Mosaics of Meaning
Summary Report

Exploring stigma and discrimination towards mental health problems with black and minority ethnic communities in Glasgow

Glasgow Anti Stigma Partnership

2007
The partners

A project like this required a range of skills and competences. Led by NHS Greater Glasgow & Clyde, the principal sponsor for the work is the national ‘see me’ campaign. Other key partners include:

Glasgow Association for Mental Health
Mental Health Foundation (Scotland)
National Resource Centre for Ethnic Minority Health, NHS Health Scotland

Work with communities in Glasgow was undertaken in partnership with the following organisations:

Youth Counselling Services Agency
Pollokshields Development Agency
Chinese Healthy Living Centre
Chinese Community Development Partnership
Shanti Bhavan
Mel Milaap
Meridian, Black & Ethnic Minority Women’s Resource Centre

Particular thanks are also due to:

Lesley Sherwood
Patricia Rodger
Centre for Ethnicity and Health, University of Central Lancashire
IAS Smarts
Florence Dioka
Iffat Bhatti
Members of all community groups who participated in the research
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.
Some findings around beliefs and attitudes

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.
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

To discuss the work of the National Resource Centre for Ethnic Minority Health in the area of mental health please contact: Dale.Meller@health.scot.nhs.uk 0141 300 1040 or Christopher.Homfray@health.scot.nhs.uk 0141 300 1038

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

References:


This report is jointly published by the Glasgow Anti-Stigma Partnership, 'see me' and the National Resource Centre for Ethnic Minority Health. Any citation from this report should be acknowledged.

A pdf of this summary is available on www.seemescotland.org

Printed on environmentally friendly paper.