio Awaz for the Hindu community - but their popularity compared to English-language radio is unclear.

3. Newspapers/magazines
Urdu-language press may be a source of influence and information for older Muslim people who are not confident in speaking English; the free newspapers such as Metro and Glaswegian are popular with those proficient in the English language.

4. All media
Participants indicated that television has the biggest influence over people’s views but should be used in conjunction with other media to reach all sectors of the BME communities (older/younger, women/men, working/not working).

5. Children/young people
There is a perception that it is easier to influence the views of children and young people and that it is important to target them through schools, colleges and, possibly, the internet (although this should be investigated as a potential means of reaching young people).

6. Other channels of communication
Use local community places to improve understanding and awareness of mental health issues. This could include local shops, billposters, health centres and, for the Chinese community, the Chinese supermarkets and restaurants.

7. Large scale events
Consider tapping into large scale events to raise awareness of mental health issues, such as festivals or religious gatherings for BME communities.
8. **Discussion groups**  
Capitalise on the fact that all the BME communities seemed keen on the idea of discussion groups (this may be especially true for young people and women, but perhaps may be less popular for the Hindu community and BME men in general). For some, it would be important to be able to speak in their own language. There should be flexibility around the timing and venue. Catering or other incentives would help encourage attendance.

9. **Working with local professionals and religious leaders**  
Local health professionals and religious leaders may be effective in influencing the beliefs and attitudes of the communities.
4.3 Feedback on the ‘see me’ campaign materials

The third section of the focus group covered participants’ perceptions and opinions of the current ‘see me’ campaign materials and was also used to gather any information and suggestions that could be used to develop campaign materials that would be appropriate for their communities.

This topic comprised the final part of the focus group discussion and, in some groups, participants clearly felt ready to leave before embarking on this section. As a result, there was little time to check levels of consensus, draw out, and explore alternative ideas. Key points are summarised below:

### Key themes:

- **Understanding the message**

  Many participants from the Muslim community (other than the young people, see below) - and the African/Caribbean community did not relate to the campaign or understand the message on the ‘see me’ posters. Some participants (around half) from the Hindu and Chinese communities did appear to understand it - however, the message seemed to be too indirect for the majority. In contrast, all the young people who took part in the research (from the Muslim and Chinese communities) seemed to ‘get’ the intended message.

- **Appropriateness**

  Participants across all the BME groups that discussed this question felt that the message was too cryptic or lateral and that the campaign (as it stands) was inappropriate as it would not be easily understood by many people in the Muslim, Hindu and Chinese communities; again, the notable exceptions were the Muslim and Chinese young people.

  The English text was not easily understood by many people, especially the older people who have difficulty with speaking and reading English;

  The Hindu community felt that the images had a ‘Western look’ and that many in their community would not easily relate to it.

  Participants from the Chinese community indicated that the phrase ‘see me’ might be inappropriate for use in an anti-stigma campaign, as Chinese people ‘do not like to stand out in a crowd’. Aside from this, however, the materials in general seemed to be quite acceptable to the Chinese participants; although participants also said that football is not an appropriate image for Chinese culture / not an image that the Chinese community relate to; further investigation of their views may be merited.

  The ‘cloud boy’ and ‘cloud girl’ cartoon strip campaign for young people seemed to be acceptable to the young Muslim and Chinese people.
Suggestions for the development of appropriate campaign material

**Text:**
- Participants across all the BME communities reported that language is a key issue and that text in all relevant languages should appear alongside the English text.

- The issue of literacy was raised - and it was suggested that the image alone should be enough to convey the message.

- Some participants suggested words and phrases to use or to avoid were offered by most groups

- Participants in the Muslim focus groups suggested that the text should provide statistics and information about symptoms of different types of mental health problem. The fact that the Muslim community would prefer a (more) ‘medical’ approach may be substantiated by the fact that participants said that doctors and nurses are held in high esteem.

- Some participants in Muslim focus groups suggested using religion and the Koran to reinforce messages.

**Images:**
- Participants in both the Muslim and Chinese communities felt it was important to use positive images.

- All the BME groups (with participants who expressed a preference) felt strongly that the image should reflect a multi-racial society, showing people from all BME communities alongside people from the indigenous white community.

- The young people from the Muslim community felt that using a celebrity of South Asian ethnicity to endorse messages would be a powerful way to communicate to all Muslim people. No other BME group made reference to ‘celebrity endorsement’.

- There was an indication that the phrase ‘see me’ is inappropriate for the Chinese community as it is considered inappropriate in the culture for someone to draw attention to themselves - the message that Chinese participants perceive this phrase to convey.
RECOMMENDATIONS (SECTION 4.3: Feedback on 'see me' Campaign Materials)

Based on the feedback from the focus groups, those engaged in the development of any future public awareness media campaign to challenge the stigma of mental health may wish to consider the following recommendations.

1. **Obvious message:**
   The mental health anti-stigma message should be more obvious (literal), and less cryptic (lateral), if it is to be understood by / valuable to all age groups across all BME communities.

2. **Multi-racial images:**
   Any adopted or created images used should reflect a multiracial society by showing all BME faces alongside white faces. Participants expressed concern that the use of Asian faces only, for example, might lead to ‘stereotyping all Asians as having mental health problems’.

3. **Be positive:**
   Participants across all BME communities expressed a preference for positive images and words; some suggestions include showing happy faces, or text that stated ‘Be sympathetic, show humanity’, ‘recovery’. If a community-specific approach was being developed, participants from the Chinese community suggested the use of dancing lions (an image of celebration), the family unit or Chinese character/s, which they felt, would really be eye catching.

4. **Celebrity endorsement:**
   Several participants - primarily younger Muslim people - felt it would be very effective to use celebrities of South Asian ethnic origin, such as (former) Miss World title holders Priyanka Chopra, Yukta Mookhey or Aishwarya Rai, Bollywood Stars or sports personalities to endorse messages. This idea could be explored further but should take account of the need to guard against stereotyping (see above).

5. **Language issues:**
   Participants expressed a preference for text in campaign materials to be written in all the main BME languages; in addition, participants thought that the visual imagery used should be able to communicate the message without the need for text where English literacy levels are quite low amongst some of the older age groups in some BME communities.

6. **Text:**
   Literal, factual information such as statistics and symptoms could be utilised to highlight issues. Medical professionals such as doctors and nurses were reported as having a positive image and held in high esteem by the Muslim community groups.
7. **Use religion as the context:**
If a community-specific approach was being developed, some participants from Muslim community suggested the use of religious ideas or contexts to support this.

8. **Cultural appropriateness:**
The development of any campaign should include significant testing in relation to the utilisation or creation of images and straplines in order to ensure cultural appropriateness for all BME communities. For example, the research indicated that the phrase 'see me' may not be appropriate to the Chinese community. It is not always in their culture for individuals to draw attention to themselves (which is how this phrase was understood); also, as football is not a significant part of their culture, use of a footballer in the campaign may be less effective.
Chapter 5 Summary of Overall Findings

Language used for mental health is an important aspect of stigmatising those with mental health problems (as it is in other forms of stigma: ie around learning and other disabilities; racism; and sexual orientation). Terms believed to be current in the Muslim and African/Caribbean communities in Glasgow were often derogatory, including ‘schizo’ and ‘nutter’. The most common words used by Muslim groups is ‘paghul’ which translates as mad or crazy. There were few if any generational differences observed in the Chinese and Muslim communities regarding words or phrases associated with mental health.

Shame is so strong in some communities that family members keep mental health problems a secret and care for the individual in isolation. Treatment is not sought in this situation where the family may hope that the problem will just go away. The value placed on family reputation may be such that the family will not discuss the mental health problems even with a doctor. The higher the status of the family, the greater may be the reluctance to discuss the issue, regardless of educational achievement.

Marriage prospects for people with mental health problems was a major concern for the Muslim, Sikh, Hindu and African/Caribbean communities. This appears to be related to the notion of mental health problems “being passed on in the blood”. Many community informants suggested that this provides a strong incentive for families to keep mental health problems a secret. “The main reason is to keep it a secret until they get married because the main thing is to get married.”

Black magic or spirits were mentioned by all communities as a likely cause of mental health problems. Mental health problems can be caused by possession by spirits or ‘jinn’ and someone might put a curse on a person or a family to avenge a wrong and this could provoke mental disturbance. On the other hand, many Chinese people referred to ‘causes’ of mental health problems such as isolation and ‘the pressures of life’. Some African studies report a belief that drug abuse is a major cause of mental health problems.

Migration and migrant status in a new environment were considered important causes of mental health problems in certain groups. African migrants in Australia reported stresses such as accommodation, new systems, unemployment, language barriers, racism and responsibilities for families back home. South Asians (mainly Punjabis) in Glasgow felt stressed by factors including the absence of parents; household duties; a low standard of living; and experiences and concerns around mugging and other forms of assault.
Fear of violence is present in some communities in Africa, with women in particular fearing aggression associated with mental health problems. Older members of Muslim groups in Glasgow also expressed a fear of being attacked – leading to a desire to avoid contact with persons with mental health problems.

