



**UNITED KINGDOM
MINORITY ETHNIC**

MENTAL HEALTH

HOW THE **CHURCH** CAN RESPOND

ABOUT THIS BOOKLET

This booklet is an introduction to UKME Mental Health and the Church's response. The information is taken from a toolkit that aims to raise awareness and to provide information for those working in the Church to assist them in gaining a better understanding of issues relevant to UKME mental health.

To download the full toolkit and read more resources, visit: churchofengland.org/UKMEtoolkit

UKME¹ MENTAL HEALTH

There has been a **wealth of evidence** produced to examine the **poorer mental health outcomes** experienced by UKME communities, showing some mental health conditions are **more prevalent among ethnic minorities**. This may be due to **social factors**, experiences of **racism** or **culturally specific traumas**. The evidence also demonstrates people from black and minority ethnic communities are **less likely to seek help at an early stage of illness**, due to a combination of lack of knowledge, stigma, inappropriate models of diagnosis and poor experience of mental health services. **UKME people also have poorer experiences once in the mental health system** and are more likely to be medicated and restrained or risk death in detention. **Organisations working with UKME communities** around mental health have recognised, and responded to, many of these issues. Understanding their work and highlighting best practice is crucial to continued work on **tackling poor mental health outcomes in black and minority ethnic communities**

RESEARCH SHOWS...

- African Caribbean people are three to five times more likely to be diagnosed and admitted to hospital for schizophrenia, in spite of lower rates of diagnosis for other common mental disorders (Mental Health Foundation, 2015)
- Mental health issues amongst Asian communities are influenced by factors including age and gender.
- Middle-aged Pakistani men and older Indian and Pakistani women have significantly higher rates of common mental disorders such as anxiety and depression (Weich et al., 2004).
- South Asian women have higher rates of common mental disorders compared to white and black women (Bebbington et al., 2009).
- Indian men have higher rates of alcohol-related problems (Mental Health Foundation, 2015).
- Older Chinese people are unlikely to recognise the symptoms of mental ill health and unlikely to know mental health problems require medical attention (Tran et al., 2008) and risk of stigma surrounding mental health means that people from Chinese communities may also be reluctant to seek help.

Download the toolkit to learn more about:
Cultural knowledge ➤ **Cultural sensitivity** ➤ **Cultural competence**

WORKING WITH UKME COMMUNITIES

Cultural Competence of Healthcare Professionals is important; it is more than being culturally aware and culturally sensitive. It is about understanding how best to relate with individuals and groups from other cultural and social backgrounds.

- Have a different way of displaying distress or symptoms from the majority white population
- Come from a culture where they aren't used to seeking professional help
- Have different beliefs with regard to the causes or treatment of illness

¹ The term UKME is used to acknowledge that the ethnicity referred to is a minority in the UK and not globally. We use the terms UKME/ BAME/ethnic minorities interchangeably to reflect people from a wide global diaspora

CULTURAL AND SOCIO-ECONOMIC ISSUES AND MENTAL HEALTH

Issues which may affect the mental health of UKME groups which are unlikely to affect the general population, including:

- **Forced marriage**
- **Female Genital Mutilation (FGM)**
- **Honour-based violence**
- **Abuse relating to spirit possession**

It is important that these aren't seen as widespread in UKME communities or as accepted by certain cultures, however, for those individuals who do experience these forms of abuse, there are likely to be severe effects in terms of physical and mental health and difficulties engaging with health services who may be unfamiliar or ill-prepared to deal with these specific challenges.

