Bringing cultural changes to mental health services through organisational development

An instrumental case study of how a mental healthcare trust in England responds to race-related equality policy in the provision of mental health services

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Abstract

This thesis presents an instrumental case study of a National Health Service (NHS) mental healthcare trust in relation to race related equality policy in the delivery of secondary mental healthcare in England. The study takes a constructionist ontological position, and an interpretivist epistemology. Semi-structured interviews were conducted with the 20 participants working at three different levels of the organisation. These include strategic leaders: Chief Executive Officer, Operational Director, Director of Nursing Quality and Patient Experiences, Director of Learning and Development, Head of Human Resources, Equality and Diversity Lead; service level middle managers: General Manager, Modern Matron, Team leader, Manager of the Recovery College; and frontline practitioners: clinical directors, psychiatrist, occupational therapist, staff nurses, community psychiatrist nurse, Recovery College instructor, all working in an adult mental healthcare setting of the organisation. Narrative interviews were also conducted with eight members of the Pakistani community living in the local service area to gain their perspectives on mental illnesses and mental health services.

The study was conducted because national race equality policy expects NHS mental healthcare organisations to change their culture and deliver equitable, culturally appropriate and satisfactory mental health services to all members of society, including those who identify themselves as 'BME' groups. However, there is evidence in the policy and research literature of inequalities in mental healthcare experienced by service users who identify themselves as being from 'BME' groups in England.

This study, therefore, explores how a NHS mental healthcare Trust is trying to bring about cultural changes in order to meet the expectations of policy as well as meeting the needs of service users of ethnic background. For example, on the organisational side, the study explored vision and strategy as well as interventions for bringing about organisational change and the views of the participants on this change. The views from the members of the Pakistani ethnic group highlight how mental illnesses are perceived and responded to within this ethnic group.

Data obtained from the staff group were analysed using a thematic framework approach. Resultant themes include: interpretation of racial equality policy in the organisation; organisational vision and strategy for change; and the challenges, barriers and facilitators to achieving the stated vision on racial equality in the service provision, especially for people of Pakistani ethnic group. The analysis benefited from the organisational development literature in analysing the data.

Data obtained from the members of the Pakistani community were analysed using a thematic narrative approach. This data reflected ways in which mental health/illness is perceived and responded to within this group including: the social identity claims that people of Pakistani ethnicity make when perceiving and responding to mental illnesses; the extent to which they associate themselves with western and/or eastern models of mental illnesses; and their identification as an ethnic group with diverse and multiple social identities. Social identity literature is used to analyse and interpret this data. The relationship between the organisational data and the ethnic

group data is discussed, and a way forward is suggested for bringing about the expected cultural change to the organisation in order to meet the mental health needs of 'BME' groups in England.

The instrumental organisational case study, along with perspectives of the service users, have served to underline the challenges for the organisation on a day-to-day basis as they attempt to meet the expectations of policy, as well as the views and expectations of people of Pakistani ethnicity.

This PhD is dedicated to my Parents,

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Abbreviations

AIE	Assessing Impact on Equality
BME	Black and Minority Ethnicity
CAMHS	Children and Adult Mental Health Services
CDWs	Community Development Workers
CQC	Care Quality Commission
DH	Department of Health
DRE	Delivering Race Equality
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, 4th Edition
EDS	Equality Delivery System
EIA	Environmental Impact Assessment
EPDS	The Edinburgh Postnatal Depression Scale
GHQ	General Health Questionnaire
HPHRP	Higher Performance Human Resource Practices
HR	Human Resources
ICD	International Statistical Classification of Diseases
LEP	Limited English Proficiency
LGBT	Lesbian, Gay, Bisexual and Transsexual
NHS	National Health Service
NSF	National Service Framework
OD	Organisational Development
ONS	Office for National Statistics
OT	Occupational Therapist
PBUH	Peace Be Upon Him
PhD	Doctor of Philosophy
R & D	Research & Development
REC	Research Ethics Committee
SRQ	Self -Reporting Questionnaire
TB	Tuberculosis
UK	United Kingdom
VBR	Value-Based Recruitment

CHAPTER ONE: INTRODUCTION

1.0 Introduction

This dissertation is for my PhD in Health Studies at the University of Nottingham (UK). My previous academic background is in Sociology, my professional experience having spanned eight years. For four years I worked with the rural poor and marginalised communities at grassroots level in Pakistan towards poverty alleviation. For nine months I worked as a lecturer in a public sector university in Pakistan. Then for three years I worked with a provincial level premier planning and development agency towards improving urban service delivery in the Punjab province of Pakistan.

From these experiences, I became interested in subjects such as national level policy development and local level policy implementation, organisational culture, changing organisational culture, organisational development and improving service quality. The concept of reducing social inequalities and improving public services for disadvantaged segments of society are included in my main research and professional interests.

1.1 Background of the study

National Statistics identify that 20% (or 11 million) of the population of England and Wales identify themselves as of black and minority ethnicity (BME) background (Office for

National Statistics, 2011). The majority of the BME population falls within a young age profile and lives in poverty-stricken inner-city areas of the UK (Ahmad and Hannah, 2009). These ethnic groups are characterised by diverse cultural attributes and as a result have various cultural characteristics that must be understood if their needs are to be met in the mental health services. In the UK, the National Health Service (NHS) organisations are responsible for the provision of various kinds of health services including mental health.

As per the Equality Act 2010, NHS organisations are required to promote and implement race-related (which includes ethnicity) equality policy in service provision. In the mental healthcare provision setting, the implementation of racial equality policy refers to the development and delivery of mental health services which are 'culturally appropriate', 'equitable' and 'meet the needs' of all service users who identify themselves as of BME background. The policy expects mental healthcare organisations to develop themselves and bring cultural changes in the way mental health services are developed and delivered, to become more responsive to the mental health needs of the BME groups (Department of Health, 2005c).

This study was conceptualised in the context of evidence highlighting the inequalities in mental health and dissatisfactory experiences of mental health service users among BME communities. Broadly, it aimed to study how mental health services are responding to the needs of people from a BME background in the context of the expectations of race-related equality policy. It investigates how a NHS mental

healthcare organisation is developing itself to bring cultural changes to the service provision and respond to the racial equality policy expectation to deliver 'culturally appropriate', 'equitable' and 'satisfactory' mental health services to one of the BME groups, i.e. Pakistani. The selection of the Pakistani ethnic group as a reference group is due to the advantage of my own background and understanding of Pakistani culture. This ethnic group is the second largest in terms of population, and also amongst the oldest in terms of emigration to the UK.

According to the 2011 census, 2% (1,112,282) of the England and Wales population is of Pakistani origin (Office for National Statistics, 2011). The study critically analyses policy relating to racial equality, particularly the policy relating to health and social care, and then examines the implementation of this policy in detail focusing specifically on the delivery of mental health services to the Pakistani ethnic group and their personal views about mental illnesses.

Table 1.1: Ethnic population of England and Wales

S.No	Ethnic Group	Total
	White	45,281,142
1	White: English/Welsh/Scottish/Northern Irish/British	42,279,236
2	White: Irish	517,001
3	White: Gypsy or Irish Traveller	54,895
4	White: Other White	2,430,010
	Mixed/multiple ethnic groups	1,192,879
5	Mixed/multiple ethnic groups: White and Black Caribbean	415,616
6	Mixed/multiple ethnic groups: White and Black African	161,550
7	Mixed/multiple ethnic groups: White and Asian	332,708
8	Mixed/multiple ethnic groups: Other Mixed	283,005
	Asian/Asian British	4,143,403
9	Asian/Asian British: Indian	1,395,702
10	Asian/Asian British: Pakistani	1,112,282
11	Asian/Asian British: Bangladeshi	436,514
12	Asian/Asian British: Chinese	379,503
13	Asian/Asian British: Other Asian	819,402
	Black/African/Caribbean/Black British	1,846,614
14	Black/African/Caribbean/Black British: African	977,741
15	Black/African/Caribbean/Black British: Caribbean	591,016
16	Black/African/Caribbean/Black British: Other Black	277,857
	Other ethnic group	548,418
17	Other ethnic group: Arab	220,985
18	Other ethnic group: Any other ethnic group	327,433

Source (Office for National Statistics, 2011)

Murphy (2008) argued that the mental health of a migrant group is determined by three factors: factors relating to the society of origin; factors relating to the migration itself; and factors operating in the society of resettlement. Murphy (2008) further suggests that all these factors play significant roles in understanding and meeting the mental health needs of migrant groups. Therefore, the proposed study argues that any attempt to improve the mental health status of the Pakistani ethnic group in the UK needs to be contextualised in

the social and cultural context from which it originates, its experiences of migration to the UK, and the acculturation and adjustment process in society. Therefore, the next section briefly introduces Pakistan and its culture as 'Pakistani' people have migrated from that country.

1.2 Pakistan and its culture

Pakistan came into existence in 1947 when the Indian sub-continent was divided into two countries (India and Pakistan) by the British. The total population of Pakistan is 132 million and it has four provinces (Government of Pakistan, 2011). 95% of Pakistan's population associate themselves with the Islamic religion. Around 70% of its population live in rural areas and the major portion of the economy is dependent on agriculture. The literacy rate is 53%. Its national language is Urdu, but there is a wide diversity in the regional and local languages being used (more than 10 different types). It also has different regional sub-cultures which make it a diverse and complex nation. For example, the culture of people living in tribal areas of Pakistan is different from those living in large urban centres such as Lahore. This suggests that there is limited uniformity in Pakistani culture.

Generally, Pakistan has an extended and joint family system. The average household size is 6.8 (Government of Pakistan, 2011). Kinship and family ties are strong, especially in rural areas. The concept of honour and social status are strongly associated with issues of sexuality and gender. The parents' role is significant in the socialisation of children and arranging their marriages. The father or husband is generally considered

to be the head of the household. Free interaction and mixing with members of the opposite sex is religiously restricted. Gender roles are culturally specified, with the male being the main bread-winner and the female being expected to look after household chores. Usually, women provide care to children, sick and older people in their family.

Pakistan has culturally specified dress and food codes which are derived from Islamic teaching. The women are expected to cover their heads and wear loose clothing that preserves their modesty. The same applies to men but they do not need to cover their heads. The type of food and its preparation are also culturally specified. For example, religion allows eating chicken but it should be slaughtered in Islamic ways. Overall, the tendency to eat meat is high among Pakistanis. Meat consumption is associated with high social status and hospitality. The consumption of alcohol is strictly prohibited.

In Pakistan, the availability of modern healthcare facilities is poor and only 1% of the total national budget is spent on health, the situation being even worse in rural areas. With 40% of the population living below the poverty line, the concept of mental health and wellbeing is not a major concern. Publically funded mental health facilities are available only in four provincial headquarters and their quality is also poor.

1.3 Migration of people from Pakistan to the UK

Mass levels of migration of people from the ex-colonies to the UK are a relatively recent phenomenon and started after the

mid-1940s. At this time, migrants filled the workforce gap required to rebuild Britain after the Second World War (Shaw, 1988). Mass migration of Pakistanis to the UK started in the 1960s and continued until the 1980s. Construction of the Mangla Dam in the Azad Jammu and Kashmir regions (Mirpur) displaced hundreds of families; according to one estimate, 50,000 people were affected (Government of Azad Jammu and Kashmir, 2011). Most of these families were residing in rural areas with a very high incidence of poverty.

Through an agreement between the British and Pakistani government, these people were facilitated to migrate to the UK for employment. Early migrants (in the 1960s) were mostly young, single men, who were illiterate and from a rural background. On arrival in Britain, they were usually employed in the textile, steel and brick industries. During those times, these industries were mainly located in Manchester, Bradford and Sheffield, the Midlands, London and Luton areas. Owing to the low incomes, these workers started living in congested houses in the respective inner-city areas. For most it was a temporary migration, but later (during the 1970s and 1980s) they were joined by their families and children. It is pertinent to mention here that although the majority of the people who migrated (or are still migrating) to the UK are from the Azad Jammu and Kashmir region, other parts of Pakistan are also represented.

Pakistani immigrants in the UK are a culturally and socially heterogeneous community (Werbner, 2002). This, in social identity terms, means that considering all ‘Pakistani’ people possess a single ‘Pakistani’ social identity would be misleading.

There appears to be little recent research on the socio-demographic characteristics of Pakistanis living in England. However, Rudat (1994) noted that a wide range of different languages are spoken by people of Pakistani origin in the UK. The language Pakistani people speak at home, and feel comfortable to communicate in without imposing any barriers, may not necessarily be spoken by the NHS practitioner who provides a service. The languages with most relevance for Pakistanis in the UK are Mirpuri, Punjabi and Urdu. As most 'Pakistanis' are from the Mirpur region, therefore, the most relevant language is Mirpuri.

Rudat (1994) further noted that among Pakistanis, English-speaking competence declined across the age bands from 95% of young men to 66% of men aged 50 to 74; amongst women the decline was much more dramatic: from 78% to 15% respectively. Amongst Pakistani women, the level of illiteracy rose dramatically from 11% of the younger women to 68% of those aged 50 to 74. Amongst Pakistanis, the youngest age band identified English as their preferred language of literacy. The educational status of Pakistanis was also poor. Rudat (1994) found that amongst Pakistani women, only a low proportion hold a degree or a professional qualification (i.e. 8%). The proportion with no UK qualifications rose to 68%. Amongst Pakistani men with no UK qualification, the rate was (61%).

Pakistanis in the UK are reported to have a good housing profile. Rudat (1994) noted that 81% of the Pakistanis are owner/occupiers, and a very low proportion of Pakistanis live in local authority housing (i.e. 5% compared to 17% for the

UK population). The predominant housing environment for Pakistanis was mid-terraces (i.e. 67% compared to a UK average of 20%). It may be that Pakistanis like to buy houses, and avoid living in council houses due to the stigma attached to living in social housing.

Regarding the form of heating used in the houses, Rudat (1994) found that Pakistanis reported a lower rate of centrally heated housing compared to Africans and Indians, and for this group, gas fires are the predominant form of heating (i.e. 63%). Regarding access to car, Rudat (1994) noted that the highest rate of access to a car was found amongst Indians, where 41% have both a driver's licence and a car and a further 3% have access to a car. Amongst Pakistanis, the respective figures were 29% and 2%.

Pakistani migrants generally remain in contact with their close and extended family members back in Pakistan. Depending upon income and social needs, it is customary for them to visit their relatives in Pakistan. This contact not only contributes to retaining their original cultural characteristics in the UK, but also later on became a significant factor for another wave of migration. This wave was through the 'fiancé visa' process.

As per UK law, a man or woman is allowed to sponsor his/her fiancé to come to the UK for marriage. Early Pakistani migrants were Muslims and it was the social norm among them to marry someone who is not only a Muslim but also a close member of their own caste or tribe (*Birderi).* Mostly marriages are arranged and are with a member of family relations (e.g. a paternal or maternal cousin).

Boys and girls born and brought up in the UK have better access to education and are exposed to wider modern British society. However, their Pakistani counterparts are generally less educated and possess relatively rural, conservative social norms. Most of the boys who came from Pakistan on a fiancé visa are uneducated or less educated and are working as taxi drivers or in restaurants. In the case of women, literacy rates are poorer and consequently they often do not work.

It is usually customary for Pakistani families in the UK not only to look after themselves but also to send money to their family members and close relatives back in Pakistan. In Pakistan, most of this money was previously used to build spacious and costly houses and very little was spent on social development such as education of their family members or improving health facilities in their area.

In the above paragraphs, I have briefly described Pakistan, its culture, and migration of Pakistanis to the UK. As this study focuses on mental health and Pakistanis in the UK, it is important to discuss the literature concerning the mental health of Pakistanis in the UK. The literature therefore, related to this is presented in chapter three. Chapter two provides the policy context for the topic.

There is a dearth of scientific evidence on the mental health of BME groups in general (Chorlton *et al.,* 2012). However, it is particularly under-researched when it comes to a single ethnic group such as Pakistani. At the policy and strategic level, there is a tendency to treat all BME groups with a single and uniform approach to mental health service provision. Ethnic

groups are lumped into broader ethnic categories which tend to override the language, religion and cultural variations. The concept of ethnicity in healthcare practice is not very well developed and understood (Møllersen *et al.,* 2005). Although NHS organisations are legally bound to collect ethnic data, however, the quality this data collected for minority groups within healthcare organisations is often unreliable (Browne *et al.,* 2014), which can limit the usefulness of this data for health service policy-making and service delivery.

1.5 Ethnicity and ethnic classification in the UK

Ethnicity is defined by the Oxford Dictionary of Sociology(1998:201) as '… *individuals who consider themselves, or are considered by others, to share common characteristics which differentiate them from the other collectivities in a society, within which they develop distinct cultural behaviour'*. From this definition, ethnicity is defined in terms of cultural and social characteristics, including language, religion and history. However, race is defined in terms of the physical and hereditary features of an individual.

