Mental health, race and ethnicity

One mistake we often make is to assume that people from black and minority ethnic (BME) backgrounds all share the same struggles with cultural difference. In fact there are as many differences within BME communities as there are between the majority white population and any one of the different cultures that live in the modern culturally diverse Scotland of today.

The common factor BME communities in Scotland share is the experience of being treated as different and experiencing stigma.

Evidence from England shows that:
- Much higher numbers of people from minority ethnic communities are subject to compulsory treatment orders
- African-Caribbean men have a 60% higher rate of depression than white people
- The incidence of attempted suicide and self-harm among young Asian women is higher than among their white counterparts
- Pakistani and Bangladeshi women have higher rates of common mental health problems (anxiety and depression) than white women.

The Equal Minds report highlights the negative effects of racism on mental health. Within a twelve month period over three-fifths of people from visible minority groups and over one half of minority white groups (for example from Eastern Europe, England or Ireland) had experienced property damage, physical assault or offensive remarks in a public place.

Institutional racism refers to practices of large organisations that result in people from minority ethnic groups being treated unfairly. It does not mean that individual workers treat their colleagues or service users differently, although in some cases this does happen, but rather that policies and practices create inequality. In mental health services, for instance, some of the assessment tools with which we are most familiar are based on a Western view of the world. One example would be the difficulty of translating the word ‘depression’ into South Asian languages. We need to understand that concepts about mental health are different in different cultures so we cannot assume that everyone share the same ideas about mental health problems.

Black and Minority Ethnic Communities and Stigma

As part of a national commitment to mental health awareness raising and tackling stigma, the Glasgow Anti-Stigma Partnership, ‘see me’ and the National Resource Centre for Ethnic Minority Health and the Glasgow Anti-Stigma Partnership published a research report Mosaics of Meaning in 2007. This work looks at the stigma associated with mental health problems among the five largest BME communities in Glasgow.

The project highlighted important findings around beliefs and attitudes including;

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Shame which is reportedly so strong in some communities that family members keep mental health problems a secret and care for the individual in isolation. The reported value placed on family reputation may be such that the family will not discuss 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 reported as 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 reported by all communities as a likely cause of mental health problems. Some cultures believe that 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. One the other hand, many Chinese people referred to ‘causes’ of mental health problems as isolation and ‘the pressures of life’.

‘I remember my mum’s uncle asking my mother what tablets I was taking and my mother told him that the tablets were for my arm and leg. But I was using antidepressants and sleeping tablets. She told him a little lie. Maybe if she had told him about this, my engagement would have broken down because my marriage was an arranged marriage. All my family know that I have depression but they didn’t tell her and her part of the family. When the engagement broke up, my family and I separated from each other. They refused me and after that I tried to commit suicide.’

Black and Minority Ethnic Communities and Care & Treatment

The Mosaics of Meaning report also highlights some important differences in reported attitudes towards treatment for mental health problems within BME communities. For example;

If Muslims believe that their problems are caused by bad spirits they are more likely to seek advice and support from their 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.

Young people from the Muslim and Chinese communities may be less likely to believe in spirits and more likely to view mental health problems as an illness. They will therefore tend to seek help from a GP.

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.

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Believing as they do in several causes rather than one single cause for illness some South Asian patients use a number of treatments at the same time (e.g. traditional treatments and modern medications).

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.

**Refugees and Asylum Seekers and Mental Health**

Contrary to some media opinion, the majority of refugees and asylum seekers have moved to this country as a last resort and to escape situations that were intolerable. This means that they have already experienced severe stress and may be vulnerable to mental health problems. They are likely to have experienced significant losses e.g. loss of home, family, friends, profession, country, culture and hopes for the future. Once they arrive in Britain they experience a further set of challenges and problems that can include coping with multiple changes, making psychological and practical adjustments in an unfamiliar setting and having an uncertain future. They may also face racism whilst trying to cope with unfamiliar cultural traditions.

It is no surprise therefore that the mental health of refugees and asylum seekers may be poor. Offering help may be difficult because many asylum seekers are fearful of anyone who may be able to influence their right to stay here and may not wish to reveal any vulnerability.


**Mental Health and Gypsy / Traveller Communities**

Gypsy / Traveller people face specific challenges related to their health needs because of the nature of their travelling lifestyle and the racism they experience. Health services in the UK are designed for people who are resident in one place for a set period of time and it can therefore be difficult for Gypsy / Travellers to access services that require more than one appointment. The majority of health boards are making efforts to provide healthcare for Gypsy / Travellers including specially trained health workers.

Racism is a particular stress for travelling people combined with a poor level of cultural understanding between travelling people and the rest of the population. This is made worse by a lack of understanding of the different types of Gypsy / Traveller groups in Scotland with false assumptions driving much of the negative response.

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Mental Health and Economic Migrants

The term economic migrant refers to people who have moved to another country to improve their standard of living or access better opportunities. Some people are deeply critical of the influx of economic migrants from other parts of Europe into Britain whilst failing to remember the massive number of people who continue to emigrate from Britain to other countries for exactly the same reason. Migration is a common life choice and could be argued to be a basic human right.

Most people choose to migrate to another country in order to improve their life chances but many do not take into account the impact of such a move on mental health. Living in another country, particularly one where the language spoken is different to one’s native language is very stressful and this stress can lead to mental health problems, especially in the first few months and years.

The World Health Organisation (WHO) has recommended that host countries make certain that mental health services are appropriate to immigrant groups; that help is available to integrate into the social and cultural life of the country and that knowledge and training of health workers is appropriate and culturally sensitive. iv

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1 Equal Minds Addressing Mental Health Inequalities in Scotland 2005
2 ‘Are you really listening? Stories about stigma, discrimination and resilience amongst BME communities in Scotland.’ NHS Health Scotland 2008
4 World Health Organisation: Workshop on mental health on migration and health in the EU, held by the European Union 27-28 Sept 2007