Differences in treatment for individuals experiencing mental health issues have also been attributed to 'cultural difference on the part of the onlooker (the person witnessing distress or distressed behaviour)'

KANE, 2014

UKME individuals may also be more likely to experience socio-economic factors which contribute to poorer mental health (Marmot Review, 2010). Factors that may influence mental health outcomes include:

- **Deprivation**
- **Unemployment**
- **Poor housing**

There are a number of explanations for these differences:

- 1. Limited awareness** of, or a reluctance to engage with, statutory services at an early stage of illness (possibly due to previous poor experiences or the belief that services are not culturally appropriate)
- 2. Stigma around mental health** in some communities. Cultural differences in the way that mental health is perceived may also decrease the likelihood of individuals seeking care before reaching crisis point.
 - a. Understandings** of what constitutes a mental health problem
 - b. Cultural expressions** of distress including the way symptoms are expressed
 - c. Expectations of services** (Kane, 2014).

UKME WOMEN AND MENTAL HEALTH

Women from non-Western cultures are more likely than women in the general population to present somatic symptoms of depression. (Latif 2014). Research shows these women may not be able to easily identify symptoms or may be unable to express them.

40%

“There is evidence that UKME individuals are 40% more likely than white Britons to come into contact with mental health services through the criminal justice system, rather than through referral from GPs or talking therapies.”

KANE, 2014

CASE STUDY

'PAUL'... IS AN OLDER MAN

"All I wanted was someone to be there, to be with me."

Paul has been in and out of the mental health system for decades. On one occasion he was held in a police cell because there were not any beds available in the local hospital. He felt that the police officers avoided him when he was in the cell because he was mentally ill. The experience of being in crisis in a cell was a major trauma in itself for Paul.

"I'm in total chaos, I have just tried to kill myself. I'm in a prison cell. I've no belt, no shoelaces, no shoes, because they wouldn't let me have them."

He feels that it is not just the police that lack empathy when dealing with people in crisis. The problem extends to professionals.

"The sort of people you need in crisis is an empathetic person."

'TANYA'... IS FROM A MIXED CARIBBEAN AND IRISH HERITAGE SHE IS ALSO A WHEELCHAIR USER

"He looked at me as if to say: 'She's just another scum on the street,' and he wasn't listening to what I was telling him."

Tanya feels that whenever she goes to a meeting or appointment, she has to prove she is a 'person' because people make assumptions based on her ethnic appearance. *"I am not the same. We're not the same."*

She has experienced discrimination inside the mental health system, and in support and wellbeing services outside of the NHS. She also feels that people with a mental illness often have their physical illnesses ignored by medical staff.

"I knew something was terribly wrong, and I phoned the hospital and said: 'You had better come and fetch me cos I'm in serious problems here,' and all they did was refer me to my GP. But you can't wait. It is not a thing that can wait. I turned up at the police station and said: 'Something is wrong here. I got to get treatment.' They just said you got to go and see your GP."

TANYA, 2015



THEOLOGICAL AND ETHICAL POINTERS²

Salient theological themes informing Christian approaches to healthcare

God the life-giver: Humans have a unique status within earthly creation; our innate dignity comes from being bearers of God's image.

God Incarnate: The incarnation indicates that the physical and the spiritual are not two separate unbridgeable realms, but that they are part of a continuum that reflects the reality of God.

God the redeemer: God freely offers eternal life through Jesus' identification with broken humanity, demonstrated ultimately in his death on the cross.

God and justice: Jesus taught that our treatment of the poor, the oppressed and the vulnerable as well as being significant in its own right is viewed by Jesus as our treatment of him.

God and community: the Trinitarian understanding of God indicates that relationship is at the heart of what it means to be a person: followers of Jesus are bound together in community.