In different Western countries, however, colour, race, ethnic or national origins are used to define and classify people into various ethnic categories. There is a lack of agreement on the use of such characteristics to classify people in social settings and also in scientific research. For example, in a systematic review of published articles on ethnicity and mental health between 1990-2004, it was found that there is a lack of clarity regarding which individual or social characteristics ethnicity refers to (Møllersen *et al.*, 2005). The authors also found that

the concept of ethnicity is not well defined in research studies. Consequently, they argue that conceptual and operational ambiguities in the definition of ethnicity limit the use of research findings on the effects of ethnicity in clinical settings.

In the UK, there are 18 ethnic categories. These are given above in the table (1.1). During the census every 10 years, and also within the NHS services, an individual is given the option to choose one category that best describes his/her ethnic group or background. In the UK policy documents, race encompasses the concept of ethnicity as well (BRITAIN, 2010). Hence, in this research, race and ethnicity are used interchangeably.

1.6 Black and minority ethnic groups and mental health services in the UK

Despite the policy expectations from the National Health Service (NHS) to provide equitable, culturally appropriate and satisfactory mental health services to BME communities, service users from BME groups are generally perceived to have a poor, differential and negative experience (Mclean *et al.*, 2003; Bennett, 2008). They also tend to avoid seeking mental health services and are often underrepresented in service utilisation (Patel and Shaw, 2009; Durà-Vilà and Hodes, 2012; Cooper *et al.*, 2013). However, this is not always the case; for example, African Caribbean people are over-represented in inpatient mental health services (Bhui *et al.*, 2003). Consistent perceptions of dissatisfaction with the quality of services by BME users and prevalence of inequalities in the utilisation of the services raises questions about the

adoption and organisational ability of the NHS to implement race equality policy.

The dissatisfactions arising from inequalities in the provision of mental health services for BME groups are historical and persisting. Evidence of inequalities in mental health services for people from BME communities was first reported in the early 1960s c.f. (Bennett, 2008). In 1999, the Department of Health, in its first National Service Framework for Mental Health (NSF), documented that mental health services were not meeting the needs of BME communities, and that there was persistent discrimination and negative outcomes for people from certain BME groups (Department of Health, 1999). Later on, this need was backed by the Race Relations Act (2000) and subsequent health and social care policies (Department of Health, 2005c).

The Race Relations (Amendment) Act (2000) imposed a statutory duty on all public sector agencies, including the NHS, to proactively promote race equality in all their functions. It required public bodies to demonstrate that procedures to prevent race discrimination are in place and effective.

The Act required all public bodies to monitor their policies of service provision and staff recruitment to make them inclusive for ethnic groups. Public bodies must monitor the implementation of policies and programmes to ensure they meet the needs of ethnic minorities, and each organisation must have a publicly-stated policy on race equality. Additionally, organisations must assess how policies and programmes can affect ethnic minorities and take remedial

action where any potential for adverse differential impact on ethnic minority communities is identified. It also required social services departments to consult with ethnic minority representatives in service policy, planning and delivery.

In addition to the legislative backing, the need for the provision of culturally sensitive and equitable mental health services to BME groups has been identified by various empirical studies (Cinnirella and Loewenthal, 1999; Mclean *et al.*, 2003) and global (World Federation for Mental Health, 2007) and national policies (Jung and Yoon, 2013).

Brach and Fraserirector (2000) argued that cultural sensitivity is important in healthcare delivery, especially for minority patients who receive healthcare from systems that are largely organised and staffed by majority group members. The literature describes varying definitions of 'culturally appropriate' and 'equitable' mental health services, though these often share common themes around 'taking into account' and 'meeting' the cultural needs of the patients in design and delivery of the services and being non-discriminatory and equally accessible. Nonetheless, such terms tend to be non-specific, ill-defined and notably difficult to measure.

The policy expectations for the provision of 'culturally sensitive' and 'equitable' mental health services to diverse ethnic and minority groups have created an enormous challenge for healthcare organisations such as the NHS. This challenge is magnified by the fact that many studies have indicated that, in comparison to the White majority ethnic

group, the prevalence of mental illness is higher among BME groups.

Studies and policy documents have also highlighted over-representation of certain ethnic groups in diagnosis of schizophrenia, deaths of BME patients in NHS psychiatric units (Department of Health, 2003), perception of fear about services (The Sainsbury Centre for Mental Health, 2002), allegations of institutional racism (Sashidharan, 2001) and discrimination and a lower utilisation of services rate among ethnic groups.

This situation necessitates an investigation into the role of NHS Trusts and their efforts to fully respond to the mental health needs of BME communities. A growing body of scientific literature from public policy, organisational and management disciplines has found that organisational components of healthcare organisations such as frontline members, clinical practices, operating systems, structure, size and leadership all play key roles in the adoption and implementation of new ideas and practices and enhancing organisational performance (Kimberly and Evanisko, 1981; Robinson *et al.*, 2003; Bhui *et al.*, 2004; Drach-Zahavy *et al*., 2004; Dreachslin *et al*., 2004; Gagnon *et al*., 2005; Yano, 2008; Lipsky, 2010). The positive engagement of such constructs results in an organisational culture which is associated with enhanced organisational performance and improved quality of the service (Mannion *et al.*, 2005; Latta, 2009; Savaneviciene and Stankeviciute, 2011; Jacobs *et al.*, 2013).

Fernando (2005) has described a number of mental health related projects provided for minority ethnic communities in England in his article. A summary of these projects are described below.

Transcultural Psychiatric Unit at Bradford

This project started in late 1970s, and was established by the local health authorities in Bradford. The aim of the project was to provide culturally sensitive services to Eastern European (mainly Polish), and South Asian (mainly Pakistani), living in the local catchment area of Lynfield Mount Hospital. The model for the project was provided by a specialist consultation team from multicultural backgrounds. The team would occasionally take over the care of people and families referred to it. However, this unit could not sustain itself because of over-subscription from users, and people involved in it could not achieve support from the hospital. The project was wound up in 1999.

Maudsley Outreach Support and Treatment Team

This project started in South London in 1989. This was a community-based service, focused upon people of African Caribbean Background. It was staffed by people of African Caribbean Background and had a flexible and collaborative approach. This project was closed down after four years because its work would be mainstreamed. However, when its work was mainstreamed, its ethnic specific activities were disbanded.

North Birmingham Home Treatment Service

This project was initiated in 1990 in Birmingham, under the direction of Professor Sashi Sashidharan, who is considered an expert on BME mental health issues. This was a community–based service with the geographic focus on North Birmingham. This service adopted 'anti-oppressive practices' in its work. However, the author doubted the future sustainability of this service.

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This project started in early 1990s in London by black people who were interested in mental health issues. The aim of the project was to develop alternative services for black people run by only black people. This project adopted a partnership model where both statutory and voluntary sectors would work together to provide services to people of black and Asian ethnic backgrounds. This project could not sustain itself due to lack of support from the statutory sector and challenges of working in partnership. This project closed in 1998.

Projects such as these, focusing on specific geography and/or ethnicity are arguably inappropriate in the era of supra-diversity the UK is currently experiencing.

Regarding good practices Fernando (2005) concluded that: 'As far I can make out, no clear–cut single 'good practice model' for multicultural services has emerged in the UK'(p.427). Noting the main challenge for these projects, he noted 'the situation in the context of the NHS is that, although local projects incorporating good practices result in short-term change, they cannot be sustained unless they are supported and validated by central authority' (p. 427).

Suggesting a way forward Fernando (2005) proposes 'changes in the way psychiatry functions may be needed if innovative multicultural practices are to be brought about and institutionalized within statutory mental health services in general. First the main need is for greater flexibility than there is at present in ways of assessing people who present with mental health problems. Perhaps one approach is to consider mental *health* (emphasis in original) rather than illness, taking the service user viewpoint as a guide to what constitutes a 'problem' and what sort of services are required'. (p.428).

1.7 Organisational culture and policy implementation

The concept of organisational culture is complex (Elsmore, 2001). However, in simplistic terms, it is a 'way of doing' things in an organisation (Ott, 1989). It includes the pattern of beliefs, values and learned ways of dealing with events during the course of an organisation delivering services (Brown, 1998). Schein (2004) defines organisational culture in terms of shared basic assumptions among a group in an organisation to meet the external and internal needs of the organisation.

These definitions and explanations indicate that organisational culture is understood in various ways. Davies *et al*., (2000) claims that although there are variations in definitions of organisational culture, two broad schools of thought can be noted. The first school of thought regards organisational culture as something that an organisation *is* (here culture is used in metaphoric ways for description of an organisation). The second school of thought considers organisational culture as something that an organisation *has*. This includes aspects or variables of the organisation that can be isolated, described, and manipulated to achieve specific goals. As the current research is focusing on the organisational culture within an NHS organisation, the literature and research will be informed primarily by the second school of thought.

The definitions and explanations stated above characterise organisational culture in terms of shared perceptions, beliefs,

values, behaviours, processes and the underlying assumptions within a specific organisation and of its members. This also indicates that organisational culture is not something which is natural; rather it is created in response to the external environment (for example, patient population or socio-political influences) and interactions of the members during their work in that organisation. Additionally, it also points towards the fact that organisational culture is learned through socialisation by its members and transmitted to newcomers as desirable ways of doing things.

Grey (2005) argued that organisational culture is central to the study of contemporary organisations. Mannion *et al*., (2005) observed that in order to address the quality and performance issues in healthcare, greater attention is being given to 'softer' aspects of organisations and professional practices which include deep-seated assumptions, values and working practices. It is noted that a range of tools is being used to assess the culture of NHS organisations, and this practice is associated with the performance of the organisations (Mannion *et al*., 2009).

After a brief description of the main concepts related to this study, the next section presents racial equality policy in a mental healthcare context.

CHAPTER TWO: AN ANALYSIS OF BLACK AND MINORITY ETHNIC UK POLICY IN MENTAL HEALTHCARE

2.0 Introduction

This chapter aims to present an analytical synthesis of policies relating to the mental healthcare of black and minority ethnic communities in England. The chapter begins with a brief description of the arrival and demographics of BME communities in the UK and their initial appearance in the mental health services. It then presents an analysis of various governmental initiatives (legislations, policies, strategies and action plans) to address ethnic issues in the mental health setting. In the final part, the whole analysis is synthesised and discussed. A detailed analysis of BME policy starting from the 1960s to 2011 was conducted, which proved helpful in gaining the policy and legislative context of the issue.

The main policy and legislative documents analysed are listed below:

i) Race Relations Act (1965)
ii) Race Relations Act (1968)
iii) Race Relations Act (1976)
iv) Race Relations(Amendment) Act (2000)
v) Equality Act (2010)
vi) National Service Framework for Mental health: modern standards and service models (1999)
vii) Delivering race equality in mental health care: An action plan for reform inside and outside services and

the Government's response to the Independent inquiry into the death of David Bennett (Department of Health, 2005c)

viii) New Horizons: a shared vision for mental health (Department of Health, 2009)

ix) No health without mental health: a cross-government mental health outcome strategy for people of all ages (Department of Health, 2011)

x) Mental Health Act (1983)

xi) Mental Health Act (1983) Amended in 2007 (Department of Health, 2007)

2.1 Arrival of BME people in the UK

The presence of non-white people in the UK is historical. Such people were found at the seaports of Britain before the 16th century. Prior to the Second World War, the majority of them were residents at the seaport towns. However, mass level migration of people from ex-colonies to the UK is a relatively recent phenomenon and started after the mid-1940s. Migrants filled the workforce gap required to rebuild Britain after the Second World War. Early migrants were mainly young, single men with economic motivation. The skills make-up of these migrants was poor. Consequently, they were mainly employed in factories and other low paid work (Shaw, 1988).

Demographically, the majority of BME population is in the young age profile and they live in the major urban areas such as London, Manchester and Birmingham. There is a lot of social, economic and cultural diversity among these ethnic groups. Overall, the economic and social profile of these

communities is low when compared to the White population. The majority live in disadvantaged and deprived areas of Britain with a high incidence of poverty and poor access to primary health care (Ahmad and Hannah, 2009).

2.2 Analysis of BME policy in mental health care

2.2.1 Responding to ethnicity in health - a general pattern

Characterising societal responses to the health needs of ethnic minorities in the UK, Bhopal (2007) argues that it followed a pattern. The first stage sought to develop an 'awareness' of problems and especially of infectious diseases among migrants carrying a risk of harming society as a whole. In the second stage, studies were conducted to find out ethnic variations in different diseases and the utilisation of health services. In the third stage, policies and plans were adopted to meet the 'special needs' of the ethnic minority groups. In the fourth and last stage, policies focused on enabling the 'general service' to meet the needs of ethnic minorities. This pattern is drawn from a study published by Johnson (1984).

Johnson (1984) identified four different themes in the published medical literature and their impacts on the health and health care of ethnic groups in the UK. According to Johnson (1984), initial focus of the literature was on 'port medicine', i.e. unusual infectious diseases prevalent among the migrants groups residing at the UK ports. The response was based on the approach to 'prevent' the infections from 'spreading' among the White population. Although this phase

dates back to pre-1945, there is evidence that a similar kind of approach continues in British health policy. For example, a tuberculosis (TB) test certificate which certifies that the holder is free from TB infection is a mandatory requirement from visitors coming to the UK from some countries, including Pakistan.

The second theme relates to 'eugenic medicine'. This focused on biology and culture in explaining the prevalence of some diseases among ethnic minorities. For example, there was a considerable tendency among health professionals to link the practice of cousin-marriage among Asian migrants with children's illnesses without scientifically confirming the causation chain (Ahmad and Hannah, 2009). Mental health issues were also interpreted with the same causality approach (Ahmad and Hannah, 2009).

The third theme relates to 'cultural medicine'. Culture was used as an explanatory factor for understanding inequalities in the occurrence of diseases (including mental health). There was a trend to make comparisons of occurrences of a disease with the majority of the White population. 'Special initiatives' focused on BME communities were started to improve their health status.

The fourth theme is related to 'service provision'. It emphasised understanding the need of the ethnic minorities instead of blaming their biology or culture for their illnesses. It also emphasised the need to adopt a broader health care policy to deliver services through mainstream health provision instead of 'special programmes' for BME groups.

The following section examines the integration of ethnicity in the development of mental health policy in the UK.

2.2.2 Early policy response to BME mental health issues (1960s-1980s)

Mental health inequalities among BME groups were first identified in the early 1960s c.f. (Bennett, 2008). These inequalities were found in the institutional settings where African Caribbean and Irish population groups were found to be over-represented and Asian people were under-represented. Health professionals responded by researching ethnic differences in diagnosis and utilisation of mental health services (Bhopal, 2007). The differences among ethnic groups were explained in terms of their differing 'culture' (Johnson, 1984). Attempts were made to improve cultural awareness of mental health professionals to help them better understand the cultural dimensions of BME service users (Ahmad and Hannah, 2009). The timeframe for this phase might be from the 1960s to the 1970s. However, these attempts were not part of any broader ethnic health policy. During this time, The Race Relations Acts (1965, 1968, and 1976) were the broader initiatives to address race issues in general.

The Race Relations Act 1965 was the first broader initiative in the UK to address race issues. The Act was primarily stimulated by 'race relations' and not a 'race health' agenda. It was enforced to reduce incidences of widespread racial discrimination in social exchange and public spaces. The Act made it unlawful to 'refuse' to serve a person, an unreasonable 'delay' in serving someone, or 'overcharging', on the grounds of colour, race, or ethnic or national origins. It

appears that during this time, the focus was on just 'serving' a person; the quality of the service was not considered.

The Act made 'discrimination' a civil offence. Its violator was not 'severely' punishable. Therefore, its effectiveness to deter discrimination on the basis of race was weak. The Act does not cover housing, employment or private boarding in its application. Most importantly, the main public services like health, education and the police were not included.

The Race Relations Act (1968) extended and strengthened the application of the Race Relations Act 1965 to include the issues of housing and employment. This law made it illegal to refuse housing, employment or public services to a person on the grounds of colour, race, ethnic or national origin. Adopting a proactive approach, the Act went a step further and created the Community Relations Commission to promote 'harmonious community relations'. Once again, the main public service organisations like health, education and the police were excluded from the application of the Act. Racial discrimination continued in different forms. In some cases there were terms and conditions employed by individuals and organisations which were discriminatory in their treatment of the migrant groups. To address this, the Race Relations Act 1968 was superseded by the Race Relations Act 1976.

The Race Relations Act (1976) built on the earlier Race Relations Acts of 1965 and 1968. However, this Act for the first time identified direct and indirect discrimination on the grounds of race. It also defined direct and indirect discrimination. According to this Act, direct discrimination

occurs when a person treats someone on racial grounds less favourably than he treats or would treat other persons, whereas indirect discrimination occurs where an individual or organisation applies a requirement or condition which persons of racial groups are less likely to fulfil. The Act covered employment, the provision of goods and services, education and public functions. However, the NHS and the police were still exempted from the application of this Act. The Act also established the Commission for Racial Equality to review the legislation to make sure it was not discriminatory to race indirectly.

Importantly, within a decade (1965-1976), a shift in the focus of the government on race issues is obvious. It started by outlawing discrimination in public spaces, then it extended to employment, housing and promoting harmonious race relations to advancing 'race equality'. This also indicates that 'race' was becoming an important issue for the government and society. At the same time, however, it is evident that a focus of the government on race and health was lacking.