Racism and discrimination have been found to be a source of mental distress and stigma for African and Caribbean communities using mental health services in Britain. One study reported a lack of culturally sensitive staff; failure to understand religion; over medication; lack of counselling and appropriate after care; lack of information; coercive treatment and general neglect. Another study mentioned the perception that “mental health services replicate the experiences of racism and discrimination of Black people in wider society” and that “Black people see using mental health services as a degrading and alienating experience: the last resort.” (Keating, 2002)

Dual stigma is experienced by BME people in Britain who face discrimination and racism, and associated social disadvantage, in addition to stigma around their mental health problems. Dual stigma compounds stigma on mental health problems through misdiagnosis, maltreatment and mistrust of the system. Hence strategies to tackle stigma in BME communities need to address stigma relating to mental health problems and racism and discrimination concurrently.
Treatment

Treatment for mental health problems may be sought according to perceptions of the causes of the problems:

- Thus young people from the Muslim and Chinese communities will be less likely to believe in spirits and more likely to view mental health problems as an illness. Hence they will tend to seek help from a GP.

- Many Muslims perceive that bad spirits caused the problem and so they might seek help first and foremost from religious leaders.

- Language barriers for people who are not so confident in speaking English might also lead them to consult religious leaders as respected members of the community in whom they can most easily confide.

- There are concerns around confidentiality when consulting doctors. Members of the Hindu and African/Caribbean communities in Glasgow expressed general distrust of doctors and social workers.

- Believing as they do in several causes rather than one single cause for their illnesses, some South Asian patients use a number of treatments concurrently (ie traditional and modern psychiatric).

- Religious solutions may be sought by Indian families when mental health problems may be assigned to ‘divine wrath, curse, black magic or karma of a previous life’. Treatment may include prayers and bathing in the temple tank.

- Holistic approaches to health treatment, where body and mind are regarded as one, are common to Chinese communities.
Summary of causes of mental health problems

Mental health problems have been seen by members of BME communities as a consequence of:

• stress
• social deprivation; living in poverty, poor accommodation and unemployment
• migration; loss of status, associated socio-economic deprivation and changes in family relationships
• difficulties in relationships; problems and worry with children, quality of marital relationships
• misusing drugs

and as:

• punishment for wrong-doings
• shameful and bringing the family and community into disrepute
• God’s will
• possession by spirits or demons
• illness

Recommendations

The global and local evidence suggests that any initiative to tackle stigma around mental health problems in target BME communities in Glasgow and elsewhere in Scotland needs to be developed in the context of the concepts and beliefs surrounding mental health that are current in these communities. We must construct solutions in partnership with communities and community organisations. It is evident that in all these communities there is a plurality of beliefs – which is matched by a desire to access different types of support, including faith based, community based, traditional medicine and mainstream services. This necessitates a wide ranging set of responses.

The findings of our work to date were explored at a development day involving all partners. When linked to the existing evidence base of what works, an initial model of intervention emerged. This model requires a range of partners to take responsibility for interventions, using different skills and tactics at individual, community and organisational levels. The following points summarize the recommendations for intervention approaches arising from the process to date:
## Community conversation

The value of engaging people in safe and supportive settings to explore issues of mental health and stigma came through as a particular need. Some of the issues are complex, sensitive and culturally specific and should be led by community organisations. Discussion groups, or workshops, are being developed with adults and older people. There were some indications that gender was an important determinant of workshop attendance and involvement. Some work with women only groups may therefore be appropriate.

### Early intervention approaches

Across the research, schools and informal youth settings were identified as important avenues for intervention. Further consultations with youth groups have identified the arts and new media as the preferred approaches for exploring and sharing perspectives.

### Media awareness

There was significant enthusiasm for developing media awareness approaches with careful targeting of media sources that are of significance to BME communities. Appropriate radio, television, newspaper and community media are identified in the report. The report also identifies differing preferences as to who would be a credible ‘source’ for each community.

### Marketing campaign

There was a real wish to develop resources to support community development activity, practitioner engagement and social marketing campaigns. Partners were generally keen to use the stories of individuals from the communities concerned. No community wanted exclusively BME community images; instead people should be portrayed from a range of backgrounds. For some of the older community groups, it was important to have different languages, reconsider the use of the term ‘see me’, and use very direct messages.
### Key opinion formers

Communities identified a diversity of organisations and individuals as being important in determining community attitudes and behaviour. In particular, faith leaders were identified as having a role in signposting individuals and families, challenging stigma through their practice and supporting awareness raising.

### Empowerment

Empowering service users from a range of BME backgrounds (who may experience multiple stigma) is identified as a particular challenge in the literature. The main route, through involvement in user movements, has not been substantially achieved. Long term persistence and investment is needed and the emerging preference is to use narratives to explore issues of stigma and of involvement.

### Influencing policy and practice of mental health and social care services

Issues were raised in the research including anticipated stigma and discrimination in relation to service use. There was also a preference for blending services that people use based upon different belief systems about the meanings of mental health problems and causation. The implications are that ‘training’ approaches for mental health practitioners are not an adequate response. Opportunities for debate and deeper engagement between community organisations and mental health practitioners are required to explore the implications for diagnosis, treatment and support. In addition, developments to mental health practice should engage at an early stage with BME community organisations and service users, for example around recovery based approaches or employability.

### Cultural engagement

Events were viewed as a positive opportunity to work with communities and to engage with significant numbers of people, using arts and drama and cultural events in particular.
As well as providing answers, the research also generated many questions. Further community research is required to improve our understanding of community beliefs and stigma. Areas for further research include:

• Gaining a deeper understanding of the impact of gender and generation and faith for each community’s beliefs and preferred responses

• Applying the approach more widely, in particular with refugee and asylum seeker communities

• Understanding how the diversity of cultures and beliefs encountered relates to concepts of ‘positive mental health’ and ‘mental health problems’

Partners feel that investigations into these issues should continue. Processes that have been developed for such investigations include community-led research, with an emphasis on constructing shared understanding rather than pre-imposing narrow philosophical and methodological approaches.

**What is happening now?**

The project’s work in 2006 was largely about gathering the evidence for action. 2007 is the year in which the ‘community conversation’ around mental health is being rolled out within the four target communities in Glasgow.

Later in 2007, the project partners will begin to evaluate the successes and weaknesses of the work to date and the national ‘see me’ campaign will be considering how the learning and experience in Glasgow can best be used at a national level.
Chapter 6 An Intervention Model
Chapter 7 References

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African communities


**Caribbean communities**


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**Chinese communities**


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Appendices

A: Guidance for Focus Group Facilitators (including focus group questions)
B: List of Participating Focus Groups
C: Recommendations for Future Community Research
D: Detailed research Findings: By Black and Minority Ethnic Community
Appendix A: Guidance for Focus Group Facilitators (including focus group questions)

GUIDANCE FOR FOCUS GROUP FACILITATORS
BME COMMUNITIES TACKLING THE STIGMA ASSOCIATED WITH MENTAL HEALTH: A GLASGOW ANTI-STIGMA PARTNERSHIP PROJECT

Project objectives:
This research is being undertaken to explore different attitudes towards mental health and the associated stigma and prejudice within different BME communities. Through a series of Focus Groups, we hope to identify key issues regarding mental health and associated stigma among Black and Minority Ethnic communities. The information gathered will be used to create a greater understanding of your communities, develop appropriate and relevant awareness / anti-stigma campaign messages; and identify the best ways to deliver them.

Overview of your role:
Your role in this exercise is to act as the mediator between your community and Greater Glasgow NHS – and, by organising and taking on the role of moderator at the discussion groups, help identify and appreciate the ways in which your community understands issues of mental health and the associated stigma - just in the same way we discussed it at the recent workshop.

NB: you are not expected to be an expert on mental health issues or the terminology used - ‘See Me’ and NHSGGC will provide you with information on the basics of mental health and issues of stigma that should help you to answer any questions the participants may ask (see Appendix).

Support on the day:
The researcher / facilitator, who came along to the workshop, will be coming to each group to support you, make notes and make sure that the key issues are recorded. She will write a short report after each group that will build towards the full research report.

Lesley will not be taking part in the discussion itself but will observe and, at the end of each ‘section’, talk with the participants for a few minutes to make sure that she has captured all the key points of particular importance.

Please allow around 15 to 20 minutes at the end of your session to chat with Lesley. You are the expert on your own community and can make sure that she understands why particular points may be significant to your community and offer any cultural information that will help her write the report.

NB: the Focus Group discussion itself should last for a maximum of 90 minutes. You will also require time to prepare before the group, have your chat with Lesley, and tidy up after the group.

The Focus Group Plan:
The Focus Group Plan provides an outline for the discussion with your community group. As this Plan is to be used by a number of different BME communities, the column on the right
offers a space for you to make notes or reminders to include issues specific to your own community. Lee Knifton from the Mental Health team at NHSGGC and Lesley Sherwood are available should you require further assistance.