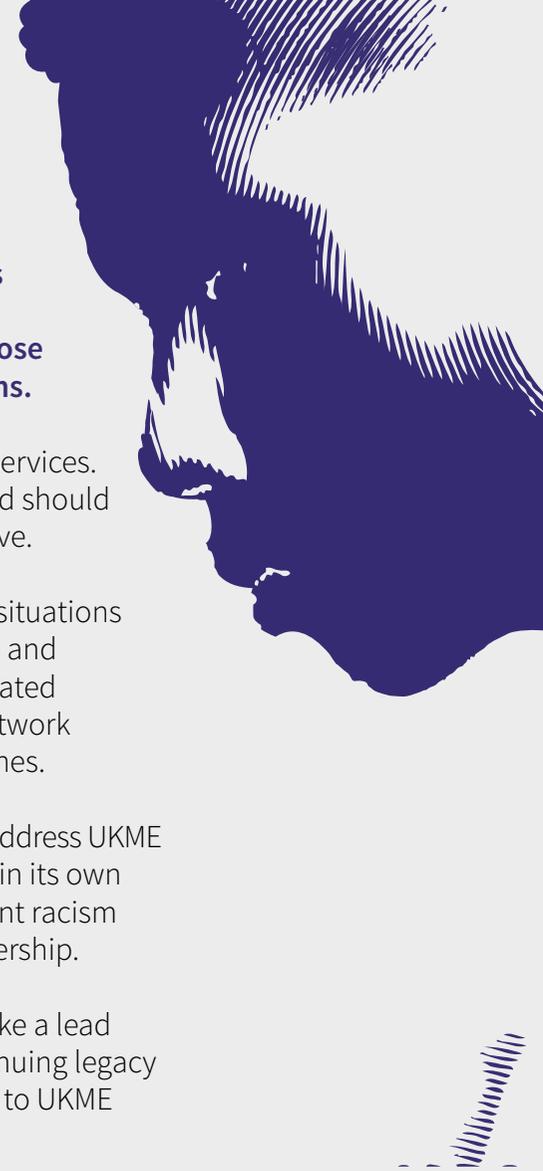
Download the toolkit to read the guiding ethical principles for the Church's response to mental health.

WHAT CAN THE CHURCH DO?

In addition to Church leaders, church workers and chaplains becoming more fully aware of UKME mental health issues, it is essential that cultural competence is displayed by all those ministering to UKME individuals with mental health problems.

- ▶ The Church has a ready-made network of communities, buildings and pastoral contacts that can be utilised in helping to design and deliver culturally appropriate and accessible services in collaboration with local communities.
- ▶ By being embedded in communities, the Church can play a leading role in helping to educate both communities and health professionals with regard to mental health issues.
- ▶ At all levels, the Church can be 'a voice for the voiceless', helping to reduce the stigma often associated with mental illness.
- ▶ A coherent strategy for developing UKME mental health services is needed, not simply more detailed planning of services. The Church of England should champion this initiative.
- ▶ Best practice in local situations ought to be identified and information disseminated using the Church's network of dioceses and parishes.
- ▶ The Church ought to address UKME inequality issues within its own structures and confront racism within its own membership.
- ▶ The Church should take a lead in exploring the continuing legacy of slavery with regard to UKME mental health.
- ▶ The Church should raise mental health awareness among its congregations, helping to minimise stigma attached to mental illness.

² This section has been adapted from 'Medical Ethics: a Christian Perspective', Mission and Public Affairs Council position paper, May 2016



6 TIPS FOR WORKING WITH UKME COMMUNITIES

1. Be conscious of our own **stereotypes, prejudices** and **unconscious bias** when addressing mental health and UKME
2. Explore **cultural competence, cultural knowledge** and **cultural sensitivity** in the toolkit to develop an awareness and confidence to address the issues affecting UKME members of Church
3. Consider the **cultural and linguistic** needs of UKME members. For example, is English their first language?
4. Work to ensure the Church becomes a **point of contact** for UKME members and their extended family
5. Explore how Church can **celebrate cultural diversity** of race, customs and language to reflect UKME members
6. Ensure there is a **link person in every church** (similar to a Safeguarding Lead) who is responsible for contacting the local adult mental health services for advice/guidance

READ THE FULL TOOLKIT FOR MORE RESOURCES:

- > A **spiritual assessment** of mental health
- > A **questionnaire** to be used within either a prison or hospital setting to assess the spiritual and religious beliefs of individuals.
- > Information to help your church take the **Friendly Places Pledge**