The 'indifference' of the government to focus on health issues of BME groups might have led them to develop alternative services and campaign for 'change' in the statutory services in the 1980s (Bennett, 2008). It is pertinent to mention here that during that period the Mental Health Act 1983 was used to detain a person who was deemed dangerous to public safety because of his/her mental illness. Given the fact that BME patients were more likely to be misinterpreted by health professionals due to culturally different behaviours and beliefs, the 'discriminatory' application of this Act seems likely. The

death of David Bennett (an African-Caribbean boy) in 1998 in a secure mental health setting whilst being restrained by nurses in a prone position, also contributed to the demand to improve mental health services for BME groups in England.

In summary, it is clear that there has been legislation and other efforts to address race issues in the UK. But health issues (including mental health) of ethnic groups were not their prime focus. The next section examines the recent policy response for the mental health of BME groups in England.

2.2.3 Recent policy responses to BME issues in mental healthcare (1990s-2011)

In 1999, the government published the first National Service Framework (NSF) for Mental Health (Department of Health, 1999) in England. It was a ten year programme with the aim to ensure the delivery of safe, sound and supportive mental health services. The framework set national standards and defined service models for promoting mental health and treating mental illness in the following five areas: mental health promotion; primary care and access to services; effective services for people with severe mental illness; caring about carers; and preventing suicide. It also established milestones and performance indicators to measure progress.

The NSF was the first policy document which acknowledged that mental health services were not meeting the mental health needs of BME communities adequately. It also acknowledged the presence of discriminatory and harassment practices in services, which has resulted in producing 'fear' among these communities. To improve services, it suggested

community engagement, personalisation of services, development of the cultural competence in the staff, recruitment of BME staff and removing communication barriers as important steps. Although the NSF did not include any specific standards on BME mental health issues, it is apparent that policy shifted its focus from 'race equality' and 'indifference' to 'meeting needs', 'community engagement' and 'personalisation' in better provisioning of mental health services.

During the 1990s, there was debate over the presence of 'institutional racism' in British public services. The term 'institutional racism' was used by the inquiry report (Macpherson, 1999) conducted into the death of Stephen Lawrence. Stephen Lawrence was a black British teenager who was killed in 1993. The report found that racism within the police services contributed to poor investigation of the case. The report recommended elimination of racism from within British public service institutions. It was probably this context which provoked the government to amend the Race Relations Act 1976 in the year 2000. The new Act was entitled the Race Relations (Amendment) Act 2000. This Act is significant in addressing race issues in many ways.

The first significance of this Act is that it imposed a 'general statutory duty' (not discretion) on public bodies to proactively promote race equality in all their functions, including service provision. It requires public bodies to demonstrate that procedures to prevent race discrimination are effective. The NHS and police organisations which were previously excluded from the three previous Race Relations Acts were also, for the

first time, included in the application of this Act (Hussain and Ishaq, 2008).

The Act required all public bodies to monitor their policies of service provision and staff recruitment to make them inclusive for ethnic groups. Public bodies had a duty to monitor the implementation of policies and programmes to ensure they met the needs of ethnic minorities. Each organisation must have a 'publicly stated' policy on race equality. Additionally, organisations must assess how policies and programmes can affect ethnic minorities, and take remedial action where any potential for 'adverse differential impact' on ethnic minority communities is identified. It also required social service departments to consult with ethnic minority representatives in service policy, planning and delivery. The Commission for Racial Equality (CRE) was given the power to take action when a public body fails to deliver expectations for the Act. Public inspection bodies (e.g. the Audit Commission), were also authorised to use their reports to highlight poor performance in race equality.

The Act seems comprehensive in safeguarding and promoting the interests of BME communities in public services, including the NHS. Importantly, it required race equality both in recruitment and service provision. Race equality in employment and service provision is interrelated and each can supplement the other. In contrast to previous race-related Acts, it required 'practical steps' from public bodies to ensure race equality in their policies and functions. But despite the fact that this Act was passed, the concerns for 'racism' were not reduced.

After the British police were 'alleged' to be institutionally racist, the British psychiatry and mental health services were also charged with the same failing: the British Psychiatric Bulletin (2001) published a paper on the presence of 'institutional racism' in psychiatry. The paper was written by Professor Sashihadran, a mental health professional of a BME background, and called for the elimination of racism in psychiatry and its practice. The paper began a debate on the subject and was endorsed by the Chief Editor of the Journal (Cox, 2001). Sashihadran (2001) argued that unless institutional racism within mental healthcare is tackled, the services would not improve for BME groups.

The debate was heightened when the Independent Inquiry Report into the death of David Bennett was published in 2004. The inquiry reported the presence of 'institutional racism' in mental health services and asked for ministerial level acknowledgement for this. The inquiry also asked the government to eliminate racism and improve mental health services for BME communities. The government did not 'wholly' accept the presence of institutional racism, but acknowledged the presence of discriminatory practices in mental health services. During the same year, the five year review of NSF was published (Appleby, 2004).

The review of NSF (2004) pointed towards the urgent need to meet the needs of BME groups. All this mounted pressure onto the government, which resulted in the enactment of the first key initiatives from the government to improve mental health services for BME groups. This new beginning started in 2005.

In 2005, the government published '*Delivering Race Equality (DRE) in mental health care: An action plan for reform inside and outside services'* (Department of Health, 2005c). This aims to reduce ethnic inequalities in access and experience, and outcomes from mental health services. It claimed that it should introduce a 'whole-system' approach to carry out 'reform' inside and outside the services to meet the needs of BME groups. The time span of the programme was only five years (2005-10). It was based on evidence published in the following documents:

i) Inside Outside: Improving Mental Health Services for Black and Minority Ethnic Communities in England (March 2003)(NHS., 2003)
ii) Delivering Race Equality: A Framework for Action (October 2003)(Equality, 2003)
iii) The independent inquiry into the death of David Bennett (February 2004)(Blofeld, 2003).

The conceptual base of the programme included three components:

i) Delivering appropriate and responsive services. It was envisioned that this objective would be achieved through organisations and workforce development. It also included directions for improvements in clinical services.
ii) Improving community engagement in planning services. This was to be achieved through the recruitment of 500 new Community Development Workers (CDWs).

iii) Collection and better use of information on ethnicity, culture and good practices. This should also include a new regular census of mental health in-patients.

To ensure its implementation, the programme created a high profile governance structure. A BME Mental Health Programme Board, informed by a BME National Steering Group directly accountable to the Minister, was set up at the Department of Health to oversee the implementation of the action plan. Its implementation was also monitored through the Healthcare Commission and the Commission for Social Care Inspection. The plan was integrated with the wider BME Mental Health Program and the government's overarching strategies for tackling inequalities and social exclusion. It also included Sir Nigel Crisp's (Chief Executive of NHS 2004) Race Equality Action Plan. The Race Equality Action Plan aimed to make equality and diversity fundamental to all NHS strategies, and to address the needs of BME communities in a systematic and professional way. Focused implementation sites were established to help identify and spread best practices. The plan acknowledged the role of the independent sector in terms of providing culturally sensitive services and passing on its expertise to the statutory sector.

Bennett (2008) observed many hurdles during the implementation of DRE. Its national lead and main architect resigned in 2006 stating lack of commitment by leadership to implement the plan. The recruitment of 500 Community Development Workers was delayed and the financial resources allocated for the programme were also diverted to other projects. Another main weakness in the programme was that

it was only planned for five years. This kind of short-term approach is less likely to result in permanent changes in the mental health system and practice (Craig and Walker, 2012). The effectiveness of the cultural awareness training to develop staff is also questionable (Bhui, 2002).

However, despite all these weaknesses, at least from the conceptual level, the continuity in the shift of policy is evident. The shift from implementing 'special' programmes for BME groups to having a 'whole-system' approach for change in the services is an important point which should not be ignored. The emphasis of the action plan on organisational and staff development, community engagement, collection and better use of ethnic data showed an increase in relevance, maturity and comprehensiveness of BME policy in mental health settings over time.

While the implementation of DRE was in its last stages, the government published its new policy for mental health services, '*New Horizons: a shared vision for mental health'* (Department of Health, 2009). The policy was said to be cross-governmental, having a collaborative working approach with twin objectives. Its first objective was to improve the 'mental health' and 'well-being' of the population; the second objective focused on improving the accessibility and quality of existing services. It identified fourteen key actions across various tiers of government but none of them were specific to BME issues in mental health services. It only suggested that personalisation of care is fundamental to addressing the needs of individuals from BME groups. It also signalled that reducing inequalities and provision of satisfactory mental health

services is challenging and an urgent task for the commissioners and providers. The policy cautioned that there is no single BME issue and there are significant risks in making assumptions of homogeneity and over-simplification. It acknowledged that the roots of mental health inequalities lie in social, not biological factors.

Interestingly, this policy only spelled out 'suggestions', 'cautions' and 'acknowledged' the root causes of inequalities in mental health, but did not outline any major and specific intervention to improve mental health services for BME groups. It only mentioned that the government would review DRE and learn from its implementation; future work on BME mental health issues would be based on the resulting learning.

'*Five years review of DRE'* was published in 2009 (Wilson, 2009). It describes the key challenges, successes and learning for future mental health policy. The review documented that DRE faced challenges in all three components on which it was based. Cultural awareness training for workforce development was not rated as most effective because of its short duration (5 days) and content. There were also difficulties in uniform and standardised collection and monitoring of ethnic data. It documented the fruits of community engagement, but the level of engagement was not as far reaching as expected. It recommended continuity in learning, better collection and monitoring of ethnic information for commissioning and service development, more focus on outcome and local level accountability, taking a single approach for reducing inequalities, re-thinking in workforce development, better engagement of users and communities, and inclusion of BME

service improvement as an indicator in Care Quality Commission (CQC). However, most of the challenges and learning documented by the DRE review does not appear to be new. Most of them had already been identified by the NSF in 1999.

The year 2010 saw another important development in the 'equality' agenda in the UK. The government promulgated the Equality Act (2010). The Act provided a single legal framework to tackle disadvantage and discrimination. It combined previous legislation relating to equity (e.g. race, disability, gender etc.) with the aim to make implementation easier for organisations. Under this Act, the following nine characteristics are called 'protected characteristics': age, disability, gender and gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation. The integration of ethnic inequality with other inequalities appears to be a healthy sign. It is expected to bring ethnicity related inequalities into the main agenda of addressing inequalities in society. But at the same time it is suggested that mental health inequalities related to race may have different dynamics compared with other protected characteristics, for example disability. Depending on the political circumstances of the UK, any one protected characteristic may get more privilege over another.

As per the Equality Act 2010, public authorities (including the NHS), when making decisions of a 'strategic' nature in their functions, must have 'due regard' to design them in a way which helps to reduce different socio-economic inequalities. The Act enforces Public Sector Equality Duty (April 2011) on

public organisations. As per this duty, the public sector, in the exercise of their functions, must have 'due regard' to the need to eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act; advance equality of opportunity between people who share a protected characteristic and those who do not (taking steps to meet the needs of people from protected groups where these are different from the needs of other people); and foster good relations between people who share a protected characteristic and those who do not.

The equality duty applies across all functions of an organisation (service, policy-making, employment, planning, procurement, and statutory decision-making). It requires equality considerations to be reflected in the design of policies and the delivery of services, including internal policies. The Equality and Human Rights Commission is responsible for monitoring and enforcing equality. The Act identified seven different types of discrimination and outlawed them.

In 2010, the new coalition government superseded previous policy on mental health (given in 2009) and published a new strategy in February 2011. The new strategy is entitled '*No health without mental health: a cross-government mental health outcomes strategy for people of all ages'* (Department of Health, 2011). The strategy aims to attain parity of esteem between mental and physical health services. Its approach is outcome focused in contrast to its predecessor which was more process oriented. Contrary to previous policy, it applies to people of all age groups.

The strategy stated that the government would encourage communities to manage their mental health, implement decentralisation and make early interventions to prevent mental illnesses. It also intends to make mental health services more sensitive to the human rights of patients and the requirements of the Mental Health Act 1983 (amended in 2007).

It has six shared objectives which include:

i) More people will have good mental health;
ii) More people with mental health problems will recover;
iii) More people with mental health problems will have good physical health;
iv) More people will have a positive experience of support and care;
v) Fewer people will suffer avoidable harm;
vi) Fewer people will suffer stigma and discrimination.

These objectives are generic and do not include any specific objectives for BME groups. However, the strategy devoted a whole chapter to the subject of reducing inequalities and promoting equalities in mental health care for population groups with 'protected characteristics', as mentioned in the Equality Act 2010. In response to the Act, NHS organisations are required to publish an Analysis of the Impact on Equality (AIE) and how it would promote equality.
This AIE appears to be drawn from the Environmental Impact Assessment (EIA) where likely negative impacts of a project on the natural, physical and human environment are identified in generic terms and actions are suggested to reduce them.

However, the case in healthcare is different. It requires a more individualistic and personalised approach to deliver quality care. The strategy also stated that the government is developing an Equality Delivery System (EDS) to help NHS organisations promote equality. To what extent this new equality system would be able to focus on addressing the root causes of inequalities in mental health care is yet to be seen.

The policy intends to reduce mental health inequality by taking a holistic approach. It suggested that NHS organisations should learn from the implementation of DRE and make services more responsive to the needs of the BME patients. It has also stated that the government would continue to research issues of race equality and address them. However, as mentioned above, as with the review of DRE, it did not identify any new learning. So, it seems that as per this strategy, there would be very few new and useful initiatives for BME groups. A recent policy document '*Closing the Gap: Priorities for essential change in mental health'* has once again documented that there are inequalities in service usage and outcome for BME groups (Social Care, 2014).

In summary, it is observed that since 1999, ethnic 'policy making' in the UK is becoming more focused and relevant to the mental health care of BME groups. It started with the acknowledgment of the failure of the NHS to 'meet the needs' of BME mental health care. Then it shifted and had a 'whole-system' approach for 'change' in mental health services. Now, it has been integrated with the broader agenda of tackling mental health inequalities backed by the Equality Act 2010.

On the other hand, BME mental health 'policy implementation' is struggling to achieve its desired goals.

2.3 Discussion on policy initiatives

This section focuses on the development of various legislations, policies, strategies and action plans on BME issues in the UK. Specifically, it focuses on the relevance of these policies to the mental health care of BME communities.

It is observed that the existence of BME related mental health inequalities are a half-century old phenomenon. It is also observed that there is continuity in the acknowledgement that services are not meeting the needs of BME groups and Black and African Caribbean people are over-represented in institutional settings. These population groups are also reported to have had negative experiences of police services. The acceptability in the use of 'coercion' in their daily practice in these two services might be a cause for the reported poor and negative experiences of minority ethnic groups.

The three Race Relations Acts in the second half of the last century were enforced to address race issues in the UK. However, it was the beginning of the 21st century which saw relatively more focused and relevant actions to improve the quality of health care for BME communities. DRE, being the key programme for mental health care of BME groups, appeared to be conceptually comprehensive but remained unsuccessful in fully achieving its stated objectives. This is evident from the fact that recent mental health strategy

(February 2011) documented that mental health services often fail to meet the needs of BME communities.

There is acknowledgement at policy level that the challenge of reducing mental health inequalities for BME groups is complex. The various steps taken by the NHS are due to the equality legislations rather than the NHS's own proactive approach to deliver 'equality' as envisioned at the time of its establishment in 1948. But despite this awareness the implementation actions from the NHS apparently are not matching the requirements of the task. There also appears to be a knowledge gap in this field.

The task of policy implementation is carried out in organisations. The organisational members play key roles in this process. How these organisational members 'make sense' of the policies and in what ways they try (or not) to achieve policy objectives are important factors in effective policy implementation. A policy which is not based on the understanding of the sense-making and interpretation process of its actors is likely to achieve poor outcomes. There is also a need to understand how a policy is filtered and practised in various levels of the organisation and within professional categories.

The policy documents reviewed in this chapter appear to be lacking focus on the implementation of the policy; they do not appear to be based on the study of the organisational behaviour of the policy implementers. The policies state what changes are required but place very little focus on how these

changed ‘behaviours’ or ‘practices’ can be achieved by the main policy actors, i.e. the organisational members of NHS.

Finally, making a comprehensive policy is one thing, but ensuring that an enabling structure and culture is in place to implement them in their ‘true’ sense is a different task. This task requires greater understanding of the organisational behaviour of the staff. The task of making a young white female nurse able to deliver ‘equal’ and ‘culturally relevant’ care to an elderly black male patient rests with the leadership and management of the NHS and relevant training bodies. What strategy would be appropriate incentive/penalty/training) to get the task done, is also a managerial question. However, at the broader level, this can be achieved through local policies aimed to facilitate organisational change and organisational development.

The next chapter will present a review of the research evidence on key subject areas highlighted by this review.

CHAPTER THREE: REVIEW OF THE RESEARCH LITERATURE

3.0 Introduction

This chapter presents a review of the empirical research published in peer-reviewed journals on ethnicity and mental health. The first section presents the methodology of the review; the second section reviews the literature that primarily addresses the mental health of the Pakistani ethnic group in the UK. The findings of the review are presented thematically and synthesised. The final section identifies gaps in the literature where further research is required.