The Plan also has an approximate time allowance guide in the column on the left - when the date / time has been decided, you can make a note of the real timings (e.g.: 3.30pm; 3.45pm etc) to help you keep the session moving and keep track of the timing for each section. In addition, Lesley will be aware of the time for each section and can help by letting you know when she would like to join the group for the ‘summing up’

Preparing for your Group:
- arrange a date when members of your community group can attend the Focus Group
- provide the participants with clear information about the date, time and place (your local community centre or regular meeting place would be best)
- try to find a room with good lighting and ventilation - place the chairs round a large table / group of tables or in a circle so that everyone taking part will be able to see each other
- try to get 10 to 12 people from your community to agree take part in the discussion
- if appropriate, call the participants to make sure they can come along on the day (this may not be necessary if you are making use of a group who meet on a regular basis)
- make sure that you have all the materials you will need on the day including:
  - this guidance note;
  - Basics of Mental Health sheet;
  - ‘See Me’ materials to show participants (Lesley will bring these);
  - flipchart and pens (take your own if one is not available at the venue);
  - extra pens and paper for participants.

On the day:
You should arrive about 20-30 minutes before the participants so that you can:
- make sure that you will be able to see a clock or that you have your watch with you to keep an eye on timing
- set the chairs out (as above)
- put pens and paper / post-it notes on the table for anyone who may want to use them
- set up a flip-chart with paper and pens – you can write key points yourself
- if possible, provide tea / coffee / water / soft drinks and snacks as it helps the participants to relax and enjoy the discussion
- make a note of the gender and (approximate) age of each participant - the research report should contain this information but you will not be required to provide names
- it is important to try to get everyone to take part – so encourage quieter participants if necessary and keep control of those who have louder voices or a lot of opinions to express by asking other members of the group to respond to comments etc
# BME COMMUNITIES FOCUS GROUP PLAN

## TIME INTRODUCTION

Approx 5 – 7 mins

- welcome everyone and thank them for attending
- introduce yourself and Lesley and any other ‘See Me’ / NHSGGC personnel present to the participants
- if they do not know each other already, ask the participants to introduce themselves
- explain that a ‘focus group’ is really just an informal group discussion – you are interested in hearing their views about their community, so the more they can contribute the better;  and explain that that there are no right or wrong answers and that every opinion is important
- explain that the session will be divided into three sections – in each one of these sections they will discuss mental health and stigma with a focus on a particular issue
- explain to the participants that Lesley will not be taking part in most of the discussion but that she will be making notes… and that at the end of each section she may ask some questions to ensure that she has captured all the points made and has a good overview of the issues that are of particular importance to your community
- explain that there will be a five minute break between each section of the discussion, so that they can make tea / coffee; take a break to go to the toilet etc
- make sure that everyone is settled and comfortable

Approx 3 mins

Before starting the open discussion:

- Using the ‘see me’ sheet provided, explain what is meant by mental health and stigma (see Appendix).

## TIME TOPIC YOUR NOTES

Approx 5 – 7 min

| SECTION 1: Identifying issues around mental health and stigma in your community |
| Q1. What is the **first word or phrase** that you think of when you hear the words ‘mental health’ / ‘mental health issues’? |
As each participants tells you their word or phrase, write them on a flip chart – then BRIEFLY discuss each word with the participants to explore why it may be associated with mental health issues.

**Issues specific to your community:**

**Q2.** Are there any common **beliefs and attitudes** about mental health in your community? (And are there differences between beliefs across generations?)

**Q3.** How do you think people in your community would **react** if they heard that someone had a mental health problem? For example:
- Fear
- Blame
- Shame (marriage)
- Pity
- Comical figures

**Q4.** Do you think that these beliefs and attitudes affect the kind of **treatment** that people from your community might seek / be offered?

**Q5.** Does **religion** play a part in your community’s attitudes to mental health? (Is there any connection between perceptions of mental ill-health and ‘spirits’ / ‘karma’ or anything similar?)

**SECTION 2: Identifying channels of communication relevant to your community**

**Q1.** Do you watch any **TV** stations or programmes related to your community? If so, how much (compared to mainstream English-speaking TV). Which ones do you like and why?

**Q2.** Do you listen to any **radio** stations or programmes related to your community? If so, how much (compared to mainstream English-speaking radio). Which ones do you like & why?
Q3. Do you read any newspapers or magazines related to your community? If so, how much (compared to mainstream English language papers). Which ones do you like &why?

Q4. How much do you think that these types of media affect awareness and attitudes…and which is the most influential for your community?

Q5. What other forms of communication are important in shaping views and attitudes that we could use to reach your community for example:
- community groups, religious groups,
- schools and colleges
- workplaces

Q6. Are discussion groups (such as this one) an effective way of communicating ideas about mental health?

Approx 8 – 10 mins

Exploring solutions

Q7. How easy or difficult do you think it will be to change negative attitudes towards mental health issues in your community?

Q8. What are the main problems we will face when trying to do this? What are the main opportunities or ways we could do this?

Q9. If a someone in your community was experiencing mental health problems who, if anyone, would they be able to go to for advice and support:
- inside your community
- outside your community

Approx 5 mins

- Summing up this section – working with Lesley to ensure all the key points have been clearly identified.

Approx 5 mins

BREAK

Approx 2 – 3 mins

SECTION 3: Feedback on the ‘see me’ campaign materials.

- Show participants the ‘see me’ campaign materials provided:
- the ‘goalie’ image (schizophrenic)
• the nurse image (depressive)
• ‘cloud girl’ or ‘cloud boy’ from the young people’s campaign
• board with the message ‘see me…see the person, not the label’

Exploring ‘see me’ existing materials:

• This campaign is centred on the words ‘see me’…

Q1. What does the phrase ‘see me’ suggest to you / your community?

Show ‘see me….see the person not the label’ board

Q2. Is this an appropriate ‘message’ to associate with people experiencing mental health issues for you / your community?

Q3. What words could be used to ask your community to have more understanding and tolerance of people with mental health issues?

Looking at the images

Q4. Would your community relate to these images?

Q5. What kind of images do you think you / your community would relate to in a campaign to raise awareness of stigma and mental health issues?

• Are there any other comments you would like to make? / Any other issues you would like to raise about stigma / mental health in your community…or about how awareness and understanding of the issues can be improved.

Summing up this section – working with Lesley to ensure that the key points from this section have been clearly identified

• Then thank the participants for coming along and end the session.

Feedback discussion with Lesley to make sure that all the key points have been noted and to clarify any culturally specific issues or comments.
WHAT IS MENTAL HEALTH AND STIGMA

Everybody **has** mental health and everyone experiences ups and downs in their mental health...

...when we are happy and everything is going well we don't think about mental health – but we all feel sad sometimes... we feel stressed, angry, upset, frustrated and all the other emotions...and sometimes our feelings can be overwhelming.

The state of a person’s mental health affects their self-esteem, their ability to enjoy life and cope with its challenges - and a mental health problem is an illness or condition that affects mental health, just like a broken leg affects physical health...

...mental health problems can affect **anyone**...1 in every 4 people will experience mental health problems... and 2 people die every day from suicide in Scotland...

...but people can recover from a mental health problem...that is not the same thing as being ‘cured’....recovery means that a person can lead a fulfilling life, even if that means receiving treatment or having symptoms

Almost everyone here will have experienced prejudice, discrimination or stigma at some time..., which will be useful in this discussion...

...today we are going to talk about our understanding of mental health...about any prejudice, stigma and discrimination that exists in our community towards people with mental health problems...

...please be as honest and open as possible...no-one is going to judge what you say...but to help people understand mental illness in the future, we need to know what you think now...
Appendix B: List of Focus Groups

The table below presents the details of each of the focus groups with a breakdown of numbers, approximate ages and gender. It also shows the date, location, facilitator’s name and language. The total numbers of Muslim and Chinese participants are also shown. There was only one focus group for each of the other BME groups.

<table>
<thead>
<tr>
<th>Focus Group</th>
<th>Language</th>
<th>Numbers (Age/gender)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Muslim Women</td>
<td>English (mostly but a bit in Punjabi)</td>
<td>8 in total (4 in their 20’s 4 in their 40’s +)</td>
</tr>
<tr>
<td>2 Muslim Women</td>
<td>Urdu/Punjabi (interpreting provided by steering group member)</td>
<td>13 in total (3 teens / 20’s 5 in their 30’s 5 at 40 +)</td>
</tr>
<tr>
<td>3 Muslim Men</td>
<td>Urdu/Punjabi (interpreter present)</td>
<td>4 in total (one man left after 30 minutes)</td>
</tr>
<tr>
<td>4 Young Muslim people (16-18 years, mixed gender)</td>
<td>English</td>
<td>8 in total (4 young women, 4 young men, 2 of whom are in the ‘hard to reach’ group)</td>
</tr>
<tr>
<td>5 Young Muslim people (professional 20+ yrs, mixed gender)</td>
<td>English</td>
<td>6 in total (2 men; 4 women) (NB. One woman was of Chinese origin but described herself as having ‘no religion’.</td>
</tr>
<tr>
<td>6 Chinese Healthy Living Centre</td>
<td>Cantonese (written Translation on flipchart)</td>
<td>12 in total (3 men, 9 women. All approx 40+ years, except for 4 younger women)</td>
</tr>
<tr>
<td>7 Young Chinese people</td>
<td>English (not all had English as a first language)</td>
<td>10 in total (5 men, 5 women in late teens – early/mid 20’s)</td>
</tr>
<tr>
<td>8 Sikh (older women &amp; men)</td>
<td>Punjabi (facilitator translated)</td>
<td>10 in total (4 men, 6 women but several left after 40 minutes, leaving only 3 men, 1 woman - for Section 2)</td>
</tr>
<tr>
<td>9 Hindu Women</td>
<td>Hindi (facilitator wrote in English on flipchart)</td>
<td>16 in total (2 of who were white and left after 35 mins. Mostly older single women 50+ years: 50-59 yrs = 4 60-69 yrs = 8 70+ yrs = 4)</td>
</tr>
<tr>
<td>10 African Women</td>
<td>English</td>
<td>9 women in total (1 in their 20’s 5 in their 30’s 3 in their 40’s)</td>
</tr>
</tbody>
</table>

Total 96
Appendix C: Comments about the Process and Recommendations for Future Research

This was the first time that NHS Greater Glasgow and Clyde had worked with some of the BME communities, organisations and individual facilitators in the context of research into mental health stigma. It was, therefore, important to reflect on the process of setting up and running the focus groups in order to inform similar work in the future and build capacity within the organisations and communities taking part. The lessons learned from the process were also a key aspect of the initiative from a national perspective. If a similar process was to be repeated in the future, the following points are recommended:

- **Support for facilitators**: most of the host organisations and facilitators demonstrated the skills to partner further research or implementation. Appropriate training and written guidance should be built upon from this work.

