As a group we started to look at mental health within BAME communities. We looked at the different issues that may affect these communities, whilst researching we found that there was a trend when discussing the effects of mental health within BAME communities, this being stigma. The stigma stems from traditional, cultural, and historical beliefs towards mental health; older generations minimal understanding of the help available towards mental health has meant that they don’t see it as an issue that can be fixed or worked towards fixing. Stigma can cause a number of issues within the communities, such as intergenerational issues. For our research, we specifically focussed on Nottingham and its young people, due to the fact that we thought it was better to focus on this demographic as they are the future and are more likely to be open to change and education about mental health. Within this report, our findings on the system we have chosen will be analysed and discussed as well as the different systems and solutions found within other countries. Also, in this essay, the findings of our research, trends, actors, and stakeholders will also be analysed. The forming of a new system and what changes we found needed to be made in order to find solutions when targeting the issues of stigma towards mental health within BAME communities.

The System

In our system we address the stigma of mental health in the younger generation within the BAME communities, specifically in the Nottingham area. In doing so we consider the key actors and institutions which impact the system. Our system highlighted the relevance of intergenerational issues, we broke this down into 3 categories, looking at: the older generation, social media and education. Firstly, we will consider the older generation and the level of power and influence they have. For much of the older generation, mental health was considered a taboo topic. Many of them feel as if there is a lack of trust for people dealing with issues, finding it difficult to trust those outside their community due to accounts of racism. They also buy into the narrative of men presenting a ‘tough’ exterior, this toxic masculinity meant that not many men within the older generation would think to reach out for mental support in fear of ruining this façade. However, the level of power held by the older generation is very limited as they have no input or power when it comes to policy changes. The intergenerational differences between the younger generational is exacerbated by social media. Social media has become more prevalent in recent years, the takeover of social media has had a direct correlation with the decline in mental health of young people. Social media can affect your mood, algorithms are designed to control and change the mood of users of social media. This is something perhaps the older generation are oblivious to; being unaware of how social media is impacting the minds of the youth. Furthermore, the current education system includes teaching about mental wellbeing, this was non-existent for the older generation who did not have access to resources and teaching about mental health. With the rise of social media and education combined, this has increased the younger generations level of power in that they are given a voice via these media platforms in which they can advocate these issues and spread greater awareness. The main two actors which impact the BAME community is religion and cultural background. Nottingham City has a large BME population which accounts for just over one third (35 per cent) of the total population. According to the last demographic census, 75% of the population of Nottingham consider themselves Christian, with other religions including Islam (0.5%), Sikh (0.3%), Hindu (0.3%), Jewish (0.1%) and Buddhist (0.2%). Suggesting that religion plays a crucial role in impacting the BAME community. For example, when looking at the Muslim community, many of the solutions related to mental health are often linked to prayer. This is the case with many other religions who offer prayer as a solution, however more education and practical advice needs to be adopted to be more effective than just the act of prayer alone. Mental health can be a complex problem and requires time to be understood, therefore its solutions are not as simple as prayer as additional support along with medical help in some cases is necessary. In addition, cultural differences may cause different views and understandings of mental health, especially in BAME groups. In some cases, relating mental health to witchcraft, possession, demonic aspects of mental health, rather than seeing it as something that that should be medically treated.

Research

Research seemed straight forward for our group because we thought we would have a large range of internet resources. We chose the method of analysing documents and websites our method of research, since we thought it would give us many ideas of how to alter our system of choice, through multiple perspectives. We came across some issues with this method but this didn’t prevent us from finding adequate ideas for our system. This section will focus on our process of research what went well, what did not go to well and what we could have changed to better our research.

The first issue we came across was the lack of information on BAME mental health help seeking behavior. This meant that research was strenuous because of how hard we had to look to find information that was relevant to our area of study. Then we also had the issue of many articles repeating themselves due to the lack of information in this area, it was almost like there wasn’t any wider research aims. This was a problem because this limited our perspective on the matter and ways we could maybe alter the system. We also were put in an awkward situation on whether we should question the research, due to the lack of information in this area. One of the main questions after the research was how reliable the data we were receiving was and if we should and if we should take the finding into account. Websites are not always trustworthy too because unless one is specific with their search it is hard to gain access to our information and even when we did, like I mentioned above, a lot of the time it was the same information. Reliability of websites was put into question at times when their seemed to be a clear purpose of the website to sell their image for a purpose i.e. donating, which then led to limited information being supplied and only the information that might catch the eye.

There were some positives of our research method though. Information on the website was of easy access to us all which meant although finding some articles or documents seems time consuming at times, there being more than one of us researching at the time cut that time shorter than what it could have been. Internet access also gave us information regarding BAME mental health to more than one country which gave us the opportunity to explore how other countries dealt with the matter of mental health help seeking behavior in the BAME community. Being able to compare was key for our group since we had chosen not to go with as survey, due to circumstance. The comparison almost filled the issue of lack of perspectives, although we could not find much information regarding the efforts domestically, another nations way of tackling the issue provided a look through another lens We were able to narrow down our focus when looking through the information too, although there was a lack of information it helped us refine the system we wanted to look at and made our aims much clearer. This was a benefit of the information being repetitive at time. Internet research was especially useful when researching cultures and understanding how they tackle cases of mental health. This is something that would have been more strenuous without easy access to information from elsewhere.