3.1 Methodology for the review of the literature

Review Question

What English language research has been published on the subject of ethnicity and mental health in peer-reviewed journals?

Search Strategy

Key terms used for searching

The following key terms were used to identify relevant papers:

i) Black and Minority Ethnicity (BME) / (in)equality / ethnicity / racism / discrimination / culture / race / Pakistani *and*
ii) Psychiatry

iii) Mental health
iv) Mental illness
v) Schizophrenia
vi) Epidemiology of mental illness.

Databases searched

The following databases were searched using the key terms identified above:

- Applied Social Sciences Index and Abstracts (ASSIA)
- British Nursing Index
- CINAHL
- International Bibliography of the Social Sciences (IBSS)
- MEDLINE (ProQuest)
- Psych Articles
- Psych INFO
- Social Care Online
- Social Services Abstracts
- Sociological Abstracts
- Web of Knowledge (ISI)
- Web of Science (ISI)
- Bibliography of Asian Studies
- Centre for Reviews and Dissemination
- EMBASE

No restriction was applied on date of publication and study type. Searches were limited to English language. Truncation symbol (e.g. *) was used during the search. Papers were also searched through hand search.

The initial online search from the databases found 22,258 references. These references were directly imported to

Endnote reference management software. After identifying and filtering duplicates, 12683 references were finally retrieved. These references were searched through relevance of their title and abstracts and 643 references were found. The following inclusion and exclusion criteria were applied to select the relevant papers:

Inclusion and Exclusion Criteria

Inclusion

- Papers focussing on both ethnicity and mental health/illness;
- Papers published in the English language;
- Papers published in peer-reviewed journals;
- Papers reporting empirical research.

Exclusion

- Papers which focus on either mental health or ethnicity without relating the two;
- Commentary and opinion papers;
- Papers published in a language other than English.

Selection process for relevant papers

- Stage-i : Inclusion by relevance of the title;
- Stage-ii: Inclusion by relevance of abstract and content.

Owing to the vast number of papers published which were found in the search, it was decided to further limit the search, directly focusing on the Pakistani ethnic group. After a thorough process of screening, the review finally identified 57 published papers on mental health/illness and the Pakistani ethnic group. In addition to this, studies are also included for discussion. These studies are conducted on Pakistanis in Pakistan and on other ethnic groups in the UK/USA.

Reporting/Analysis

The selected papers were tabulated in five columns including: reference; focus of the study; study design; quality assessment and learning point/comment. The key themes were identified and papers arranged accordingly. A textual commentary was constructed to synthesise current understanding of the relationship of the Pakistani ethnic group with mental health/illness and the factors that influence this relationship. As the research was being proposed within the context of ethnicity/race, a few relevant studies conducted on other ethnic/race groups in the UK and other countries were also included.

All the papers focusing on Pakistanis were included in the review and none of them were excluded due to poor quality. This was done because of the relatively few number of papers found. The summary table is presented here to show the number of papers which fell into each theme.

Table 3.1: Number of research review papers in each theme

Serial No	Theme	No. of Papers
1	Prevalence of mental illness among the Pakistani ethnic group	10
2	Causes of mental illness among the Pakistani ethnic group	15
3	Conceptualisation/expression of mental illness among the Pakistani ethnic group	7
4	Mental health help-seeking behaviour and the Pakistani ethnic group	11
5	Mental health services and experiences of the Pakistani ethnic group	3
6	Perspective of health and social care professionals on ethnicity and mental health services	7
7	Methodological issues around ethnicity and mental health research	4

3.2 Mental health and the Pakistani ethnic group in the UK

3.2.1 Prevalence of mental illness among the Pakistani ethnic group

Knowing the correct prevalence of mental illness for any population group is critical for planning and the provision of required services. The current review has identified conflicting results on this subject for the Pakistani ethnic group. For example, regarding the prevalence of schizophrenia, an early population-based small-scale epidemiological study in a fixed area of South London found higher rates of schizophrenia among Pakistani immigrants than in the native-born White British population (Bagley, 1971). However, a mental hospital admission-based study on schizophrenia in England indicated

lower rates of admissions in 1971 and 1981 in this ethnic group (Cochrane and Bal, 1989). The higher level of prevalence of schizophrenia but relatively lower rate of hospital admissions may point towards an early gap in mental health service utilisation amongst Pakistanis living in the UK with a diagnosis of schizophrenia. However, inequalities in mental health service utilisation still persist (Bansal *et al.*, 2014), which could be a reflection of unmet needs.

The higher prevalence rate of schizophrenia among Pakistanis documented in the early 1970s may be attributed to their experiences of migration, lack of social support and struggle to settle into the host society. The underutilization of mental health services may be due to lack of awareness of the services, language barriers, the stigma attached to hospitalisation for psychiatric illnesses and importantly, differences in the social construction of mental illness and help-seeking behaviour.

In contrast to the above mentioned findings, Cochrane (1979) in a study of Asian and White British children, noted a lower prevalence rate of behavioural problems and hospital admissions among Asians (including Pakistanis) than their White-British counterparts. A lower prevalence rate of behavioural problems among Asian children may be due to the nature of their socialisation pattern in the family and parental control. However, lower hospital admission rates might be due to similar reasons to those cited above for schizophrenia cases.

Regarding the prevalence rate of depression and Common Mental Disorders (CMD), Weich *et al*. (2012) presented the comparative prevalence rate of Common Mental Disorders (CMD) among a representative sample of White, Pakistani, Irish, Black Caribbean and Bangladeshi individuals living in private households in England. Data was collected through a national cross-sectional survey of 4281 adults aged 16-74 years. CMD were assessed using the Revised Clinical Interview Schedule (CIS-R). The authors documented differences at a modest level in the prevalence of CMD among the ethnic groups with some considerable variations with reference to age and sex. In the Pakistani ethnic group, middle-aged men (35-54 years) and older women (55-74 years) were found to have a higher prevalence of CMD than their White counterparts. The depressive age groups identified in this study may be related to marriage patterns and gender roles in the Pakistani ethnic group.

Similarly, in another population-based study, Gater *et al*. (2009) compared the prevalence, development and persistence of depressive disorders amongst Pakistani and White European ethnic groups. This was a six-month prospective cohort design study undertaken at the primary care level in an inner city area in the North of England. 924 Pakistanis and 932 White European people completed the initial questionnaire. In the follow-up component of the study, 208 participants were interviewed. The 20 item Self Reporting Questionnaire (SRQ) was used to screen for possible depressive disorders. A depressive disorder was diagnosed if the participant fulfilled the criteria for ICD-10 depressive episode or DSM-IV current major depressive disorder. All

those with a depressive disorder were invited for follow-up interviews six months later and the same measures (ICD-10 and DSM-IV) were repeated. The researchers observed that depressive disorders were more common in women of Pakistani origin than their White European counterparts. The researchers also found that depressive disorders were more persistent among Pakistanis over the age of 50.

The above studies have shown higher rates of depressive disorders among Pakistani women compared to their White counterparts. The results of this study can be endorsed by another study conducted by Fazil and Cochrane (2003) in the West Midlands of England, who found that Pakistani women have a higher rates of depression than white British women. This study was conducted with 200 women (100 Pakistani and 100 White) selected randomly through GP registers. GHQ-28 was used to screen these women, and it was found that 44% of women of Pakistani origin and 14% of native White women were above the threshold of 10 on the Severe Depression Scale of GHQ-28.

However, a study conducted among a sample of 100 Asian (including Pakistani) immigrants in the UK also found gender differences were prevalent in psychological distress within the ethnic groups (Furnham and Shiekh, 1993). The researchers found a higher prevalence of psychological distress amongst females compared to males. The UK based results of a higher prevalence of common mental disorders among Pakistani women than men are endorsed by several population-based studies undertaken in rural and urban areas of Pakistan (Mumford *et al*., 1996; Mumford *et al*., 1997; Husain *et al*.,

2000; Husain *et al*., 2007; Taqui *et al.*, 2007; Ayub *et al*., 2009; Husain *et al*., 2011). It seems that in the Pakistani context, depressive disorders are a 'gendered' phenomenon with women more likely to have higher rates of prevalence. Studies have also focused on variations in the prevalence of psychological distress among first and second generation Pakistani migrants and found no significant differences (Furnham and Shiekh, 1993).

Findings from these studies highlight that there are ethnic inequalities in the rate of prevalence of mental disorders in the UK. Both males and females from the Pakistani ethnic group are reported to have a higher rate of depressive and schizophrenic disorders than their White counterparts.

These results also show that no conclusive findings exist regarding the prevalence of common and serious mental disorder among Pakistanis in the UK. The inconclusiveness of the prevalence of mental illness among the Pakistani ethnic group is also previously documented by London (1986) in a review article. London (1986) suggests that better data on the epidemiology of mental illness among Pakistani immigrants to the UK may be obtained by having larger sample sizes which take regional origin and religion into account.

3.2.2 Causes of mental illnesses among the Pakistani ethnic group

Identification of the etiological factors for mental distress among the Pakistani ethnic group can play an important role in developing and delivering relevant interventions. The literature has identified various psycho-social factors including

family conflicts (between husband and wife, parents and children), lack of social support, lack of adherence to Islamic religious practices and racism.

Hussain *et al*. (1997) identified marital issues, poor physical health and housing as three important factors causing depression among Pakistani women. Older people of South Asian origin are found to be experiencing a higher level of depressive symptoms when having poor physical health conditions (Williams *et al.,* 2015). Lack of social support and lower level of acculturation, specifically in English language, is also found to be an important contributing factors to developing and persisting depression among pregnant and non-pregnant Pakistani women in the UK (Chaudhry *et al*., 2012; Husain *et al.*, 2012; Nilaweera *et al*., 2014). Similarly, another study on the persistence of depression among Pakistani women consisting of a mixed sample of first and second generation immigrants found family conflicts, isolation from family and loss of control over personal feelings and children's behaviour to be important contributing factors (Gask *et al*., 2011). Although in this study women have indicated that they lack control over the behaviour of their children, a study undertaken by Mujtaba and Furnham (2001) found a higher level of parental over-protection and conflict among a sample of Pakistanis girls in the UK. The study found that over-protection is associated with eating disorder scores (EAT) among the girls. High parenting control is also found to be associated with poor mental health among adolescents of the Pakistani ethnic groups in the UK (Maynard and Harding, 2010). This over-protection of girls may be related to one of

the ways of controlling their sexuality and the concept of preserving their modesty and family honour (*Izzat*).

Additionally, socio-economic factors are also found to create health inequalities among Pakistanis in the UK (Mangalore and Knapp, 2012; Mindell *et al.*, 2014). For example, the disadvantages of Pakistani families are found to be an important explanatory factor for poor mental health among pregnant women (Prady *et al.*, 2013) and cause a higher rates of socio-emotional difficulties among Pakistani children in the UK (Zilanawala *et al*., 2015).

An important theme identified by these studies is the role of the family as a cause and cure of mental distress among the Pakistani ethnic group in the UK. In Pakistani culture, it is commonly observed that the family institution is given much importance. Although the trend is changing towards a more nuclear family system (especially in urban areas), most of the population still live in joint and extended families. In more rural contexts, the role of joint and extended family is a double- edged sword. On the one hand it helps with socialising children, provides social support and reduces feelings of loneliness; on the other hand failure to fulfil family obligations may also become a precipitating factor for psychological distress. These factors are identified in the research. For example, a study conducted in one of the largest urban centres of Pakistan (Karachi) found that older people living in nuclear families are 4.3 times more likely to suffer from depression than those living in joint families (Taqui *et al*., 2007).

In Pakistani culture, issues around marriage and family relationships are governed through traditional cultural norms. These norms restrict free choice in mate selection (especially in the case of women). A married man or woman is expected to be socially sensitive to the expectations of in-laws in the family. Failure to do so can cause tension among the family members which consequently is manifested in various forms of psychological distress and depression. Similarly, socialising and controlling the behaviour of children is traditionally considered an important task for the parents. Parents are urged to socialise their children in broader religious-cultural contexts. Children, who are second generation immigrants, are expected to follow the cultural practices of their parents, which may conflict with the norms of the wider UK society. What children and young people of second generation Pakistani immigrants learn at home may not be practised in the wider social and cultural context of the UK. Therefore, issues arising from intergenerational cultural conflict and social exclusion may potentially become a source of continuous mental stress in the family.

A few studies of Pakistanis living in the UK also indicate the role of not following religious practices in causing mental distress. Cinnirella *et al*. (1999) reported that in their study British-Pakistani Muslim women cited lack of faith and not offering five prayers daily as a cause of depression and schizophrenia. Among this group mental illness was used as a criterion to categorise Muslims as either 'good' or 'bad'. As the mental illness was perceived to be caused by not adhering to religious practices, thus the mentally ill were classed as 'bad'. Their mental illness was also linked to the will of God and it

was believed that the illnesses were caused by spiritual factors. Similar kinds of religious explanations for mental distress are reported by Bhui *et al*. (2008b) for this ethnic group.

The studies reported above have identified the role of psychological and social factors in causing mental disorders among the Pakistani ethnic group. These findings indicate that causes of mental disorders in this group are socially embedded. These findings are supported by studies conducted on other ethnic and racial groups in the UK, the USA and Hong Kong (Warheit *et al*., 1975; Jenkins *et al.*, 1997; Wong and Lieh-Mak, 2001; Mallett *et al*., 2002; Cooper *et al*., 2008). However, in contrast to these studies, Kirkbride *et al*. (2008) found that higher rates of psychoses among BME groups (including Pakistanis) are not influenced by socio-economic factors.

There is also published research which identifies the role of racial and ethnic discrimination in causing common mental disorders among ethnic groups in the UK. For example, Bhui *et al*. (2005) published research on the role of racial/ethnic discrimination and common mental disorders among workers in the UK. They found that racial and ethnic discrimination showed a strong association with common mental disorders. Heim (2011) noted that a higher level of racism is associated with lower levels of psychological wellbeing among the Pakistani ethnic group in the UK. The role of racial discrimination in causing distress is also supported by Moradi and Hasan (2004b) in their study in the USA.

The studies presented above have reported that a variety of social factors contribute towards the causation of different types of mental disorders among Pakistani and other ethnic groups in the UK. Significant causes highlighted by these studies include the role of family, marital issues, intergeneration and cultural conflicts, religion, unemployment and racial discrimination. On the basis of the findings above, it can be argued that the efforts to promote better mental health among ethnic groups in the UK are likely to bear fruit if the causal mechanisms are well understood and addressed accordingly. For example, it is generally assumed that people of Pakistani origin in the UK have good family connections and support, but here it is identified that there is a lack of social support, especially to pregnant women.

3.2.3 Conceptualisation/expression of mental illness among the Pakistani ethnic group

It is commonly observed that in Pakistani culture mental illnesses are conceptualised in terms of possession by some invisible spirits *(Jinn)*. The existence of such spirits are present in verses of the holy Quran. The Quran mentioned that God has created and controls such phenomena. It is thought that these spirits can inhabit the mind and body of a person and control behaviour. Therefore, the conceptualisation and expression of mental illness plays a significant role in attitudes towards help-seeking, diagnosis and consequently the treatment and outcome for people experiencing mental disorders.

There is evidence which indicates that people of Pakistani origin somatise their depressive symptoms and aggressive

behaviour is considered as a significant symptom of mental illness (Tabassum *et al.*, 2000). Previously, Mumford *et al*. (1991) confirmed somatisation of depressive symptoms in the Pakistani ethnic group and explored the conceptual equivalence of Bradford Somatic Inventory (BSI) among White British and Pakistanis. Using factor analysis, the authors identified four similar principal clusters of symptoms in both ethnic groups. The symptoms identified a relationship to the head, chest, abdomen and fatigue. The authors concluded that both ethnic groups somatise depressive symptoms and there are conceptual similarities across the two cultures in this. However, the authors suggested that culture does play a significant role in how individuals interpret the depressive symptoms. Research conducted in Pakistan has found a strong link between medically unexplained symptoms and depression among children (Imran *et al*., 2014). On the basis of these findings, it is important to screen children for psychological and emotional issues when they present unexplained somatic symptoms.

The role of culture in interpreting and describing depressive symptoms is also recognised by Fenton and Sadiq-Sangster (1996). In their qualitative study on culture, relativism and the expression of mental distress among South Asian women (which include Pakistanis), the authors found that women used culturally specific language terms and phrases to describe their mental distress. For example, the authors found that the women used 'thinking in the heart illness' (p.81) as a term to describe depression and 'thinking too much, thinking and thinking in my heart' (p.75) as phrases in the description of mental distress. The authors also found that there is very

little focus on individual or personal issues in the accounts of the mental distress of these women. This demonstrates that depression is a socially embedded phenomenon in this ethnic group.

The debate around somatisation of depressive symptoms and its cultural relativity is further studied by Burr and Chapman (2004). Using a discursive approach to the depressive accounts of the South Asian women (including Pakistanis), the authors argue that women present somatic symptoms for describing depression to 'legitimate' (p.433) their illness and negotiate access to healthcare facilities. The authors further suggest that this process of negotiation is not specific to any culture but applies to all healthcare negotiations amongst all population groups.