- **Language**: the language issues need careful additional planning if the focus group is to be held in a language different to that spoken by the researcher/reporter.

- **Numbers of participants**: a maximum number of participants for each focus group should be set (the ideal is eight-to-ten). If more than this number is expected, the facilitator should try to organise two groups separate focus groups. When groups exceed ideal numbers, quieter participants may not be confident or loud enough to be heard.

- **Getting representative views**: wherever possible, separate age and gender-specific focus groups from each BME community should be organised. This research exercise demonstrated that views differ significantly across generations and any future work might highlight differences in the opinions of men and women, working and non-working and so on. Having a significant demographic spread within a single focus group is problematic because, for example, younger people may defer to the views of their elders.

- **Hard to reach people**: consideration how to involve those who might be considered ‘hard to reach’ and, should they attend a general group, how their views can be elicited sensitively; a focus group dedicated to the ‘hard to reach’ group/s might be appropriate.

- **Checking process**: The researcher should take time with the facilitator at the end of each focus group to check understanding of key points or cultural issues.

- **Incentives**: Providing each host organisation with an ‘incentive’ budget seemed to work well and should be discussed (and agreed) with facilitators as to how it could best be used.

- **Interpreting Service**: There is a need to liaise with service sponsors to discuss roles and requirements of the Glasgow Interpreting Service in relation to research project involvement.
Appendix D: Research Findings: by Black and Minority Ethnic Community

This appendix presents the research findings by BME community:

- Muslim (a synthesis of all five Muslim groups),
- Hindu
- Sikh,
- Chinese (a synthesis of two Chinese groups)
- African/Caribbean

A note about ‘representativeness’: Qualitative research of this scale is in part hypothesis-generating, and often seeks ‘typical’ rather than fully representative samples. Five focus groups were carried out with the Muslim community: two with women only, one with men only and two with young Muslim people of both sexes. The synthesis of their views may provide a reasonable insight into the views of the Muslim community in Glasgow. We can be less confident about the ‘representativeness’ of the views of the Chinese community as there were only two focus groups (one of which was with young people). We should also be less confident about the ‘representativeness’ of the Hindu, Sikh and African/Caribbean focus groups as the Hindu group was comprised of older single women only; the Sikh community focus group was made up of older people attending a day centre; and the African/Caribbean focus group consisted of women only. However, these findings will be linked to the literature review in order to inform the development of interventions.

1. Beliefs and attitudes around mental health and stigma in BME communities

1.1 Words or phrases associated with mental health issues

- Participants were asked to say the first word or phrase that comes to mind when they hear the phrase ‘mental health or mental health issues’. Key themes emerging from each BME community in relation to this introductory question were:

**Muslim Community**

- one of the first words mostly commonly referred to by participants in all the Muslim groups was the Urdu word ‘paghul’ which translates as ‘mad’ or ‘crazy’.
- most of the initial words/phrases described the more extreme end of the mental health spectrum e.g. ‘psycho’, ‘schizo’ ‘nutter’.
- there were also some references to milder forms of mental illness such as depression, stress, or ‘thinking too much’ but these followed more extreme ones.
- participants in both groups of Muslim young people (but not the other groups) mentioned phrases that relate to being mentally disabled e.g. brain damaged, retarded, disabled, ‘a bit slow’.
Hindu and Sikh Communities

- participants in both groups made far fewer references to severe forms of mental illness, nor was there any mention of ‘paghul’, (which highlights the significance of language and terminology in this field of work.) Words and phrases used by participants focussed instead on milder forms of mental illness and the causes such as family worries or loneliness
- participants in the Hindu group was the only group to refer to the physical symptoms of poor mental health such as palpitations and nausea
- participants in the Hindu group made one of the very few references to phobias

Chinese Community

- there were brief references to ‘madness’ but otherwise participants in the Chinese groups referred to milder forms of mental illness such as stress and depression
- there was quite frequent mention of ‘causes’ such as isolation and ‘the pressures of life’
- claustrophobia was mentioned by the young people
- apart from these points, there was little difference between views and opinions expressed in the mixed age group and the young people’s group

African / Caribbean Community

- as with the Muslim groups, participants in this group mentioned word/phrases at the severe end of the spectrum (e.g. madness, insanity)
- mental disability was also mentioned by participants – this issue was barely touched on in the other groups

1.2 Beliefs, Attitudes and Reactions to Mental Health Problems

Participants in each focus group were invited to give their views on what they felt their community’s common beliefs and attitudes were to mental health problems and what sort of reactions their community would have to a person suffering from a mental illness.

In general, there was a good deal of consistency in the beliefs, attitudes and reactions across the BME communities. This is reflected in the fact that the categories for reporting the findings of the focus group research are very similar across all the different BME groups. Some important differences between the BME communities do exist, however, in terms of consistency or strength of views held.

Within the Muslim and Chinese communities, separate focus groups with young people were held. This highlighted some differences across generations and, where they exist, these are indicated in the report. It was reassuring to find there was reliability in what the older generation perceived the younger ones would think and what they actually thought, and vice versa.
Main issues emerging from each BME community are as follows:

**Muslim Community**

- **Shame and Secrecy**: participants expressed strong feelings that mental health problems bring shame on the family and this provides a strong drive to keep the condition secret. There is a sense that people will gossip within the community and that friends (and even some professionals) cannot be trusted. In many respects, there appears to be a culture of being brought up not to be open about issues and to keep problems within the family.

Slightly different views were expressed by the young people. Although participants said there would be some sense of shame and concealment they thought they would be more open, understanding and tolerant (due, they believed, to ‘education’); they also reported that they would confide more in friends than they would with family.

- **Causes of mental illness**: many participants expressed a strong belief that mental health problems are not an illness, and perceive causes to be ‘possession’ (by ‘Jinn’) or that “someone has done ‘Black magic’ to you”. Other perceived causes were that it is “a punishment from God because you have been bad” or that person is ‘just plain lazy’. Despite these predominating views, some participants felt that mental ill-health is an illness and deserves sympathy. Young people were significantly more accepting of mental ill-health as an illness and although there was still some belief in ‘Black magic’ and spirits these are not as strongly held as those in the older generation.

- **Marriage**: participants expressed very strongly that people would avoid marrying into a family in which someone had a mental illness; the attitude seemed to be based in a belief that mental illness will damage marriage prospects because of notions of ‘inheritance’ which, in turn, provides a strong incentive for families to keep mental illness a secret within the family. [NB: this is in accordance with the Public Attitude Survey]

- **Avoidance**: participants indicated that one of the first reactions to mental illness is that of avoidance - people will avoid and isolate a mentally ill person and often the whole family too. There was some indication that this may be due

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8 Beliefs that mental illness can be caused by possession by spirits or ‘Jinn’ appeared to be common amongst the participating BME groups. The belief is that spirits of the dead are all around us, some are good, some are bad. Bad spirits, such as poltergeists, can randomly possess people if, for example, they are standing under a tree at the wrong time of day. The person will appear quite suddenly to be ‘mad’. This is referred to in the Koran and other religious and philosophical writings including the Bible, the Torah and Plato. For Muslims, spiritual, rather than medical, treatment will be sought in which the Imam will direct the person to recite relevant passages from the Koran. Exorcisms, similar to those performed by the Catholic Church, can also be performed.

9 Some participants referred to a belief that ‘Black magic’ can be a cause of mental illness, that is, that someone would place a curse on a person (or family) if they had done wrong to them. This might result in, for example, your business going downhill. Signs of ‘Black magic’ would be e.g. eggshells scattered around the perimeter of your garden or that things started to go wrong after a certain person had visited.
to beliefs of ‘contagiousness’.

- **Homogenous condition**: participant responses indicate that there is a perception that all forms of mental illness are ‘lumped together’ at the severe end of the spectrum, with milder conditions not really being considered / recognised at all (this is verified by the fact that more severe end of the spectrum was referred to more readily)

- **Fear**: participant responses also indicate that people may make assumptions of danger and fear that they may be attacked or killed; interestingly, this was not mentioned by the younger people.