If we were to repeat this research again, I think as a group we would agree that a survey would have been good to accompany the internet research. This would have allowed us to have primary data specific to our aim. Our research method was limited, and a survey would have allowed us to have some quantitative data that could have been used to provide concrete and objective evidence for why our solutions would help increase the awareness of mental health in the BAME community ultimately increasing help seeking behavior. Qualitative data would have also been available for our group through the survey which would have helped get a reason for certain behaviors.

Research findings

The finding outcome of the research revealed that there is a stigma associated with mental health within the BAME community. Reasons for this are because of cultural differences that don't correlate with western idealistic culture, and religious reasons that reject the scientific notion of mental health. This prevents people in the BAME community from taking the issue seriously. It stems from the fact that mental disorders in low and middle-income countries do not have the global health policy’s attention. Therefore, little information exists on the adaptability of western mental health models in developing countries. Secondly, in the research it was found out that in the BAME community, both genders male and female have their own distinctive hardships when dealing with mental health. For example; women in Uganda have to face poverty, abuse, less education, forced marriages, sex trafficking, fewer job opportunities and other restricted activities outside of the home. In fact in Uganda, survey’s have documented high rates of gender-based harassment with over 80% of female clients undergoing trauma-focused treatments, experiencing at least one sexual assault during their lifetime. Although, in Uganda, monitoring and assessment mechanisms exist, they are challenged primarily by shortage of transportation, scarcity of qualified human resources, uncoordinated priority setting, lack of a research agenda, and inadequate feedback to the districts. Therefore, rather than large-scale surveys, collecting data that is focused on regional studies, in order to capture conditions related to cultural content of socioeconomic status, ethnicity, diet, literacy, attitudes, therapies, adult, teenage, and child health is crucial in understanding and questioning mental disorders of who, what, where, when and how. Without this knowledge, it is impossible to grasp the needs of individuals with mental disabilities or to establish meaningful programmes and budgets. Nonetheless, researchers must be conscious that anecdotal evidence and inadequate analysis and assessment will sabotage meaningful interpretation, research, and development programmes. This will result in wasteful preparation, execution and results.

In essence, the solution that was found is that there should be an ongoing push to implement western mental health models into the developing countries so that mental disorders are taken seriously in such communities. Charity groups such as UNICEF and religious groups should help build a better relationship between BAME communities, education should be implemented to the youth with role models visiting different schools who can relate with the students especially to the women in Uganda. In fact, global health aid agencies are encouraged to partner together to promote and assist national governments in their attempt to strengthen a sustainable, cost-effective, comprehensive integrated health care systems that provide a complete equality by universal coverage and initiatives to strengthen the infrastructure through credible data and research. In addition, healthcare providers such as the Word health organisation (WHO) should implement training and support to the healthcare providers in Uganda and other BAME communities to deliver individually tailored and culturally sensitive care to the people. This latter approach would result in a more effective mental health system for the Ugandan people and other BAME communities, with improved care, outcomes, and overall mental health services and will decrease the number of mental disorders amongst the community.

Our system is one involving many institutions and actors, however, as a group, we decided that the the following institutions were our main focus to target. We concluded that focusing on influences such as religion, charity, education etc, we would be able to create changes through influencing this change within these groups. Additionally, we highlighted that we also wanted to focus on the more medical side of things, thus looking at medical factors such as training, advertising within organisations and healthcare. This decision was made due to the fact that these types of institutions can be used to help build knowledge and understanding of mental health, and also create opportunities for people to learn how to seek help, or provide help. We intend to make changes such as enhancing advertising about Nottingham’s BAME Community in institutions such as local religious groups, and medical centres. As such, this will ensure that there is a wide sense of community, and somewhat invite people into the community through the simple knowledge that it exists. As a result, there will be a sense of similarity and understanding within the community, and more of a relatable social group to be part of, able to talk about similar issues they may be facing. In addition, religious groups, alongside charities, may also be able to build a better relationship between BAME communities through events such as fairs, which involves the mixing of different BAME members. Education may also have a large influence regarding BAME groups and mental health. As a group, we thought changes could be made within schooling systems to send a wider variety of speakers in to connect more heavily with certain groups that may face different struggles to others outside of their community. We suggested this change in order to give members of the BAME community a chance to speak to someone who may be going through, or has been through difficulties with similar or alike issues, making them feel a sense of reassurance, or advising particular places to seek help. These ideas come from a sense of understanding within our group regarding BAME communities and mental health. Having all been part of the BAME community growing up, to the present day, we can understand the stigma, and lack of knowledge or care when it comes to mental health within the community. There are many factors we pointed out, such as religion, culture, and many others which specifically affect the community and its outlook on mental health. Having also grown up in schools where we could directly see the lack of relation between us, and those offering help, it seems difficult to determine whether they could understand your problems, and would have been helpful to have someone who understands similar things we do. This can relate to the ideas we raised regarding health care, and what could be changed in order to benefit the BAME community. Healthcare providers need relevant training and support in developing effective communication strategies to deliver individually tailored and culturally sensitive care. We conclude that these changes would have a positive impact on the system, as members of the BAME community may feel an enhanced sense of awareness regarding their mental health, and a wider sense of knowledge of how they might seek help or talk to someone who may understand their issues. Additionally, workers in other systems such as health care can be tailored to be more culturally sensitive to patients within the BAME community, rather than disregarding cultural, religious issues that may also pose as a barrier to nursing their mental health issues.