Recent studies conducted in Pakistan found good validity of Western diagnostic and screening instruments for depression/anxiety in a Pakistani context. A study was conducted by Karmaliani *et al*. (2007) to compare the diagnostic validity of two measures for assessing depression and anxiety among pregnant women in one of the largest urban centres of Pakistan (Hyderabad). The instruments compared were Aga Khan University Anxiety and Depression Scale (AKUADS) which is developed in Pakistan in the Urdu language; while the second measure was the 'How I Feel Scale' which was developed in the USA. The authors found that both instruments showed similar results and had good internal consistent reliability.

Another study identified in the literature was conducted by Syed *et al*. (2008) in a rural setting in Pakistan (Gujrat) to screen for psychological distress among a self-motivated sample. The six villages with a relatively high proportion of emigrants to Norway were selected. The researchers compared the concordance of the western-based Hopkins Symptom Checklist (HSCL-10) and the Pakistan Anxiety and Depression Questionnaire (PADQ). The authors found HSCL-10 is applicable to the Pakistani context and it is comparable with PADQ. The authors concluded that HSCL-10 can be used for screening in clinical and epidemiological settings for the immigrant Pakistani population in Western societies. Similarly, the Edinburgh Post-natal Depression Scale (EPDS) is also validated for detecting depression in pregnancy among women of Pakistani origin in the UK (Husain *et al.*, 2014).

However, in contrast to the above mentioned studies, Williams and Hunt (1997), in a study among South Asians living in Scotland, found that the General Health Questionnaire-12 (GHQ-12) is less sensitive to certain stressful situations experienced by these ethnic groups and especially women in these groups. The authors concluded that this measure underestimates the distress faced by these women in certain situations.

From the above discussion, it appears that there may be variations in the interpretation of depressive symptoms across cultures, but the symptoms themselves may be shared. The practice implication is that the professionals working with a culturally diverse population should be sensitive to the cultural variations in the interpretation of the symptoms of mental

illness. It also implies that the mental health assessment tools used for mental illness should be culturally and linguistically sensitive to the Pakistani ethnic group in the UK.

3.2.4 Mental health help-seeking behaviour among the Pakistani ethnic group

Linking causes of illnesses with supernatural beings provides 'legitimacy' for people to seek spiritual healing (Fazil *et al.*, 2006). Culturally-determined causal beliefs of mental distress are found to be significant predictors of attitudes in seeking professional help among the British-Pakistanis (Sheikh and Furnham, 2000). Previous studies have indicated that religious coping strategies are employed among Pakistani Muslims in the UK. For example, Cinnirella *et al*. (1999) noted that among a British-Pakistani Muslim women's group, prayer was perceived as a very effective coping strategy for depression and schizophrenia. However, the study noted that there are inter-generational differences on the use of religious coping, with older members tending to use more religious coping than younger ones. Similarly, Bhui *et al*. (2008a) reported that during mental distress, Pakistani participants showed a greater tendency of compliance to religious practices to reduce mental distress. The practices include distancing oneself from greed, listening to religious programmes, a desire to help others and showing respect and offering hospitality. Research on different cultural-religious groups in the UK has found that Muslims (Pakistanis being the largest group) are most likely to use religious coping instead of seeking professional support in depression (Loewenthal *et al*., 2001). Muslim faith healers are not only consulted for depression, but for more serious mental illnesses as well. For example, it is found that such healers are

also frequently consulted for substance misuse and psychosis (Rashid *et al*., 2012). These healers question the utility of scientific methods in treating mental illnesses.

However, previous research has also highlighted that the use of religious coping is not a straightforward decision, rather it is utilised in certain hierarchies and its preference varies among first and second generation Pakistani migrants. Tabassum *et al.* (2000) in their study indicated that consultation with GP services was considered to be the first preference by the majority of the respondents. Faith and religious coping was the second preference and this rate was lowered for second generation females. Importantly, hospitalisation was regarded as a last resort to cope with mental illness.

In parallel to the above, Dein and Sembhi (2001) studied the use of traditional healing practices among South Asian (including Pakistani) psychiatric patients in the UK. The authors found that 28% of the respondents used traditional healing during some stage of their psychiatric illness. The authors found that the age of the patients was a significant factor for the use of traditional healing. Similarly, a study conducted in Lahore (Pakistan) found that traditional healers are often used by psychiatric patients before resorting to formal and professional psychiatric services (Farooqi, 2006).

These studies indicate that people from the Pakistani ethnic group tend to use religious and traditional coping strategies for mental illnesses. However, a study undertaken by Commander *et al.* (2004) found contrasting results and noted that none of the South Asians among their sample had

consulted lay or traditional healing for the previous six months of their mental distress.

Another important factor influencing mental health help-seeking behaviour of the Pakistani ethnic group is the stigma associated with mental illness and the fear of gossip in their community (Bradby et al., 2007). Wheeler (1998) found that the hospitalisation of women for a mental illness is strongly stigmatised among the Pakistani ethnic group. Even close family members were reported to stigmatise hospitalisation for mental illness. Hospitalisation of women was also reported to increase the prospect of divorce, marginalisation from participating in family decisions, and loss of respect and family status. The author noted that even the children of hospitalised parents are stigmatised by their peers. Findings from this study are helpful in explaining the reluctance to access hospitalisation for mental illness as a last resort among the Pakistani ethnic group, as noted by Tabassum *et al*. (2000). These findings may also be useful to explain the lower rate of hospitalisation among cases of schizophrenia in the Pakistani immigrants, as documented above by Cochrane and Bal (1989). However, caution is needed in directly associating higher levels of stigma with a lower level of utilisation of statutory mental health services among Pakistanis in the UK, because research has also found that a higher level of education and acculturation can mediate the intention to utilise psychological services instead of religious and traditional healers (Pilkington *et al.*, 2012).

From the above studies, it can be argued that the mental health help-seeking behaviour of Pakistani people in the UK

consists of a mixture of traditional and western ways. This conclusion can be strengthened by evidence from a systematic review conducted in Pakistan, which concluded that there is a co-existence of traditional and western ways of help-seeking behaviour among Pakistanis in Pakistan (Anwar *et al.*, 2012). In the UK context, the 'candidacy' model of access can be helpful in explaining mental health service utilisation among Pakistani people (Dixon-Woods *et al*., 2006). According to this model, an individual's identification of his or her 'candidacy' for health services is structurally, culturally, organisationally and professionally constructed. Using the candidacy model, a systematic review focusing on primary healthcare found that candidacy of the Pakistani service users to access services in the UK is constrained where there is lack of a fit with professional ways of working and different cultural categorisation (Garrett *et al*., 2012).

3.2.5 NHS Mental health services and experiences of the Pakistani ethnic group

People's experiences of mental health services are very important for the treatment, outcome, future engagement and improvement of services for the patients and their carers. A study conducted in England reported that users of Early Intervention Services (EIS) by the Pakistani ethnic group were not satisfied with its quality (Penny *et al.*, 2009). The users perceived these services to be concerned with medication rather than integrating other psychological and social interventions. Families and service users reported that the interpreting service was not provided regularly. They reported that this service was only used when required by a doctor, but not when families wanted to get detailed information from the

doctor. The research also documented a difference in the perception of the role of family and doctors in the treatment and care of the patients. Respondents from the younger generation suggested greater involvement of the users and family in the care decisions, whilst the older generation considered the role of the doctor as an expert and more important. The author observed that a lack of shared understanding and communication barriers between service users and service providers were the major obstacles to good quality services.

A further study conducted by Wheeler (1998) found that Pakistani service users expressed their dissatisfaction with the services offered and reported negative social effects of medication. The service users reported that treatment with drugs made them 'lazy' with constant feelings of tiredness and sleepiness. Consequently, they were unable to perform their domestic responsibilities and felt humiliated and guilty.

Further experiences of South Asian (including Pakistani) mental health service users were studied by Bowl (2007) and noted that services are not responsive to the 'particular' needs of this community. The participants of the research suggested launching special awareness programmes, increasing the cultural competency of the staff and enhancing funding to improve the services. On the basis of this research, Bowl (2007) concluded that a comprehensive 'cultural change' in the UK mental health services is needed to improve services for the Pakistani ethnic group. The author suggested community and service users' involvement as ways to improve the services. Recent evidence from dementia care in the UK

has found that the services are not well-informed about the needs of Pakistani service users (Regan, 2014). Based on this, the author highlights that dementia services need education on how to treat service users of a Pakistani origin.

Although the studies on experiences of mental health service users from the Pakistani ethnic group are limited in number and the sample sizes are small, one can appreciate the barriers and gaps in the services. These are: lack of cultural competency in the staff; language and communication; poor funding for appropriate services; inadequate access to non-drug interventions; and lack of community and service user's involvement in the care. The research studies conducted on other ethnic communities in the UK also identified similar issues in the services (Mclean *et al*., 2003; Bowl, 2007).

3.2.6 Perspectives of health and social care professionals on ethnicity and mental health services

This section includes studies on the perceptions and experiences of the mental health professionals regarding black and minority ethnic groups in the UK. It is assumed that the findings also apply to the Pakistani ethnic group with the possibility of some variation.

Chandler-Oatts and Nelstrop (2008) reported that mental healthcare professionals have expressed experiences of fear in dealing with patients of African-Caribbean origin. The fear among mental health professionals regarding black patients is also documented by an inquiry report on the deaths of three black men in the UK mental health services (Department of Health, 1993).

The subject of ethnicity-specific stereotypical perception among the mental health professionals is further examined by Burr (2002), who studied the perceptions and understandings that members of mental healthcare professionals have about women from South Asia including Pakistani ethnic groups and how much these are derived from cultural stereotypes. The sample of the participants was from diverse professional backgrounds. The mental health professionals attributed the prevalence of depression among South Asian women to personal predisposing factors (such as genetics and the inability to cope with stressful events), and South Asian culture (patriarchal and repressive culture, arranged marriages and cultural conflict). These observations are supported by Nazroo (1998), who noted that in the UK, health related ethnic inequalities historically have been explained in terms of genetic and cultural differences.

These findings suggest a lack of shared understanding about the causality of mental illness among the professionals and the South Asian (including Pakistani) communities. It was also perceived by the professionals that the South Asian (including Pakistani) communities stigmatise mental illness more strongly than the White British community. There was also a perception that members of South Asian (including Pakistani) communities 'look after their own' (p.843). The author concluded that knowledge of mental health professionals about the South Asian (including Pakistani) women is constructed upon stereotypes of western culture as superior to a construction of eastern cultures as repressive, patriarchal and inferior. The professionals perceived the South Asian (including Pakistani) culture as a cause for depression among

the women and viewed adoption of Western culture as a remedy. The author suggested that these stereotypes become incorporated as 'fact' and have the potential to misdirect diagnosis and treatment. On this basis, the author argued that cultural stereotypes of the mental health professionals demonstrate a 'racist discourse' (p.836).

Some of the findings outlined above are also highlighted by Saltus (2006). In this study, the author investigated the views of mental health and social care professionals on improving the quality of mental health services for BME groups in Wales. The professionals reported that they face the following difficulties: translating mental health terms across diverse cultures and languages; a prevalence of strong mental illness-related stigma in BME (including Pakistani) communities; language barriers; a lack of training to collect and use ethnic data; and absence of strong leadership in the services to implement the ethnic agenda. Similar kinds of challenges are identified by another study on perinatal depression management in primary care (Edge, 2010). In this study health professionals reported: a lack of training and knowledge in identifying cultural and special needs of BME women; lack of clarity in professional roles and care pathways; poor coordination among different agencies involved; lack of time; staff shortages and non-compliance with professional guidelines. Further barriers such as a lack of funding and partnership with the BME voluntary sector are reported by Barn (2008).

Similarly, a study undertaken in Leicestershire with the Child and Adult Mental Health Services (CAMHS) practitioners found

that staff considered language barriers carried the potential for misunderstanding and errors in diagnosis and treatment (Dogra and Vostanis, 2007). The study also found variations among the staff in conceptualisation of terms such as culture, diversity and ethnicity. The staff were also found to be unaware about their training needs in diversity and previous trainees were not satisfied with the quality of training in this area.

The above identified that the challenges faced by mental health professionals are serious. These challenges can complicate diagnosis, may become hindrances in developing trust between professionals and service users, and consequently marginalise service users of an immigrant background (Sandhu *et al*., 2013).

3.2.7 Methodological issues around ethnicity and mental health research

Recruitment of participants from ethnic minority groups in mental health related research is found to be lower than in majority ethnic groups (Brown *et al*., 2014a). Elaborating the reasons, the authors found that as well as the stigma attached with mental illnesses and language issues are also important hindrances for ethnic minority people to participate in mental health research. These reasons are also supported by a systematic review specifically focusing on identifying recruitment of South Asians in mental health trials (Brown et al., 2014b). The authors highlight the need to consider ethnic minority specific issues in the design phase of a research project. Therefore, use of appropriate methodology is crucial for studying and understanding the complex phenomena of

ethnicity and mental illness. Groleau *et al*. (2007) argued that there are limitations in the use of quantitative methods alone for understanding mental health issues for ethnic groups, which are subjective in nature and embedded in specific cultural context. The authors argued that a mixed-method approach is useful for better understanding of the mental health issues and in designing appropriate mental health interventions for culturally diverse communities.

Similarly, Chandler-Oatts and Nelstrop (2008) elaborated on the utility of focus group discussions as a helpful tool in eliciting the views of African-Caribbean mental health service users in developing guidelines and recommendations for managing violent behaviour. The authors concluded that focus group data from users can be useful along with other data to develop guidelines which are sensitive to the needs of the service users from a diverse cultural background.

3.3 Summary of the research review

This research review has found overwhelmingly that the majority of the studies on people of Pakistani origin in Britain are related to depression (illness type), conducted in primary care (care setting) and on women (gender focus). Similarly, methodologically, the studies both for service users / communities / patients and service providers / professionals are skewed towards qualitative approaches. Geographically, the samples selected are mostly from inner-city local areas with a relatively high concentration of Pakistanis (geographical focus).

Overall, the review has identified that the prevalence of depression-related mental illness in people of Pakistani origin is relatively higher among women. The review has also noted that women of Pakistani origin have higher rates of illness prevalence as compared to their White counterparts. The earlier research has also documented a higher incidence of schizophrenia among this ethnic group in comparison with the majority White ethnic group.

The research studies reviewed for the Pakistani and other ethnic groups have demonstrated that psychosocial factors are generally held responsible for causing mental illnesses among these groups. Family conflicts, social isolation, intergenerational and cultural conflicts, racism and poverty are identified as significant factors contributing to the development and persistence of common mental illnesses among people of Pakistani origin.

The way various ethnic communities conceptualise and express mental illness may not be similar to the medical terms and expressions of the White majority. The native culture of ethnic groups plays an important role in interpreting the symptoms of mental illness. The review has clearly identified the use of culturally specific terms and phrases in the expression of mental illnesses among various ethnic communities including the Pakistanis.

It is observed that both in Pakistan and in the UK, Pakistani people tend to associate mental illness with religion and seek traditional and religious methods of coping. In-depth analysis of the studies reviewed indicates intergenerational differences

in help-seeking behaviour where the younger generation were found to be adhering to a more Western approach. The strong stigma attached to mental illness and hospitalisation is another important factor which limits the professional help-seeking behaviour of Pakistani people.

Mental health service users and their carers have reported unsatisfactory experiences when using statutory mental health services. The experiences of service users highlighted a number of organisational, structural and staff-related barriers. Among the important barriers are: language; ethnic specific stereotyping; lack of cultural awareness and shared understanding; less prescription of non-drug treatment intervention; less community and users' involvement; an incompetent and barring role in primary care, and stigma.

Interestingly, the studies which reviewed the perspectives of mental health professionals manifested some similarities among the issues identified by the service users and the professionals. For example, professionals highlighted the need for in-depth cultural competency training and reducing the strong mental illness stigma in BME communities. The research on the professionals also validated that ethnic specific stereotyping exists in mental health services.

The methodological review of the studies presented here demonstrated that qualitative approaches are appropriate to study experiences of mental health help-seeking and help giving. Because of the relatively subjective and contextual nature of mental health problems, it is suggested that qualitative approaches may be more useful to help in

understanding the phenomena (Groleau *et al.*, 2007; Chandler-Oatts and Nelstrop, 2008).

3.4 Theoretical framework

As the current research is mainly focused on ascertaining the organisational perspective and approach in meeting the expectations of the racial equality policy in the service provision, the next section presents literature on bringing about cultural change in the organisation through an organisational development approach. It is pertinent to mention here that introducing cultural change into mental healthcare organisations through an organisational development approach is also suggested in the national policy document for mental health (Department of Health, 2005c).