**Hindu Community (older women)**

Amongst the Hindu community, beliefs, attitudes and reactions were very similar to those found in the Muslim focus groups. For example:

- **Shame**: participant responses indicated that attitudes of shame and secrecy were predominant.

- **Causes**: participants cited ‘Black magic’ as a key cause of mental illness; other suggested causes included family history, stress and ‘family worries’. Possession by spirits was not explicitly mentioned.

- **Marriage**: the notion of ‘inheritability’ was common – although not universal - among participants; again, this has important implications for marriage prospects.

- **Avoidance**: participants indicated that avoiding or ignoring the affected person was a common reaction.

**Sikh Community (older men and women)**

The Sikh community focus groups reported beliefs, attitudes and reactions that are similar to the Muslim community, although views seemed to be less extreme across the range of group participants.

- **Shame**: the sense of shame and need to conceal the problem was expressed less consistently amongst the Sikh participants than amongst those in the Muslim community.

- **Causes**: although participants expressed beliefs around ‘Black magic’ and possession, there was also more acknowledgment of mental ill-health being an illness for which people needed sympathy and support and which may have been brought about by stress and problems, ‘It’s not their fault, it might be due to unkind people or a bad environment’. This is in keeping with the milder forms of mental health problems referred to.
• **Marriage:** As with participants from the Muslim community focus groups, there was strong belief, that mental illness has a genetic component and is ‘passed on in the blood’. This belief (again, in accord with the Muslim community) seems to be tied up in fears of remaining unmarried, for example, ‘The main reason is to keep it a secret until they get married because the main thing is to get married’.

• **Education and mental health issues:** there was a also consensus among participants from the Hindu community in regard to another reason as to why mental illness may affect marriage prospects - that mental health problems lead to low educational achievement. Educational achievement is of very high importance to this community (even for women who may not work after marriage). ‘If a child has a mental health problem they will not get a good education and so people will not marry into that family’.

**Chinese Community**

The issues raised within the focus groups with the Chinese community showed some consistency with those raised in the other BME communities in regard to notions of shame and secrecy, however, there seemed to be differences in the perceived causes of mental health problems.

• **Shame:** participants indicated that there is a sense of shame within the family and the need for secrecy around mental health issues. Throughout Chinese culture, people care very much about ‘not losing face’. As the Chinese community in Glasgow is very small and ‘everyone knows everyone’, people are reluctant to talk openly about issues that might bring perceived shame (to avoid gossip). The young Chinese participants, however, reported that they are more open and willing to discuss mental health issues than older people.

• **Causes:** as with findings from the Sikh focus group, participants cited a belief that mental health problems are caused by particular issues such as relationship problems and family worries. This sits alongside typical reactions that the Chinese community might have towards someone who has mental health problems – mainly sympathy and pity - and of the need for support and understanding. There was no mention of inheritability or potential effects of marriage prospects, in contrast with views expressed in the Muslim, Sikh and Hindu communities.

• **Homogenous condition:** older participants indicated that people [of their generation] are reluctant to admit there is a problem and are, therefore, likely to hide it, unless it is very severe. As in the Muslim community, this compounds the notion of mental illness being a homogenous condition.

• **Fear:** although there was no explicit mention of ‘avoidance’ behaviour, a few participants felt their community would be fearful of ‘strange behaviour’ associated with mental health problems. This was only mentioned briefly and did not appear to be a major issue.
• **Alcohol**: the relationship between alcoholism and mental health was mentioned by the young people, the only reference to alcohol in any of the groups.

**African / Caribbean Community**

• **Shame**: participants expressed the belief that there is a definite sense of shame associated with mental health problems

• **Causes**: as with the Muslim, Sikh and Hindu focus groups, participants said that there is a strong belief that mental health problems can be caused by ‘Black magic’. There is also a perception that people ‘never really get cured’ and therefore people treat them differently and with suspicion.

• **Inheritability**: participants also expressed the belief that mental ill-health can be passed down through families (in accord with the views of the Muslim, Sikh and Hindu focus groups). This was not mentioned, however, in the context of marriage prospects being affected.

• **Avoidance**: participants felt that a common reaction within their community would be to avoid a person with mental health problems and, in many cases, the whole family, as it may be a ‘cursed family’. Again, this avoidance reaction is consistent with the views of the majority of other BME communities involved; the exception to this was the Chinese community, where participants who did not express this view or indicate that they might engage in this behaviour.

• **A Western Illness**: there was a sense that mental health problems at the less severe end of the spectrum are fundamentally a ‘Western problem’ and occur in the African / Caribbean community as a result of pressures of immigration / living within a host society. Participants suggested that, in Africa, people [experiencing a mental health problem] may have access to family support so that they can ‘heal themselves’ by sleeping, walking, for example.

1.3 **Treatment Issues**

Participants were asked whether their beliefs and attitudes to mental health problems affect the kind of treatment people from their community might seek or be offered.

• There are some common themes about treatment emerging from each of the BME communities.

• Main issues emerging from each BME community are as follows:

**Muslim Community**

• **Who to approach for help?** participants suggested that the perceived cause of the mental health problem and confidence in speaking English would influence the type of help people would seek:
- the Imam at the Mosque would be the first port of call for many people, especially for those who believed the cause of the problem to be Spirits/Jinn and those who are less confident in English; the Imam would say prayers and provide a recitation from the Koran.
- participants said that a person would need to go to a special person to treat mental ill-health caused by ‘Black magic’/curse.
- the younger generation (who view mental ill-health an illness) and those who are ‘more educated’ are more likely to go to their GP.

- **Avoid Mainstream Medical Services**: participants thought that a common course of action would be to avoid seeking ‘medical’ help (with the exception of young people and ‘educated’ people) because:
  - many people think that the problem will resolve itself, ‘They’ll get over it’ or ‘lots of love will solve it’...
  - of a fear that it would become common knowledge and gossip (there was an indication that doctors are not particularly trusted in this respect)
  - mental ill-health is not regarded, by some people, as an illness but rather is caused by family inheritance, ‘Black magic’/Spirits and, therefore, medical intervention would not be of use.
  - of the possibility, raised by participants in two of the groups, that ‘people ask too many questions’ and that acquaintances in the waiting room would ask why you are there.
  - of issues around communicating (effectively) in English; this seemed to be a significant factor in avoiding going to the doctor and speaking to the Imam instead.
  - it might result in extreme measures such as going to an asylum (there seemed to be a significant fear of this outcome).

- **Medication**: prescription drugs, although mentioned infrequently, seemed to be viewed with some suspicion ‘Drugs only sedate the person - there is no cure’.

- **Size of family**: participants in one of the focus groups with young Muslims felt that the size of the family in which the person belonged might affect the course of action; for example, someone with mental health problems in a large family may be sidelined.

**Hindu Community (Older Women)**

- as with Muslim focus group findings, participants expressed a reluctance to seek help or to comply with treatment, reasons for this were not explored.

- participants expressed very negative views of doctors and social workers. This was not fully explored but seemed to centre on the perception that these professionals do not intervene until crisis point is reached.

**Sikh Community (Older Men and Women)**

- participants only briefly explored issues of treatment were but it was clear that
the group felt that ‘medication will not work’.

**Chinese Community**

- **Avoid mainstream ‘medical’ help:** participants indicated that, in general, the Chinese community are reluctant to seek help. The main reason for this appears to be language difficulties. Despite interpreters being used frequently by members of the Chinese community, there are 2 key issues:
  - concerns about confidentiality being breached in such a close-knit community
  - they feel that working through an interpreter will communicate inadequately (or will ‘dilute’) their feelings

- **Young people are more likely to seek help:** while participants in the young people’s focus group indicated that they might approach their doctor or counsellor for help, they also might continue to conceal a mental health issue from their family and friends

- **Traditional therapies/remedies:** again, participants in the young people’s focus group mentioned that traditional remedies, such as feng shui, might be sought but there was no further exploration of this issue

**African / Caribbean Community**

- **Who to approach:** participants indicated that the African / Caribbean community living here would seek help from:
  - their Pastor / Church; most Africans living here reported to be Christians belonging to the Pentecostal Church
  - their GP/ counsellors who would, preferably, be of African / Caribbean origin or ethnicity
  - traditional / alternative practitioners such as the herbalists, spiritual healers
  - information services, where they would be able to source information on who they could approach for help and counselling

- **Avoiding mainstream medical help:** in accordance with other groups, participants expressed strong distrust of health care / staff and social services

- **Medication:** participants indicated that there is a distrust of medication because of potential problems of addiction

- **No Cure:** participants indicated that there is a perception that people never really get cured

**1.4 Religious and Spiritual Influences on Attitudes to Mental Health**

Focus group participants were asked if they felt that religion played a part in their community’s attitudes to mental health and if there is any connection between perceptions of mental ill-health and ‘spirits’ or ‘Karma’. Key themes are summarised
NOTE: a number of complex ideas and issues were raised in this part of the focus group. Often these needed to be clarified by the researcher with the focus group facilitator after the end of the focus groups. It is worthwhile providing a ‘community definition’ of some of these ideas here, before the focus group findings are reported.