3.4.1 Organisational development and organisational change

Organisational development (OD) is a system-wide application of behavioural science knowledge to the planned development, improvement and reinforcement of the strategies, structures and processes that lead to organisational effectiveness (Cummings and Worley, 2014). Organisational effectiveness includes responding to the needs of the users as well as the regulations and other governmental agencies which provide resources and legitimacy to the organisation. Therefore, OD is considered to be a comprehensive strategy for bringing about organisational change as it encompasses theory, practice, methods and values (French and Bell, 1999). Healthcare systems worldwide are experiencing pressure to change the way they operate to reduce the cost of care, but at the same

time enhance the quality of care (Anders and Cassidy, 2014). Therefore, organisational change and its relationship with the quality of healthcare is not limited to any country, rather it is considered as an evolving international agenda (McKee *et al*., 1998). Specifically, to support policy implementation, OD can help healthcare organisations to ensure they have enough capabilities, as well as willingness among organisational members, to use these capabilities to link the requirements of new policy with local level organisational culture (6 and Peck, 2005).

This means that OD literature is applicable to the NHS mental healthcare context, where the NHS organisations are legitimated and funded by government agencies and are expected to respond to the needs of the service users, including those of Pakistani background. It is noted that OD is playing an increasingly key role in helping organisations to change their culture to achieve the desired goals (Burke, 1982; Borman *et al*., 2003).

OD has a strong practical orientation (Bate, 1990) and it suggests practical methods to promote change in health services by aligning the objectives of users, the government, other organisations and clinical staff (Peck, 2005). This means that OD literature can be helpful in studying how NHS mental healthcare organisations can change the culture to provide a better service to BME groups (including Pakistani), and meet the policy expectations. OD knowledge can help NHS organisations to assess themselves and their environments and revitalise and rebuild their strategies, structures and processes. OD can also help NHS organisational members to

go beyond surface changes to transform the underlying assumptions and values governing their behaviour. These underlying assumptions and values related to behaviour are part of the organisational culture, which is of interest to this research.

OD is carried out through a sequence of activities, actions and events intended to help an organisation improve its performance and effectiveness. Such OD interventions purposely disrupt the status quo in deliberate attempts to change an organisation or its sub-units toward a different and more effective state (such as meeting the needs of service users of Pakistani background).

There are four interrelated organisational issues that are key targets of OD interventions. These are:

Strategic issues: In the mental healthcare context, organisations need to decide what services they will provide and the population they will serve, as well as how to relate to their environments and how to transform themselves to keep pace with changing conditions. These are critical issues for an organisation such as the NHS. OD methods aimed at these issues are called strategic interventions. These methods include integrated strategic change, merger and acquisitions, alliance and network development, and organisational learning. Notably in this research, this has included working in partnership with the BME third sector, and organisational learning as a strategic intervention.

Technology and structure issues: organisations must decide how to divide work into departments and then how to coordinate among those departments to support strategic directions. They also must make decisions about how to deliver services and how to link people to tasks. OD methods dealing with these issues are called techno-structural interventions and include OD activities relating to organisation design, employee involvement, and work design.

Human resources issues: These issues are concerned with attracting competent people to the organisation, setting goals for them, appraising and rewarding their performance and ensuring that they develop their careers and manage stress. OD techniques aimed at these issues are called human resources management interventions. These issues are particularly relevant to this research because these are the people in the organisation who make policies, those who interpret them and those who implement them at the grass roots level.

Human process issues: These issues deal with social processes occurring among organisation members, such as communication, decision-making, leadership and group dynamics. OD methods focusing on these kinds of issues are called human process interventions and most commonly include conflict resolution and team building. Human process issues are also relevant to this research because issues of communication among the team members, especially with the service users, are of paramount importance to the delivery of a good quality mental health service. Similarly, issues involved in decision-making concern the implementation of racial

equality policy, provision of leadership for racial equality issues, and group dynamics among the team; the group dynamics involved when the service providers and service users interact with each other are also relevant for this research.

3.4.1.1 Overview of organisational development interventions

The major OD interventions for organisational change are closely related to the above cited four target areas. The major OD interventions identified in the literature are:

3.4.1.1.1 Human process intervention

These interventions focus on people within organisations and the processes through which they accomplish organisational goals. Related to this research, workforce development and team building are the two main interventions. Workforce development encompasses a range of human and organisational development activities aimed at skilling the workforce to achieve the desired goals (Conway *et al*., 2006). Individuals working in organisations are provided with training and education to support the organisational development and change process (French and Bell, 1999). Training and development intervention aims to increase the organisation members' skills and knowledge.

In the UK mental healthcare context, workforce development has been identified as an important intervention in bringing cultural changes in mental healthcare to address race related mental health inequalities (Department of Health, 2005b). These all have implications for human resourcing, and

particularly how NHS organisations develop their staff within the complex and resource constrained health-care context.

In the context of this research, the literature has identified that cultural competence training is used in the healthcare context to help staff better address the needs of the people of minority. The aim of cultural competence training is to make the staff 'aware' of different cultures, and this is considered as a fundamental step to organisational development and addressing health inequalities. NHS organisations are giving attention to achieving organisational goals on race through enhancing the competencies of staff involved in the delivery of the services. This is being done through Equality & Diversity and other training. However, the effectiveness of this training in developing the required level of cultural competency in the healthcare setting is not determined (Brach and Fraserirector, 2000; Anderson *et al*., 2003). So, there is a need to systematically evaluate these interventions to better understand the added value of these investments (Betancourt, 2003).

Care is needed when making decisions about the objective of workforce development and how it is done (van Buuren and Edelenbos, 2013). Decisions need to be made on whether the aim of the workforce development is transmitting theoretical insights or on insights developed in practice. Secondly, what method(s) would be used to develop a particular competence in the staff, whether the training would be online, in the classroom or on-the-job. In the context of diversity training, for example, it is noted that the race of the trainer influences the perceptions of whether the training is effective or not

(Liberman *et al*., 2011). Therefore, these questions are relevant to this research, where it is important to see how the content and method of race equality-related competence development is being used by the NHS to bring the desired cultural changes to the organisations.

The training provided by NHS organisations on cultural issues focuses primarily on the learning of individual employees with the expectation that the employee will apply the learning in their practice, and thus improve services. However, it is noted that the relationship between individual learning and organisational learning and change is a difficult one (van Buuren and Edelenbos, 2013). The trainees may not be encouraged to use their newly learned insights in practice because of the lack of support from line managers. Therefore, such training programmes remain external events with too few connections to the reality of the organisation.

A training programme introduced without the involvement of the frontline staff may not help to address issues faced by frontline staff in their everyday practice. The frontline staff may also not find the textbook principles, policy and legal expectations and theoretical insights. These employees need to see the direct applicability of these principles to their own practices. Just making frontline staff aware of what is expected may not be helpful as they also need to know how to fulfil those expectations (van Buuren and Edelenbos, 2013). It is important to note here that the training provided by the NHS to address equality and diversity issues is encouraged by central government, and the frontline staff may not have any involvement in its content development and delivery.

3.4.1.1.2 Techno-structural interventions

These include interventions focusing on an organisation's technology (task method and job design) and structure (division of labour and hierarchy). In the context of this research, the relevant interventions may include appointing an equality and diversity lead in the NHS organisation with the aim to address issues expected in the racial equality policy. The intervention may also include giving representations to BME background people in the organisational governance structure, and to volunteer organisational membership. Downsizing in the organisational workforce which is being undertaken in the NHS workforce is also relevant to this research.

3.4.1.1.3 Human resources management interventions

These interventions focus on personnel practices and are used to integrate people into organisations. Three methods of change associated with developing and assisting organisation members to better integrate with their organisation include: career planning and development; managing workforce diversity; and employee stress and wellness. As managing workforce diversity is closely related to my research, I will focus only on this intervention.

Managing workforce diversity: Diversity is the presence of differences among members of a social unit. Managing workforce diversity means including people who are considered in some way to be different from traditional members. These differences may relate to gender, race, religion and so on. Here I will just focus on ethnic diversity.

Societies are becoming ethnically diverse and hence diversity is seen as a significant factor in social life. Making the workforce representative of service users is identified as a helpful factor in better performance of the organisation. In the UK race policy literature, recruitment of BME staff in the mental healthcare workforce is identified as a way to bring about cultural changes and improve the service (Department of Health, 2005b). This is based on the value-in-diversity perspective.

The value-in-diversity perspective argues that a diverse workforce attains better organisational outcomes such as corporate profits (Herring, 2009), and a competitive edge in innovation, problem solving and flexibility in adopting change (Cox and Blake, 1991). The important thing to note here is that value-in-diversity may be helpful in certain organisations and service contexts, but not in others (Janssens and Zanoni, 2005). For example, racial diversity in the workforce may be helpful in a supermarket such as ASDA, but it may not be in the mental healthcare context, where there is a great deal of stigma attached to mental illness in the Pakistani community, and the people of Pakistani background may not like to share their personal social and psychological experiences with professionals of their own background or community.

There are also financial and operational challenges in achieving diversity in the workforce. It is noted that when an organisation is struggling financially, it becomes difficult for that organisation to invest in controversial or demanding change such as diversity (Davidson, 2011), and the current financial challenges faced by the NHS organisations are well

documented. Therefore, it seems difficult for NHS mental healthcare organisations to actually diversify their workforce for each of the protected characteristics (e.g. race, gender, age, sexual orientation) at each level of the organisation. These challenges firstly include, but are not limited to, difficulty finding qualified and bilingual people from the targeted ethnic group. Secondly, people from that target ethnic group may not like to work in certain organisations or professions. For example, nursing and especially mental health nursing, is not perceived as an attractive profession by the Pakistani people. The recruitment practices of an organisation may be explicitly or implicitly discriminatory to certain social groups because of their cultural or religious practices. For example, an organisation may appreciate certain types of dress code or facial outlook.

Similarly, people involved in the recruitment process may have conscious or unconscious prejudices about a certain social group (such as Pakistani) based on their personal experiences about the group. So there might be both the organisational side as well as ethnic group side issues which may be hampering workforce diversity.

The literature has identified a mismatch between organisational and ethnic group perspectives in the recruitment and retention of people from minority ethnic groups. For example, Murray *et al.* (2010) investigated the perceptions held by the police and community members of minority ethnic groups about the recruitment and retention of culturally and linguistically diverse police workforce in an Australian context. The authors identified that the police force

has negative attitudes towards minority groups adopting policing as a profession. The police force also cited that people from ethnic minority groups lack qualifications and English proficiency. However, this view was rejected by the participants from the ethnic community, and alleged a Victorian police racially-biased organisation, suggesting that their communities are deliberately overlooked in the recruitment process. The issue of racism and discrimination is not only limited to recruitment, but also to the retention of people of minority ethnic community in the organisation. These issues are also addressed in the discussion chapter of this thesis.

There is also an absence of well researched evidence in the NHS mental healthcare context which can indicate that workforce diversity alone can improve the quality of services. The most important thing in mental healthcare seems to be the approach, and skills-set the professionals use when treating people of any background, including Pakistani, in the UK. The physical and cultural resemblance does not seem to be the only factor in providing a good quality service to people who use the facility.

In summary, organisational development is the application of behavioural science knowledge to achieve organisational objectives, including changing culture. Organisational development is achieved through organisational development interventions. These interventions include: human processes, techno-structural and human resource management. Interventions related to both human processes and human

resource management are specifically related to this research, and are also dealt with in the discussion chapter.

The discussion now turns to social identity theory which is used to understand the data collected from the members of Pakistani ethnicity.

3.4.2 Social identity theory

Social identity is the sense of a person's self-concept derived from their perceived membership of any social group (Hogg and Vaughan, 2008). Social identity theory attempts to explain how social behaviour is influenced by the group membership of the individual (Alexander Haslam, 2014). Understanding social identity of a person is important because during life, how an individual feels, thinks, and behaves is influenced by his or her social identity (Tajfel, 1972). In the field of healthcare, social identity theory is found to be helpful in studying human social behaviour related to symptoms appraisal, coping, clinical assessment, depression and rehabilitation (Alexander Haslam, 2014), as well as perceptions about the quality of the services (Dreachslin et al., 2012).

The intellectual origin of social identity theory is in social psychology, and is based on Tajfel's early work on categorisation, social perception and inter-group behaviour (Abrams and Hogg, 1999). Therefore, in terms of the Pakistani ethnic group in the UK, it is important to understand whether a person of Pakistani ethnicity belongs to the 'Pakistani' group or wider British society? If either, what are the complexities and tensions involved in the mental health context?

An individual can have a single or multiple social identities, and the social identity or (identities) he/she will have would influence how he/she experiences the social world (Jenkins, 2008). This is especially true for more visible types of social identity like ethnicity, and belongingness to a minority group like Pakistanis in the UK.

The basic assumption of social identity theory holds that an individual's self-concept and self-esteem is influenced by his/her membership of social groups (Forsyth, 2013). Accordingly, an individual's attitudes towards societal out-groups and the beliefs underpinning these attitudes help in-group members to distinguish themselves from out-groups (Eagly and Chaiken, 1998). Furthermore, an out-group will receive discrimination, stigma, feelings of unimportance, and marginalisation. It might be the case that people from BME background in the UK are seen to be an out-group by White majority staff and are therefore receiving discriminatory mental healthcare.

3.4.2.1 Conceptual structure of social identity theory

Social identity theory has a number of conceptual components which are used to explain the role of group membership in human social behaviour. These components are described below:

3.4.2.2 Social identity, collective self and group membership

Social identity and personal identity

Social identity refers to collective self-conceptualisation in terms of shared characteristics of a member of one or more

social groups such as ethnicity, race, and gender, whereas personal identity is self-conceptualisation in terms of individual personality attributes such as intelligence, greed and charm (Hogg, 2006). It suggests that social identity deals with 'we', 'us' and 'them' conceptions of the self, while personal identity addresses the 'I' and 'you' construction of self.

People take their cultural knowledge and ways of expressing distress with them when they migrate from one culture to another. However, in the host culture their original cultural identity, and associated knowledge and ways of expressing distress, is likely to change through the process of assimilation or biculturalism (Bhugra, 2004). There is scope for enormous tension in a person's identity if they belong to an ethnic sub-group. The potential for Pakistanis in the UK to become Westernised in order to succeed in life or adopt Western ways of thinking and behaving seems challenging because of peer-pressure from their ethnic group.

Social and personal identities vary in their subjective importance and how they are accessible in the minds of people (chronic accessibility) or in the immediate situation (situational accessibility). However, in any given situation only one identity is psychologically salient to structure a sense of self, social perception, and social behaviour. Salient identity or the form that the identity takes will change as the situation or context changes. Therefore, it might be the case that Pakistanis in the UK may have had good experiences of the maternal healthcare provided by the NHS, but poor experience with the mental health services or certain aspects of the

mental healthcare system. The quality of the health service is not determined by any single factor, rather a multitude of factors which influence the perceptions of healthcare quality (Donabedian, 2005). The incorporation of social identity features of service users is important in motivating him/her to use the services (Langner *et al*., 2013). The provision of mental healthcare services by NHS organisations may not be incorporating features related to the social identities of the Pakistanis in the UK.

Dimensions of selves and types of social identities

There are three dimensions of self (Brewer and Gardner, 1996). These include *individual self,* which is defined by the personal traits differentiating self from all others. It seems difficult for a member of an ethnic minority to establish their 'individual self' because their ethnic group membership provides them with psychological and social security, which may be different for the White majority.

The second type of self is called the *relational self*. It is defined by dyadic relationships between the self and specific significant others. In terms of the relationship between social groups, Pakistanis maintain little friendships or 'bridges' into other ethnic groups, including White British. The Pakistani ethnic group is found to be under assimilated in the host British society, the reasons being religious and cultural differences and language barriers for the first generation that were not able to speak English.

The third type is the *collective self* which is defined by group membership which differentiates 'us' from 'them'. This poses

the greatest challenge for integration among different ethnic groups.

Brewer (2001) identified four types of social identities as:

i) *Person-based social identities* – emphasises how properties of groups are internalised by individual group members as part of the self-concept. The main Pakistani properties internalised by a member of a Pakistani ethnic group may include religious and cultural practices, including ways of perceiving and responding to mental health issues.
ii) *Relational social identities* - defines the self in relation to specific other people with whom one interacts in a group context. There are tensions for Pakistanis who wish to integrate more with the White majority. This includes social pressure to conform to Pakistani properties in perceptions and responses to mental health issues.
iii) *Group-based social identities* – these are equivalent to traditional definitions of social identity. Thus, typical of Pakistani culture is that mental illnesses are generally attributed to supernatural beings, and responded to in a non-western way. This may create tensions in the UK healthcare context.
iv) *Collective identities* – these refer to a process whereby group members do not just share self-defining attributes but also engage in social action to forge an image of what the group stands for, and how it is represented and viewed by others. Pakistanis portray positive and negative images, for example, Pakistanis are considered to have large families and look after their own.

3.4.2.3 Social categorisation, prototypes and depersonalisation

Prototype and metacontrast

A *prototype* is people's cognitive representation of a category or a group. It consists of a set of soft attributes such as perceptions, attitudes, feelings and behaviour that are related to one another in a meaningful way, and that simultaneously capture similarities and differences between in-group and out-group members. Professionals working in mental healthcare organisations would have prototypes about service users whose membership is of an out-group such as the Pakistani category or group, and vice-versa. The set of unclear attributes possessed by both groups would consist of how they generally perceive each other, but also how both groups perceive and respond to mental health issues.