**Spirits / Jinn:** the belief that spirits of the dead are all around us - some good, some bad - and that mental illness can be caused by possession / as a result of being possessed by spirits or ‘Jinn’ / ‘Djinn’.

**‘Black magic’**: understood as a cause of mental illness; a person would place a curse on another person (or family) if they had been wronged by them

**Karma:** raised mostly by participants in the Hindu focus group, this is a belief, originating in Hinduism & Buddhism, that states that a person’s actions and conduct during the successive phases of their existence determine that person’s destiny – in other words, a person’s actions will have consequences on what happens to them in this life (and future incarnations)

- Main issues emerging from each BME community are as follows:

**Muslim Community**

- **Influence of religion:** participants in the Muslim focus groups were unanimous in their belief that religion plays a part in their community’s perceptions of mental health. It seems this is particularly so for older people as ‘*culture and religion go hand in hand*’. All other BME groups consulted endorsed the notion that older people, in particular, feel there is a strong connection between religion and mental health issues.

- **Influence of religious leaders:** participants indicated that the Imam would be the first point of contact for many people, especially those who are older, or who are not confident in speaking English. The exceptions would be people who are not religious or many young people, who would tend to approach their GP first.

- **Test or Punishment from God:** many participants expressed a belief that mental illness might be a test or punishment from God (for an individual, not for the family if it occurred within the family). This was not mentioned by any of the other BME groups

- **Religion as a support:** participants said that people (in their community) turn to religion to try to cope with mental illness (they prefer this approach to ‘*drugs* / medication) and expressed a strong belief in spiritual healing – praying to make things better. There is a belief that people can find their own cures and that God will protect them

- **Closeness to God:** participants indicated that there is a belief in their community that if a child is ‘simple’, or an older person is neglecting themselves, they are “*close to God*”
• ‘Black magic’: participants indicated that there is still a strong belief that mental ill-health as a result of a curse or ‘Black magic’ happens; findings from the young people’s focus group showed that this is accepted by some of the younger generation too

• Spirits/Jinn: participants indicated that if this was felt to be the cause of a mental health problem, people would go to the Imam for exorcism of spirits

• Karma: there is no concept of / belief in Karma in the Muslim Community

• Levels of religious knowledge: participants indicated that those who are knowledgeable about the Muslim religion have more freedom but those who are less knowledgeable ‘live in fear’

• Influence of religion over treatment: some participants in the young people’s focus groups felt that if people were not religious, they would go to the doctor instead

**Hindu Community (Older Women)**

• Influence of religion? participants indicated that the influence of religion and religious leaders on perceptions of mental health issues is much less significant than for the Muslim Community. The group felt that prayers can help the family to cope but they cannot solve the mental illness itself

• Influence of religious leaders: participants indicated that Hindu priests have less power and influence over people than the Imams; their role is largely around performing rituals leaving people find their own interpretation of the scriptures

• ‘Black magic’: as with the Muslim community, participants indicated that Hindus believe in ‘Black magic’ and that mental ill-health can occur as a result of a curse or ‘Black magic’

• Spirits: there was no mention of spirits and / or possession

• Karma: The group reported that many (but not all) Hindus (and Buddhists) believe in Karma, ‘if you were bad in a past life, you will suffer in this one’. (NB: the Muslim and Sikh community do not believe in this concept)

**Sikh Community (Older Men and Women)**

• ‘Black magic’: participants indicated that there is a perception that ‘Black magic’ is only done in Pakistan and India and not performed here in the UK; this was not mentioned by any other group. Participants also reported that belief in ‘Black magic’ is very strong, especially if people are of low social class, ‘less educated’, older, or from a rural background
- **Spirits / Possessions:** participants indicated that the Sikh community also believe in possession by spirits (in accord with the Muslim community)

- **Influence of religious leaders:** participants indicated that people from their community believe religious leaders can help counteract ‘Black magic’ or possession by spirits, reinforced by a strong perception that medication will not work

**Chinese Community**

**NOTE:** There is not a single predominant religion in China; however, there are many common spiritual beliefs in which, for example; people may worship their ancestors or gods. There is evidence of some belief in Karma (which may stem from a Buddhist tradition), curses (‘Black magic’) and possession by spirits, although these are mostly held by older or ‘less educated’ people. There is a strong culture of superstition (e.g. things that are lucky or unlucky); these beliefs span the generations, including young people.

- **Influence of religion:** participants indicated that although there is no single main religion, there are many followers of three main traditional religions - Daoism, Confucianism and Buddhism; Islam and Christianity have also been present in smaller numbers in China for centuries.

- **Spiritual Beliefs:** participants indicated that people in their community may worship their ancestors and certain Gods (e.g. Tree God, Kitchen God)

- **Spirits:** participants reported a belief in Spirits or ghosts (Jung Gwai) and the need for exorcisms (NB: few people would do this here in the UK although it is common practice in Hong Kong)

- **‘Black magic’:** participants indicated that people in their community believe that they can be cursed by someone

- **Karma:** participants reported that some people in their community, especially older people, believe in Karma

**African / Caribbean Community (Women)**

The links between religion and mental health / ill-health appeared to be quite strong in the African/Caribbean community who took part in the research, both in the context of being a ‘cause’ of mental health problems (a punishment from God) as well as being a source of comfort and healing. Belief in ‘Black magic’ also appears to be strong and more universal than in some of the other BME communities consulted.

- **Influence of religion:** participants indicated that a large number of African-born people living in the UK believe in a Christian God (Pentecostal Church) and that they ‘put trust in the Church’. They expressed a belief that mental health
problems could be linked to a person having committed a sin against God. A strong belief that God can heal and that ‘confession’ provides a ‘release’ also exists in this community, and that people with mental health problems need the prayers of others

• ‘Black magic’: there was a consensus among participants that mental health problems could be linked to demons or spirits that were ‘sent’ to you if you had offended someone
2. Challenging Stigma: Channels of Communication and Possible Solutions

2.1 Television

Participants were asked if they watched any TV stations or programmes related to their community and, if so, how much compared to mainstream English-speaking channels.

- Key themes and issues emerging from each BME community are as follows:

**Muslim Community**

- **Channels**: most of the participants in Muslim focus groups mentioned Zee TV, Star Plus (Hindi and English), PTV (Urdu), ARY, GEO and QTV for religion

- **Comparison to English-speaking TV**: participants indicated that most of the older people in their community prefer to watch Asian channels, mainly because they are less confident in English and prefer own-language channels

- **Young people**: younger participants said that they watch the non-English language channels because they are the preferred channels of the older generations in the house (Urdu speakers), but that they would prefer not to. In addition, they also reported that young people watch some music channels such as Zee Music and BFU Music

**Hindu Community (Older Women)**

- **Channels**: most of the participants in the Hindu focus group mentioned Zee TV and Star Plus

- **Comparison to English-speaking TV**: most of the participants indicated a preference for Indian/Asian channels because of language, although they also watch English channels

**Sikh Community (Older Men and Women)**

- **Channels**: most of the participants in the Sikh focus group mentioned Zee TV and Star Plus

- **Comparison to English-speaking TV**: participants indicated that they would prefer to watch mainstream TV (at a time when the group was mostly composed of men. The facilitator felt strongly that many of the older women would have preferred Asian channels because of age and background
Chinese Community

Note: The Chinese Community in Glasgow are currently comprised of approximately half-Cantonese and half-Mandarin speakers. Cantonese speakers can generally understand Mandarin but Mandarin speakers cannot usually understand Cantonese.

- Channels: the Cantonese-speaking participants indicated that those in their community tend to watch TVB; the Cantonese-speaking participants reported that those in their community tend to watch Phoenix; both channels require a digital receiver in the form of a box or dish.

- Comparison to English-speaking TV: participants indicated that most people in their community (especially older people) prefer Chinese-language channels.

- Young People: participants in the young people’s focus group reported that they watch both Chinese channels and mainstream channels (NB: most young Chinese people who took part understand Cantonese even if they do not speak it).

African / Caribbean Community (Women)

- Channels: most of the African / Caribbean participants reported that those in their community watch OBE (Original Black Entertainment).

- Comparison to English-speaking TV: participants expressed a preference for watching mainstream TV.

2.2 Radio

Participants were asked if they listen to any radio stations or programmes related to their community and, if so, how much compared to mainstream English-speaking radio.

- Key themes and main issues emerging from each BME community are as follows:

Muslim Community

- Radio Stations: most of the participants in the Muslim focus groups mentioned Radio Awaz (a Scotland-wide station that also produces a popular ‘Newsletter’); they also reported that Radio Ramadan is very popular although it is only available during the month of Ramadan and has traditionally been broadcast in a variety of languages including Urdu, Arabic, Punjabi and English.

- Young people: BBC Asian Network, Sunrise and Akaash were mentioned only by participants in the young people’s focus group.
• **Comparison to mainstream radio**: There was no clear consensus on the debate of dedicated language stations vs. mainstream, with two out of the three groups (that were asked) reporting that Radio Awaz was more popular than mainstream radio (including the young people’s group)

**Hindu Community (Older Women)**

• **Radio Stations**: most of the participants in the Hindu focus group cited Radio Awaz but mentioned that not everyone gets a signal

• **Comparison to mainstream radio**: participants offered no indication of the popularity of Radio Awaz compared to mainstream radio

**Sikh Community (Older Men and Women)**

• **Radio Stations**: most of the participants in the Sikh focus group cited 1072 and Sky Radio (from which people can access Indian radio programmes)

• **Comparison to mainstream radio**: participants reported that most people in their community prefer mainstream radio

**Chinese Community**

• **Radio Stations**: participants reported that there is no longer a Chinese language radio station (there used to be a BBC one)

• **Young Chinese people**: participants in the young people’s focus group reported that young people in their community did not to listen to much radio at all, saying it was ‘*not relevant to them*’

**African / Caribbean Community (Women)**

• **Radio Stations**: participants in this group seemed to think there was very few, if any, radio stations specifically aimed at the African/Caribbean community that they could access

### 2.3 Newspapers and magazines

Participants were asked if they read any newspapers or magazines related to their community and, if so, how much compared to mainstream English language papers/magazines.

• Key points and main issues emerging from each BME community are as follows:

**Muslim Community**

• **Papers/magazines**: participants in the Muslim focus groups cited the *Daily Jung* (UK-wide in Urdu and English), Urdu newspapers on the internet and
Urdu Women’s magazines. *Glaswegian* and *Metro* were also mentioned frequently and seem to be popular because they are free. The *Asian Extra* is also free but only comes out about every 2 months. Mainstream papers were mentioned too (*Daily Record, Evening Times* and *The Herald*).

- **Compared to English-speaking papers**: participants indicated that choice of print media is a language issue for their community; older people, who are less confident in English, read the Urdu press; young people or those who are confident in English read mainstream newspapers and magazines.

- **Young people**: participants in the young people’s group reported that they mainly read the English press (few young people seem to be able to read Urdu). *Eastern Eye* is being promoted to young people (published in English).

**Hindu Community (Older Women)**

- **Papers/magazines**: participants reported that there are no Hindi or Punjabi language newspapers or magazine although they indicated that people in the community would read them if they were available.

**Sikh Community (Older Men and Women)**

- **Papers/magazines**: participants reported that there is some Sikh Punjabi community press, although specific names were not offered.

- Participants indicated that people in their community mainly read English language press.

**Chinese Community**

- **Papers/magazines**: participants reported that people in the community read *Sing Tao*, published in Chinese. *Metro* is popular because it is free. ‘YES’ magazine is being promoted to young Chinese people.

- (NB: there is one main written form of Chinese, which is used by both Mandarin and Cantonese speakers; this written form is not always understood by British-born people of Chinese ethnicity, even if they speak Mandarin or Cantonese).

**African / Caribbean Community (Women)**

- **Papers/magazines**: participants reported that there seems to be no specific African newspapers available. Some participants said they read *Metro* because it is free. There seemed to be an indication that some young people in the community read African newspapers on-line.
2.4 Using the media and other mechanisms to influence beliefs and attitudes to mental health

- Participants were asked to what extent they felt that TV, radio and newspapers could influence their community’s awareness and attitudes towards mental health. This was followed by discussion about other possible means of communication in shaping people’s views and attitudes on mental health, such as religious groups, schools and discussion groups.

- Key themes and main issues emerging from each BME community are as follows:

**Muslim Community**

- Participants reported that TV was the most powerful way to influence peoples’ attitudes towards mental health and stigma, although most participants indicated that a campaign utilising all three main media (TV, radio and print) would be the best way to reach everyone in their community, whether they are working or not. In particular Urdu-based TV dramas and Urdu newspapers would be the key way to influence older people

- indicated that community groups [group discussions] are a very effective way of influencing views, although participants stated that these must be confidential. Schools, mosques (especially after Friday prayers), doctors surgeries, workplaces, the internet [predominantly for young people], (translated) posters in local shops and billboards were also mentioned as ways to reach and influence the community. It was suggested that health visitors could play a vital and influential role in communicating ideas, as they are going into people’s homes

- suggested that religious gathering and social events and festivals would also be a good way of reaching the community (providing refreshments is always effective at attracting people)

- were very positive about discussion groups as a way of communication ideas about mental health, although some people felt that the topic of mental health might put some people off. Also, confidentiality would have to be agreed and groups should be held in the evenings if men were to be able to attend

participants in the Muslim focus group for young people

- felt that discussion groups would be really interesting but that they would need an incentive to turn up (in accord with the older people, they said that refreshments would be a good incentive); they also felt that discussion groups would not be of interest to older people as they are ‘narrow-minded and too set in their ways’ and that ‘they would all argue’ - however this does reflect the views expressed by older participants within the other Muslim focus groups
Hindu Community (Older Women)

participants in the Hindu focus group

- said that TV (and, in particular, dramas) would be the most influential media to reach and influence their community - although it should be noted that this was a group of older women, who do not work and might watch daytime dramas

- felt that another possible means of communication that would be effective is ‘word of mouth’

- indicated that discussion group/s would have only limited support and would be welcomed only if there was to be some action, 'otherwise it’s a waste of time’ [NB: discussion groups could initiate a ‘word of mouth’ approach to raising awareness and changing attitudes]

Sikh Community (Older Men and Women)

There was only brief discussion on this issue during this focus group; participants in this group

- thought that, in order to raise the issue of mental health problems with older people, it would be best to come to a specialist centre like Mel Milaap

- expressed lots of enthusiasm for the idea of discussion groups on mental health

Chinese Community

participants in the Chinese focus groups

- cited TV as being potentially as being the most influential form of media for the Chinese community, although the Chinese press - Sing Tao - was also mentioned

- indicated that other ways of communicating effectively with the Chinese community would be through community centres such as Chinese Healthy Living Centre, Wing Hong, San Jai and Meridian

- suggested other potential ways to reach their community as Chinese Supermarkets, Chinese restaurants and the Chinese language schools (and schools and colleges in general)

- thought that events that bring large groups of people together would be popular reported that the Chinese community as a whole are always willing to learn and to listen to talks by experts

participants in the Chinese focus group for young people
• felt that the older people would not want to attend discussion groups as most of them only have one day off a week

_African / Caribbean Community (Women)_

participants in the African/Caribbean focus group

• felt that it was important to bring people together to talk about emotional issues but that it was important to be able to express yourself in your own language – French, Swahili) especially if talking about emotional matters

2.5 _Attitudes to Change and Sources of Support_

Participants were asked whether they felt that it would be _easy or difficult_ to change negative attitudes towards mental health issues in their community. This was followed by exploring potential _problems_ and _opportunities_ for doing this. Finally, focus groups participants were invited to give their views on whether they felt someone within their community, who was experiencing mental health problems, would seek advice and support from inside or outside their community.

• Key points and main issues emerging from each BME community are as follows.

_Muslim Community_

• _Easy / Difficult?_ participants in all of the Muslim focus groups felt that it would be difficult to change attitudes to mental health issues in their community and would need a prolonged and consistent approach. The young people felt that older people would be very resistant to change because attitudes are ‘deeply ingrained’ - but indicated that it would be much easier to change the views of younger people.

• _Problems identified:_
  - getting people together at suitable time/venue
  - participants having the confidence to come and talk about mental health
  - language (interpreters would be needed; lack of appropriate terminology needs to be addressed)
  - combating fixed views, judgmental attitudes, lack of understanding and lack of interest a ‘why should I bother?’ stance

• _Opportunities suggested:_
  participants felt that it was important to try to change the negative attitudes to mental health issues and talked about involvement of professionals / people respected in the community who can talk to people in their own language (e.g. Imam)
  - use of seminars to educate and raise awareness to help people realise it is an illness ‘recognising that there is a problem is 50% of the problem’
  - use of existing community centres to bring people together and consider targeting day centres for older people
- use of incentives to encourage attendance e.g. tea/coffee etc
- tap into religious groups at the Mosque
- use of the media (including TV dramas)
- give positive feedback such as praise or a certificate.
- confidentiality should be assured

- seeking assistance inside/outside community:

  **Inside:**
  - confidentiality was identified as the biggest issue with regard to seeking help from within the community, ‘People don’t want to be talked about’
  - people would probably look for help and advice inside the community if they were not confident in English (i.e. mostly older people) in which case most would go to a religious leader first
  - participants suggested that there was a fear - although it is not clear how widespread it might be - of the risk of ‘ending up in the asylum’ if someone was to go to their GP about a mental health issues (this is reported to stem from storylines in TV dramas)
  - participants thought that the ideal situation would be to know a trusted professional, such as a friend who is a doctor or professional
  - findings indicate that would seek help from inside the community if they felt they needed help to counteract ‘Black magic’ or spirits
  - BME community projects were identified as a potential source of help and support as they are culturally sensitive

  **Outside:**
  - the majority of participants agreed that they would prefer to go outside the community unless there was a language issue or that religious help was needed
  - there was strong agreement that young people would go outside the community for help and support in order to preserve confidentiality and because language is not an issue
  - participants thought that people might go outside the community if they felt that the situation was ‘out of control’

**Hindu Community (Older Women)**

- **Easy / Difficult?** all participants agreed that it would be very difficult to change attitudes in their community.