Prototypes are helpful in describing and evaluating categories and in prescribing group membership related behaviour. They chart the contours of social groups and tell us not only what characterises a group but also how that group is different from other groups.

Prototype development is a lifelong process. Both formal (such as training) and informal (everyday interaction and life experiences) processes influence the development of prototypes for a category or group. There might be some similar characteristics among mental health professionals and service users who come from a Pakistani background. For example, second generation Pakistanis can speak English, as do the professionals. There might be some service users of

Pakistani background who may share Western ideas on mental health. It seems that if there are more similarities in the prototype of mental health professionals and service users of Pakistani background, the professionals are more likely to deliver a satisfactory service to the users, provided the professionals are not ethnically discriminatory, and they have organisational support available to provide a satisfactory service to the users.

However, if the mental health professionals and the service users who come from a Pakistani background have differences in their prototype about how mental illnesses are perceived and responded to, then there might be issues with the quality of the service received. For example, a service user of Pakistani background may not associate with Western models of mental health and illnesses; however the professional working in an NHS organisation may be trained in the Western model. Here we see a difference in the prototype of the professional and the service user. This difference in prototype may result in the delivery of an unsatisfactory service. Also, if the professionals are holding prejudices based on beliefs of the ethnicity of the users, then it is likely that the service user would have a negative experience.

Therefore, the important question is how the professionals engage with the people of *difference:* what prototypical picture they have about service users who physically look different from them, and who may not share the same cultural and ethnic background; what kind of opportunities of formal and informal learning is offered to the professionals to develop prototypes about service users of a Pakistani background;

what systems and procedures are in place within the organisation to make sure that professionals do not hold ethnicity-based discrimination and prejudice?

Prototypes maximize *entitativity,* which is the property of a category that makes it a cohesive and clearly structured entity that is distinct from other entities (Hamilton and Sherman, 1996). They obey the *metacontrast principle* – which is the ratio of perceived intergroup differences to intragroup differences and thus highlight similarities within groups and differences between groups (Tajfel, 1959).

If we compare the Pakistani ethnic group with other minority ethnic groups such as Indian or Bangladeshi, there might be some similarities and some differences. The similarities may be in terms of physical features and some religious or cultural beliefs and practices. A member of the Pakistani ethnic group may have more physical similarities with an Indian, but totally different religious practices. On the other hand, a member of the Pakistani ethnic group may not have physical similarities with an Irish man, but may have larger similarities on religious practices. The metacontrast principle may also be applicable in an intra-group setting, where a member of a Pakistani ethnicity group may share the same national background with another member of Pakistani ethnicity, but may be different in terms of cultural and religious practices. In the UK context, and in this era of globalisation and supra-diversity, it seems challenging to apply the metacontrast principle and identify characteristics which are applicable to all members of an ethnic group.

Categorisation and depersonalisation

Social categorisation is the 'ordering of social environment in terms of groupings of persons in a manner which makes sense to the individual … and helps as a guide for action' (Tajfel, 1978,p:61). Social categorisation is important as it provides a cognitive base for social identity processes (Turner, 1987). It might be the case that professionals working in the NHS mental healthcare system order social environments for Pakistani people on the basis of their physical features or cultural practices known to them from training and informal learning.

The act of categorising an individual as a group member transforms how they are seen. Instead of seeing a person as an individual, we see that individual through the lens of the prototype, and attach prototypical attributes to them. In this way the individual is perceptually *depersonalised,* which means viewing someone as having the attributes of a category. This may result in attaching incorrect attributes to the individual, as an individual may not wholly associate with attributes of a particular group. The act of social categorisation from mental health professionals may result in approaching an individual service user of Pakistani background with a generalised approach, thus ignoring the individual and personalised approach. A generalised approach may not be helpful in meeting the needs of the service user in a mental healthcare context. It may also have psychological consequences for an individual, and as a result being wrongly perceived and treated. At the heart of mental healthcare is having a very personal and individualised focus (Freeth, 2007).

Also if the prototypical attributes are positive, depersonalisation results in favourable perceptions for the social category or group. However, if the prototypical attributes are negative, this may result in generating ill-feelings for that category. It is clear from the literature that within the UK context, Pakistanis suffer from identity stereotypes. Some of the stereotypes about Pakistanis may be positive, but more often they are negative. Pakistanis are called 'Paki', perceived as religious extremists and/or terrorists, not behaving well with their females, and so on.

Psychological salience

To affect behaviour, a social categorisation needs to be a psychologically salient base for perception and self-conception. Social identity salience is based on two concepts, i.e. *accessibility* and *fit (Oakes, 1987)*. Individuals frequently use accessible and valued social categories such as gender, race and profession to make sense of self and social context. These categories are chronically as well as situationally accessible. It seems the case that professionals working in the NHS mental healthcare context are frequently using accessible and valued social categories such as ethnicity, gender and physical features to make sense of the social self and social context of the Pakistani service user. However, like other individuals, Pakistani service users also have many non-ethnic identities derived from their education, occupation, leisure, consumption and neighbourhood factors (Modood *et al*., 1997).

The sense of self and social context is made through understanding how well the categorisation accounts for similarities and differences among people (structural or

comparative fit) and how well the stereotypical properties of the categorisation account for why people behave as they do (normative fit). If the fit of the categorisation is poor (for example, where similarities and differences do not correspond to people's gender or race and people do not behave in gender- or race-stereotypical ways), people trawl through other accessible categorisations (political orientation, religion, profession etc.) until an optimal level of fit is obtained. This process is not automatic. People are motivated to make a categorisation that favours the in-group fit and may go to some lengths to do this. Salience is not only a cognitive-perceptual process but is also a social process in which people may compete or 'negotiate' over category salience.

The categorisation that optimally fits becomes psychologically salient in that context as the basis of self-categorisation, group identification, and prototype-based depersonalisation. This may be especially true for Pakistanis in the UK as they are negatively stereotyped. It signifies similarities in the in-group and differences among inter-groups. It also increases perceived entitativity, and strengthens context-relevant group and intergroup behaviours.

3.4.2.4 Social identity motivations

Social identity is motivated by self enhancement, uncertainty reduction and optimal distinctiveness.

Self-enhancement and positive distinctiveness

Self-enhancement or positive distinctiveness is an important distinguishing characteristic of group life and intergroup relations. This leads to ethnocentrism and the belief that 'we'

are better than 'them' in every possible way. For the mental healthcare professionals who are trained in the Western medical model, they might perceive that their model of mental illnesses is better than the Eastern or Pakistani model of mental illnesses. This ethnocentrism of mental health professionals towards the Western mental health model and cultural practices would result in not appreciating and integrating Eastern or Pakistani models of mental illnesses and treatment methods.

Uncertainty reduction

The second motive for social identity is uncertainty reduction. This motive is cognitive and has a direct association with social categorisation. Individuals try to minimise feelings of uncertainty about themselves and the social world around them. They strive to understand themselves and others. Social categorisation provides group prototypes to individuals about their behaviour. These prototypes are, to a large extent, consensual among the group members.

This behaviour becomes complicated in mental health contexts where service users may have spiritual explanations of the illness, and yet the professionals may have bio-medical explanations. This complication is more basic even before we consider the psycho-social, economic and discrimination related factors.

Optimal distinctiveness

This is the third motive that may be involved in social identity processes. Here individuals aim to achieve the optimum level

of inclusion and distinctiveness within and between social groups and situations.

3.4.2.5 Norms, conformity and influence

Group norms suggest perceptions, attitudes and behaviour. If an individual identifies with a group, then he/she is more likely to act in the normative framework suggested by the group than if he/she does not identify with the group (Terry and Hogg, 1996). For example, if a member of Pakistani background associates himself/herself more with the Pakistani ethnic group, he/she is more likely to act in the normative framework suggested by the Pakistani ethnic group. He/she may have the same explanations of mental illnesses as other members of the Pakistani ethnic group. However, if a member of a Pakistani background associates with White English ethnicity, then he/she may have a different normative framework, hence a Western model of mental illnesses.

From a social identity perspective, group prototypes describe and prescribe identity-defining behaviour (Turner, 1991). The self-categorisation in a social group results in conformity to in-group norms, called normative behaviour, as it assimilates self to the in-group prototype (Abrams and Hogg, 1990). Therefore, conformity to the group prototype or norms is not superficial; rather it has greater depth where people's behaviour is changed to match with the appropriate self-defining group prototype if this is true. Members of a Pakistani background, therefore, may not be conforming to the group norms related to mental illnesses on the superficial level, rather they would have a deep association with the group prototype.

Social identity is also a base for *social influence,* which means that individuals can influence others if they embody the social identity of those being influenced. For Pakistanis in the UK, the big influences could be members from their own group, who may have gone through mental health problems. Among Pakistanis, it is found that their ethnicity as a source of identity is closely linked with their religion; consequently, their day-to-day social practices are influenced by their ethnic as well as religious identity (Jacobson, 2006). Therefore, members of the Pakistani ethnicity group may also be influenced by the Islamic discourse on mental health issues.

In summary, it seems appropriate to conclude that social identity theory can be helpful in understanding how people of Pakistani origin living in the UK construct their social identities, and how this social identity is practised, demonstrated or responded to in the mental health context.

Concluding the discussion around theoretical frameworks for this study, it is appropriate to delineate that, in the discussion section, this study considers the ways in which the NHS mental healthcare organisations can bring cultural changes through an organisational development approach to match with the social identity features of the service users who identify themselves (or are identified by others) with minority groups such as Pakistanis.

3.5 Identification of research gap

On the basis of the policy and the research review, it is noted that there are many issues on ethnicity and mental health

which need better scientific understanding. However, a common issue identified is to understand and critically examine how mental health services in the UK are trying to develop themselves to bring about cultural changes to provide good quality services for ethnic minority communities. This is the focus of the present study with a focus on the Pakistani ethnic group in particular. It will also include organisational responses to the policy expectations regarding ethnicity-related inequality in the access, treatment, experiences and outcome of mental health services.

Therefore, this research addressed the following main question.

3.6 Research question

How is an NHS mental health service organisation responding to the mental health needs of the Pakistani ethnic group within the context of policy requirements to provide culturally appropriate and equitable mental health services to black and minority ethnic groups?

3.7 Aim of the study

The aim of this study is to explore how racial equality policy is being implemented in one secondary mental healthcare organisation, and to assess the adequacy of this implementation from the perspective of the Pakistani ethnic group living in the local catchment area.

3.8 Objectives of the study:

i) To understand how racial equality policy is understood in a mental health setting;
ii) To explore vision, strategy and challenges for bringing organisational change in relation to racial equality policy in a mental health setting for the Pakistani ethnic group;
iii) To examine the organisational change interventions being undertaken by the studied organisation to bring cultural changes in the relations to the expectations of racial equality policy;
iv) To explore how members of the Pakistani ethnic group living in the UK perceive, explain and respond to mental illnesses in the context of their ethnicity-related social identity;
v) To consider the relationship between this community's needs in terms of mental health services, and the organisational response to them;
vi) To make recommendation for practitioners, managers and policy-makers regarding better implementation of racial equality policy in secondary mental healthcare setting;
vii) To identify areas for future research.

3.9 Rationale for the study

Recent mental health policy once again documented that mental health services do not meet the needs of BME communities (Jung and Yoon, 2013). Dreachslin *et al*. (2004) reviewed research on racial and ethnic diversity and organisational behaviour and found a lack of research in this area. Mannion *et al.* (2005) observed that the evidence-base

linking organisational culture and specific aspects of performance in the NHS is under-researched. Little research has been done to understand the adoption and implementation of racial equality policy in mental healthcare settings of the NHS from an organisational development and social identity perspective.

Furthermore, the UK Medical Research Council (2010) in its *Review of Mental Health Research* also identified the need to research the ways to improve services for people of black and minority ethnic groups.

This research will add to the knowledge-base around how a mental healthcare organisation is responding to the policy expectations to develop and bring cultural changes for the provision of good quality mental health services to people who associate themselves with BME groups. It focuses on how the racial equality policy is interpreted by the organisation and its members at different levels, what challenges the organisation and its members are experiencing to respond to the policy expectations, and what are the barriers and facilitators for the organisation to achieve its goals on race.

3.10 Implications for mental healthcare

There is a lack of empirical research that explores the organisational perspective on implementation of racial equality policy to deliver multicultural and equitable mental health services for BME communities in NHS secondary mental healthcare context. Gaining a detailed understanding of the organisational perspective on the implementation of racial

equality policy in the secondary mental healthcare setting has important implications for working towards improving mental health services for BME users and reducing inequalities in mental health.

CHAPTER FOUR: PHILOSOPHICAL ASSUMPTIONS, METHODOLOGY AND METHODS, INCLUDING ETHICAL CONSIDERATIONS

4.0 Introduction

This chapter presents the philosophical assumptions underpinning the research, research methodology, methods for data collection and analysis and ethical considerations. This research adopted two methodologies. Firstly, a qualitative organisational case study was undertaken to gain a perspective of organisational members on the issue of racial equality in the provision of secondary mental health services. Secondly, through a narrative methodology, the views of people who identify themselves as of Pakistani ethnicity was explored regarding their concept of mental health and illness, and their views and experiences of mental health service provision.

The first section presents the philosophical assumptions of this research and the following section explores the rationale for case study methodology and its strengths and weaknesses. The final section is focused on narrative methodology.

4.1 Philosophical assumption of this research

In order to highlight the philosophical assumptions of my research, it is necessary to identify the ontological and

epistemological position and the methodological standpoint from which the research has been conducted.

4.1.1 Ontological position

Ontology is concerned with the existence and nature of things in the world (Benton and Craib, 2011). In social science philosophy, ontology makes assumptions about the existence of things and their conditions of existence in a specific discipline (Marshall, 1998). It concentrates on the question of what kind of things can and do exist, and what is reality? It addresses questions such as 'what kind of being is the human being? What is the nature of reality?' (Denzin and Lincoln, 2013: 26). Ontological questions also include whether social reality is external to social actors and if it already exists or whether reality is something which people are continuously constructing (Bryman, 2008). The ontological question also revolves around a discussion of whether or not there is a single objective reality.

The ontological questions can be approached in two ways. The first way is derived from objectivism. Objectivism suggests that there is single social reality, and it exists 'out there' independent of the actors involved (Hartas, 2010). The objectivist approach to ontology seeks 'objective' truth in its research endeavours.

The second way to approach the question of the existence of social reality is through a subjectivist approach. Within the methodological literature, subjectivist approaches are associated with social constructionism (Bryman, 2012), which

means that the terms subjectivism and constructionism are sometimes used interchangeably.

A constructionist ontological position considers social phenomena as perpetually constructed and reconstructed by social actors involved through their continuous processes of social interaction (Bryman, 2008). Social constructionism views that social properties and meaning are constructed through interaction and the interpretation of people, rather than having a separate existence (Robson, 2011). This suggests that social reality is constructed through the experiences and perceptions of the actors involved (Collis and Hussey, 2013). The social constructionist approach emphasises the world of experience as it is lived, felt and undergone by people acting in social situations (Schwandt, 2007). A constructionist approach to ontology uses inductive reasoning and a qualitative type of research, which is different from the objectivist ontological position which uses deductive reasoning and undertakes quantitative types of research.

A constructionist ontology challenges the objectivist ontology which considers social categories such as organisation, culture and ethnicity as fixed, pre-given and independent of the actor's role (Bryman, 2008). Therefore, this research considers the fluid and flexible nature of culture within an NHS organisation, and the ethnicity related social identity of BME background service users. Concepts of organisational culture and ethnicity are considered amenable to change through the actions of social actors. This research sees the possibility of altering organisational culture through various organisational

development interventions (Camargo-Borges and Rasera, 2013).

'Organisation' is a social construct (Camargo-Borges and Rasera, 2013). Organisations are made up of people, and these people are part of society. Organisational practices geared to meet the expectations of racial equality in service provision are also social constructs. People learn these practices through formal and informal socialisation processes, both inside and outside the organisation. Thus, a subjectivist/constructionist ontology is most appropriate to achieve the aim of this study: exploring how the studied organisation is aiming to change itself to provide good quality services to the people of Pakistani ethnicity.

'Race/ethnicity' is also a social construct (Harris and Sim, 2002). People construct a 'racial/ethnic' identity through their social interactions in society. These constructs have different meanings for different people, and are used differently in different geographical and social contexts. This suggests that notion of 'race/ethnicity' is a contentious, and treating 'race/ethnicity' as a single objective construct is not appropriate.

Thus this research is conducted through a constructionist or a relativist approach to ontology which considers that there are multiple realities just as there are many researchers and participants (Denzin and Lincoln, 2013). So, if I consider that the nature of reality is that it does not pre-exist, rather it is constructed in the interaction of the participants. Then the

next question is how we know this or construct knowledge, which is also called epistemology.