- **Problems identified:** a number of significant issues raised were in accord with those identified by the Muslim groups, including ignorance and lack of understanding; lack of sympathy strong belief that it runs in families

- **Opportunities suggested:** again, these mirrored those raised in the Muslim groups education, awareness, communication and discussion groups

- **seeking assistance inside/outside community:** the Hindu participants expressed a clear consensus that people from their community would seek
information and assistance outside the community for fear of confidentiality being breached

**Sikh Community (Older Men and Women)**

- **Easy / Difficult?** participants in this group felt that it would depend on people and their circumstances, for example, it would be more difficult to change the attitudes of those in their community who are older, of lower class, ‘less well educated’ and from a rural background.

- *(Problems and Opportunities: Not discussed)*

- **seeking assistance inside/outside community:** as with the Muslim and Hindu groups, participants indicated that people in the Sikh community would clearly prefer to go outside their own community for help and support on mental health issues

**Chinese Community**

- **Easy / Difficult?** participants from these groups felt it would be very difficult to change the negative attitudes to mental health issues among the Chinese community. As with the Muslim groups, the young Chinese people felt that it would be much easier to change the attitudes of young people (because they have more understanding and are more adaptable) than older people who are ‘more stuck in their ways’.

- **Problems identified:**
  - young people might not take it seriously
  - language might be a problem for older people

- **Opportunities suggested:**
  - use community workers who can talk to people in their own language to raise / discuss issues with their own community
  - for young people, use a multimedia approach (TV, magazines, newspapers)
  - for older people use community settings such as the Wing Hong Elderly Centre

- **seeking assistance inside/outside community:**
  - in accord with the Muslim, Hindu and Sikh communities, participants indicated that people in the Chinese community would prefer to seek help and support from outside their community, unless there was a language issue; despite this, participants said it would be good to have access to Chinese psychiatrists and nurses.
  - again, in accord with the Muslim community, some of the Chinese participants felt that it would be helpful to have a friend who was also a professional but admitted that, even then, people might not fully reveal the extent of their problems
  - participants reported that Chinese people (especially older people) like to
use facilities and services such as hospitals

African / Caribbean Community (Women)

- **seeking assistance inside/outside community**: there was a sense among participants in this focus group that people in their community would prefer to seek support from within their community; if this preferred help was not available to them, they would go to the church or GP. There was strong support for employing more doctors, social workers and community workers of African ethnicity and that it was suggested that the skills of asylum seekers could be used in this respect.
3. Feedback on the ‘see me’ campaign materials

The third part of the focus group was designed to find out participants views on the current ‘see me’ campaign materials, and to gather any suggestions around potential future adaptation of the campaign / development of a specific campaign strand more appropriate to their communities.

This was the final part of the focus groups and, in some of the groups, some of the discussions were rather hurried and there was little time to check levels of consensus and/or for drawing out alternative ideas. Due to time constraints, this section was not discussed at all by the Sikh community.

- Key points and main issues emerging from each BME community are as follows:

Muslim Community

- **Understanding the message?**
  - participants in the Muslim focus groups – with the exception of the young peoples group – did not understand the intended meaning of the ‘see me’ campaign materials. Instead, they felt it was trying to communicate, for example, that the nurse was working with depressed people or said ‘if she’s depressed what hope do we have’; they also perceived the goalie to be fit and in control.
  - the young people understood the messages but felt that they were not appropriate images for the whole Muslim Community, ‘they won’t understand it’, and ‘it’s more for educated people’.

- **Appropriateness:**
  - participants indicated that people in their community (especially older people) would not be able to read the English text and that it would need to be written in their own language as well as English. They said that this would definitely make people stop and look, if it was on a billboard
  - participants also said that the message needs to be less cryptic, ‘My Dad definitely wouldn’t know what that is all about. It needs to be more obvious’, and that for the message to be understood and appreciated by their community, it would need to be more direct e.g. giving facts and information about conditions.
  - a key issue identified by participants in this group was that many of them did not know the word ‘schizophrenia’ on the goalie’s t-shirt, which rendered the ad meaningless

- **Suggestions for campaign development / future campaigns (text, images and other):**

  TEXT:
  - there was a suggestion from participants in one group that text is more important than images
participants felt that written message should be more explicit and explanatory; e.g. ‘mental depression’, and/or ‘Be sympathetic, show humanity’. There was one suggestion that the word ‘mental’ should be avoided as this has negative connotations (e.g. ‘you’re mental’) highlighting the issue of (lack of) appropriate terminology in languages other than English

- any text would need to be translated so that older people can understand it but that this should be alongside English text and not exclusively Urdu

- the text should make people aware that
  - that mental ill-health can happen to anyone and that it is common (1 in 4 people experience some form of mental illness and so on)
  - that there is a spectrum from mild-severe, ‘it’s not all Paghul’
  - different conditions have different symptoms – with some guidelines as to what they are; participants indicated that this community like medical words and facts

**IMAGES:**
- participants suggested the use of Asian faces and dress, although some felt that there should be a mixture of white and Asian faces in case the use of Asian faces only communicated the message that all Asians have mental health problems. One group discussed that fact that they felt that people see a headscarf and think ‘Muslim’ or terrorist’ and that use of identifiably Muslim images could have negative connotations and results and should therefore be used with caution.
- use of positive, happy faces
- use of religions e.g. ‘Islamic point of view says….’
- doctors and nurses are held in very high esteem in the Muslim community but it is not quite clear whether the group felt it would be good to use them as part of the campaign or not – although any message conveyed by a health professional would obviously carry some weight.
- any campaign would need to be tailored to older people re. language and context (e.g. TV dramas)
- radio adverts are effective, (there were a few references to cleverly scripted adverts on Radio Ramadan)
- the young people in particular felt it would be ‘really eye-catching’ (for the whole community) to have Asian celebrities on billposters and TV adverts; they also felt that TV adverts were most effective if they were shocking, like the recent anti-smoking ads

**Hindu Community (Older Women)**

**Understanding the message?**
- some (fewer than half) of the participants seemed to understand the message while others thought that the nurse image was saying ‘I am a nurse and I can help you’ and/or that the goalie was in prison /behind bars.
• **Appropriateness:**
  - the only comment from participants from this community was that the images have a 'Western' look and, therefore, they felt they could not relate to them.

• **Suggestions for campaign development / future campaigns (text, images and other):**

**TEXT:**
- it was suggested that languages relevant to their community could be used (in addition to English)

**IMAGES:**
- there was a strong message from the participants that, in order for any campaign to be accessible and effective regardless of the literacy of the audience, the image alone should be able to communicate the message without the need for text
- in accord with the Muslim community, the Hindu community felt that a mixture of white and Asian (and other BME communities) faces should be used in any campaign to avoid stigma on the grounds of culture or ethnicity

**Sikh Community (Older Men and Women)**

• This section was not covered due to time pressure but the facilitator felt that the Sikh Community views would be quite similar to those of the Hindu Community.

**Chinese Community**

• **Understanding the message?**
  - many of the participants seemed to understand the message that the campaign was trying to communicate, including the young people, although it was difficult for the researcher (because of language) to get a clear picture of this. It is interesting to note that the young Chinese people felt that it was too 'indirect' for older people and that the older people in their community would not understand it at all.
  - participants reported that they liked the posters and said the campaign messages would definitely influence their thinking.

• **Appropriateness:**
  - the text on the current campaign posters translates easily into the written form of Chinese; participants indicated that the text would need to be translated in order for everyone in the Chinese community to be able to understand the message.
  - participants reported that football is not relevant to the majority of the Chinese community as it is not part of their culture.
  - participants in the young people's group reported that 'schizophrenia' had very negative connotation (mainly of danger) for the Chinese community.
- participants in the young people’s group said that the phrase ‘see me’ was not appropriate because, in the Chinese community, no-one likes to stand out and this phrase seems to demand attention (rather than recognition).
- the young people like the cartoon strip image but suggested that it should be in colour

**Suggestions for campaign development / future campaigns (text, images and other):**

**TEXT:**
- participants made suggestions for alternatives to ‘see me’ such as ‘Tell your secret’ or that the campaign should use positive words such as ‘understanding’, ‘happiness’ and ‘recovery’
- one young person felt there were too many words in the cartoon strip campaign and felt there should just be one or two cartoons

**IMAGES:**
- participants felt that it was not important to use Chinese faces but that a mixture of faces should be used.
- Participants suggested the use of positive images such as
  - dancing lions (in Chinese culture this is symbolic of health, happiness, celebrations
  - the family unit, which is very strong in the Chinese culture
  - a Chinese (written) character which would really capture the interest of older people (but young people may not be able to read it).

**African / Caribbean Community (Women)**

**Understanding the Message:**
participants did not really understand what the campaign was trying to communicate and the phrase ‘see me’ did not seem to mean anything in particular to them. They assumed that the footballer’s top showed his name and said they would not associate the images with mental health issues.

**Suggestions for campaign development / future campaigns (text, images and other):**
Again, like the Muslim, Hindu and Chinese communities, the African/Caribbean participants felt that it was important to show all BME faces as well as white ones.
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