4.1.2 Epistemology

Epistemology asks questions about the nature of knowledge (Guba and Lincoln, 1994) and the relationship between the researcher and the phenomenon being researched (Denzin and Lincoln, 2013) and whether a natural science research model is appropriate to study the social world around us (Bryman, 2008). It asks the question of how do we know what we know and what should be considered as acceptable knowledge in a discipline as well as should the natural science model be used to study a social phenomenon? (Briggs *et al*., 2012). It also asks the question of whether or not social science can be objective and value free (Dickson-Swift *et al*., 2008).

There are two main positions in epistemology: positivism and interpretivism. Positivists argue that the external and independent existence of the social world must be constantly taken into account. Proponents of positivism claim that properties of social reality can be observed directly (Gray, 2013). However, philosophers such as Habermas (1990) question the idea of objectivist research and truth. Therefore, the inter-subjectivity of the people is considered important, and it is said that the researcher and the participant co-construct reality (Denzin and Lincoln, 2013).

Interpretivists concentrate on the subjective meanings attributed by people to the social phenomenon. Here the role of the researcher is to understand the multiple social

constructions of meaning and knowledge (Robson, 2011). Intellectual heritage of interpretivism includes Weber's notion of Verstehen, the hermeneutic-phenomenology and symbolic interactionism (Bryman, 2008).

Interpretivists argue that knowledge needs both the researcher and the research participant to engage rather than detached from each other (Dickson-Swift *et al.*, 2008). However, objectivist researchers believe that reality can be captured accurately without being influenced by the researcher and social characteristics such as race, gender, culture (Grbich, 2012). A detached and objective stand of the researcher is rejected by Giddens (1993) who argues that researchers always have an influence on what they are studying. Hence, it is suggested that in order to understand the experiences and realities of another person, the researchers need to acknowledge their own subjectivities (for example, values, beliefs and emotions) and how they may influence the research process (Giddens, 1993).

It is noted that all research is interpretive as it is guided by a set of beliefs and feelings about the world and how it should be understood and studied (Denzin and Lincoln, 2011). Additionally, interpretive epistemology argues that the subject matter of social sciences (people and social institutions) is different from natural sciences; hence natural science methods are not useful to study social sciences (Bryman, 2012).

Research situated in an interpretivism perspective focuses on an exploration of the way people interpret and make sense of

their experiences in the worlds in which they live, and how the contexts of events and situations and placement of these within the wider social environment have impacted on social understanding (Grbich, 2012). Interpretivism views reality as culturally derived and historically situated interpretations of the participants and the researcher (Crotty, 1998).

As this research seeks to explore the experiences of service providers and service users in relation to racial equality expectations in the service provision in the UK context, an interpretivist epistemology was most appropriate. This approach is helpful in providing understanding and interpreting the social roles of people in their everyday situations. These experiences and views may not be understood in a mechanical view of reality as promoted by positivist epistemology. The interpretivist epistemology also assists in understanding the participants' own perceptions of their practices as these cannot be fully understood when separated from their social context as suggested in the positivist paradigm. Therefore, it is fitting that this study adopts interpretivism.

A constructivist stance was adopted in undertaking this research. Through this stance, this research attempted to capture a range of relevant perspectives that would address the identified knowledge gap on the issue of race in the provision of mental health services in NHS context. This necessitated the use of qualitative methodology as these methodologies are particularly suited to the exploratory and constructive nature of research (Dickson-Swift *et al*., 2008). It is argued that social constructionism fits well with

organisational development (Camargo-Borges and Rasera, 2013). Identifying the relationship between social constructionism and organisational development, Camargo-Borges and Rasera (2013) noted that social constructionism encourages dialogue among different stakeholders in the organisations, which can result in co-creation, and implementation of intervention for organisational development. This participatory and democratic approach to organisational development can also help reduce resistance for bringing desired organisational changes in complex organisations like the NHS.

4.2 Study design

In parallel with ontological and epistemological standpoints of this research, a qualitative approach has been adopted whilst undertaking this study.

Identifying the characteristics of qualitative research, Denzin and Lincoln (2013) summarised that qualitative research is firstly interested in the qualities of entities and on the processes and meanings that are not experimentally examined or measured in terms of quantity, amount, intensity or frequency.

Secondly, qualitative researchers stress the socially constructed nature of reality, the intimate relationship between the researcher and what is studied, and the situational constraints that shape inquiry. Qualitative researchers acknowledge the value-laden nature of social inquiry. They seek answers to questions that stress how social

experience is created and given meaning. This is in contrast to the quantitative approach which emphasises the measurement and analysis of causal relationships between variables instead of focusing on the process.

Denzin and Lincoln (2011) identified five main differing points among quantitative and qualitative research. These points are summarised:

Firstly, qualitative researchers might use numbers or statistics but they seldom report their findings in terms of complex statistical measures or methods that quantitative researchers use. Qualitative researchers also do not use the traditional quantitative criteria of judging internal and external validity of the research.

Secondly, qualitative researchers accept a postmodern view of reality, which considers that there are multiple realities. Qualitative researchers view quantitative methods as *one* way of knowing the reality of the social world.

Thirdly, qualitative researchers believe that they can get closer to the actor's perspective by using techniques such as detailed interviewing and observation. Quantitative researchers do not have flexibility to ascertain a subjective perspective of each single respondent because they depend on inferential empirical methods and materials.

Fourthly, because of their interest in the everyday life of the people and considering the constitutive nature of social reality,

qualitative researchers are more likely to focus on everyday practices of individuals in society. Qualitative researchers study small samples, and they are interested in the particularity of specific cases. However, quantitative researchers study large samples derived through random sampling. Because of the large sample size, quantitative researchers may not be able to study a phenomenon in depth.

Fifthly, qualitative researchers value rich descriptions of the social world in the form of quotations from the data. However, quantitative researchers, with their generalised focus, are less concerned with such detail.

Qualitative research has the flexibility to collect empirical data through a variety of methods such as case studies, personal experiences, introspection, life stories, interviews, artifacts and cultural texts and productions, along with observational, historical, interactional and visual texts. Qualitative researchers also have the flexibility of using a wide range of interpretive methods for analysing data. Qualitative research does not belong to any particular discipline, and it is used in variety of disciplines (Denzin and Lincoln, 2011).

Keeping in view the above characteristics of qualitative research, it seems appropriate to use a qualitative design to explore the perspectives of the service providers and service users on the issue of race equality in the provision of secondary mental healthcare context. Seeing the phenomenon from the perspective of the people being studied is important, as the people being studied are the ones who are experiencing the social reality under investigation. In the context of this

research, these are the organisational members working in the secondary mental healthcare setting, who interpret and are expected to implement the racial equality policy in their everyday practice.

Similarly, the members of the Pakistani ethnic group living in the local area are the ones who experience mental health/illnesses in their everyday life, and how it is perceived and responded to in their ethnic group. Therefore, this study has examined the subjective experiences of the organisational members in relation to meeting the expectations of the racial equality policy in the service provision, as well as the experiences of the members of the Pakistani ethnic group relating to mental health/illness and mental health services in the context of their ethnicity-related social identity.

As the study adopted a qualitative approach, an exploratory and unstructured approach was used during the data collection and analysis. The sampling process used was also flexible. A flexible approach was also used during the interviewing process. This research did not impose any prior theoretical framework or concept, rather an inductive approach was used in the analysis and the discussion of data. In inductive analysis, the researcher identified patterns and themes emerging from the data instead of imposing any existing framework, and finding evidence to confirm or reject it (Quinn, 2002).

4.3 Research methodology

Methodology is the science of methods which are used to produce knowledge (Grix, 2002). It helps to justify the methods employed to address the research question. As mentioned above, this study has employed two methodologies. These include an organisational case study to explore how the organisation as a service provider is changing its culture to provide good quality and recovery- oriented mental health services to the members of the Pakistani ethnic group living in the local catchment area. The second methodology used is narrative to understand how the people of Pakistani ethnicity view and respond to mental illnesses, and how they construct their social identity in relation to mental illnesses and mental health services. The next section describes the case study methodology.

4.3.1 Methodology–I: Case study

A case study is an intensive study of a single case or a small set of cases (Gerring, 2007). A case study methodology embraces the complexity of the phenomenon because it accepts that there may be multiple factors involved in the occurrence of the phenomenon. This methodology allows for the phenomenon to be studied in real time and within naturally occurring events, using a variety of different data collection methods (Stake, 1995; Creswell, 2013; Yin, 2013). The product of a good case study is insight but it can also be used as an exploratory kind of evidence (Gerring, 2007). The findings originating from a single case or set of cases may be used to shed light on a larger group of cases (Gerring, 2007).

There are different types of case studies as presented by Stake (1995), Bassey (1999) and Yin (2013). The current research was neither seeking a theory building, nor was it a theory testing endeavour (Bassey, 1999); therefore, an exploratory case study was used because the aim was to understand how the studied NHS mental healthcare organisation was responding to the issues of racial/ethnic diversity in service provision. Using the Gerring (2007) case study research design typology, this study could be typified as a synchronic single-case study where the TRUST acted as the one case and the interviews conducted with the staff acted as the in-case investigations. This study was cross sectional; hence it did not have any significant longitudinal or diachronic aspect.

Case study methodology has been used widely in studying organisational characteristics and culture (Ogbonna and Harris, 1998). In a healthcare context, organisational case studies can provide understanding on the role of micro and macro level organisational factors within an organisation for quality improvement strategies (Baker, 2011). For example, Cooke (2006) has used organisational case studies to consider the management of problematic nurses in the NHS context. An instrumental case study methodology is used where there is a need for in-depth understanding of an issue and an interest in getting insight into the question by studying a particular case (Stake, 1995). In instrumental case study, the selected case is used as a mean to understand a particular issue, which in this case is 'response of an NHS Trust to race equality policy in the provision of mental health services'. It suggests that this research was not interested in the case (TRUST) itself. An

instrumental case study methodology is in tune with social constructionism as both aim to deepen our understanding of the phenomenon through their in-depth and collaborative approach between the researchers, and the participants (Gubrium and Holstein, 2008) Consequently, , an instrumental case study methodology was used to answer the research question and achieve its objectives in the present study.

A case study approach facilitates the collection of detailed information about a phenomenon in its natural setting and the researcher can develop a rich understanding of the issues under investigation (Ruddin, 2006). Additionally, a case study can provide a useful approach to explore questions of 'how' events and results can be understood and explain as well as 'what' happens (Roberge and van Dick, 2010). Therefore, this approach would help with a detailed and in-depth exploration of 'how' an organisation is responding to the 'race' in the service provision, and 'what' are the views and experiences of the organisational members on this issue. It is argued that a case study methodology provides scope for the exploration of multiple perspectives on the organisational attempts to develop, deliver and manage culturally appropriate and equitable mental health services, as expected in the racial equality policy, for the service users who associate themselves with Pakistani ethnicity.

Yin (2013) identifies case study as a particularly valuable approach as it takes into account the contextual conditions of a given phenomenon. A review of the literature suggests that there are certain complex issues in the implementation of racial equality policy within mental health services which may

compete and conflict, creating complex challenges for mental health professionals aspiring to deliver satisfactory services. Emphasis on the context is also important for this study. The context for this study is an adult mental health service delivered by a secondary mental healthcare NHS Trust in England. This organisation (hereby called by a pseudo name 'TRUST') as a whole, and the adult mental health services setting, would have their own organisational culture and ways of responding to the expectations of the racial equality policy for the service provision. This research has its own policy context, which is the racial equality policy as stated in the Equality Act 2010. The timing of this research is also important, because this research is conducted at the end of a 5-year, well-funded programme aiming to reduce mental health inequalities among BME communities in England. This programme is called 'Delivering race equality', and its timeframe was from 2005-2010. This research started in mid-2011. The issue of context is also relevant to studying the social identity of the Pakistani ethnic group in relation to mental health. There are different ethnic groups living in England, all of them having their own migration history and original cultural context.

One of the objectives of the research is to explore how the organisational culture influences the implementation of racial equality policy in the service provision. Organisational culture can be explored at many levels within an organisation and across different professional and occupational subgroups (Schein, 2004). The focus of the current research in terms of organisational level was on the 'whole-organisation' including strategic, middle and frontline levels of the selected NHS

organisation. Thus, it included strategic, managerial and frontline members. This gave an understanding of the organisational processes involved in the design and delivery of mental health services for the BME groups. The 'whole-organisation' was selected because quality of service is not determined by any single level, process, professional or occupational group; rather it is a combination of many factors (Mannion *et al*., 2005) and also the fact that such an approach would be helpful in understanding important cultural characteristics of the selected organisation (Hackman, 2003).

In terms of analysing culture, there are three major levels of cultural analysis, i.e. artefacts, espoused beliefs and values, and basic underlying assumptions (Schein, 2004). At the surface is the level of artefacts which are visible organisational structures and processes and include: the architecture of the physical environment; language; technology; products (mental health services in this case); its style as reflected through clothing; manners of address; emotional displays, and myths and stories about the organisation; its values; observable rituals and ceremonies. Espoused beliefs and values include strategies, goals and justifications, perceptions and actions. Basic underlying assumptions include the unconscious, taken for granted beliefs, perceptions, thoughts and feelings. According to Schein (2004) the basic underlying assumptions ultimately determine values and action in an organisation.

4.3.2 Limitations of case study research

Despite its many advantages as stated above, case study research also has limitations. Yin (2014) summarised the

various limitations of a case study research. These include: lack of generalisation; lack of explanation of why things happen the way they do; and the amount of time and resources needed to complete a single case study or a small number of cases.

The main criticism of case study research is that findings from an individual case or a small set of cases are not generalisable to other cases; hence case study research is not useful for developing scientific knowledge. This kind of criticism mainly comes from researchers who hold a positivistic view of science and ignore the diversity and complexity inherent in a social science phenomenon (Donmoyer, 2000). It is argued here that human behaviour is context-dependent, and attempts to predict these behaviours in terms of universal laws so that theories may prove erroneous (Guba and Lincoln, 1994).

Furthermore, it is noted that the history of scientific advancement is replete with the instances where a single case proved helpful in the development of new understanding about a phenomenon (2011). This point is also supported by Gerring (2007) who noted that in-depth understanding of an individual case can help to interpret results across a larger set of the population. Therefore, knowledge obtained from the single case studied here can be used to shed light on the racial equality policy and its practices in the delivery of secondary mental health services. The comprehensive description provided through the illustrative quotes of the participants in the findings section of this thesis can also help with applicability of the findings in other similar contexts.

It is said that case study research lacks the comparative advantage over experimental designs in explaining why and how something happened. It is important to note that selection of a research methodology is done according to the aim of the research. The aim in this research was not to explain things in terms of why and how they happened; rather to focus on exploring the phenomenon.

Lastly, in case study research, it is depth rather than breadth which is desired. Therefore, although resources and time is spent on studying one case or small set of cases, it is worth doing as it provides deep understanding instead of in a survey such as a large sample, where the results may be superficial and generalised.

4.3.3 Choosing the organisation and gaining access

The critical factor in defining a case study research project is identifying an individual unit and specifying its boundaries (Flyvbjerg, 2013). This individual unit may be a 'functioning specific' or 'bounded system' (Stake, 2008). BME groups in the UK are not evenly distributed geographically. Therefore, an NHS mental health service provider organisation (TRUST) located in an area which is populated by a diverse ethnic population seemed an appropriate case to gain insightful into the issue. The TRUST is selected as a 'case'.

The Pakistani ethnic group is used as reference group against which the organisational implementation of racial equality policy is explored. This case study of a particular ethnic group serves to focus and limit the scope of the study, and is selected because of my own ethnic roots in this group.

However, it is of interest in itself, particularly because of the paucity of published research pertaining to this population group. This reference group will throw light on the organisational responses to the specific needs of any particular group and the experiences and met and unmet needs of people from a specified ethnic community.

4.3.4 Access to the participants and sample

Selection of the NHS organisational members was done through purposive sampling. Purposive sampling is a non-probability type of sampling, in which a sample of the participants is studied which enables the researcher to address specific needs of the project (Robson, 2011). Purposive sampling of key players in the development and delivery of services to people from BME groups is identified and selected for inclusion in the study; this is helpful in providing valuable insights and diverse perspectives on the issue under investigation (Creswell, 2007).

Through the ethical approval process, I was granted permission to access staff by the Research and Development department of the TRUST. Subsequently, at the beginning of November 2012 I contacted the Equality and Diversity Lead of the TRUST to be my organisational gate keeper and facilitator in the data collection process. However, the Lead indicated that he/she was unable to be the organisational gatekeeper, because of his/her position and lack of competent authority. The Lead suggested a senior person (i.e. the Operational Director of the local services division). I shared details of the study and asked the operational director to facilitate the data collection process within the TRUST. The operational director

agreed, and delegated the task to a member of his/her team (i.e. the Head of HR in the local services division).

I contacted the Head of HR of the local services, and arranged a meeting. In the meeting, I shared details about myself and the study and the process involved in the data collection. The HR Head shared the organogram of the TRUST. We both had a discussion on the organogram and the roles of the people at different levels of the organisation. From a strategic level, I purposively selected the CEO, the Operational Director, the Head of HR, the Equality and Diversity Lead of the TRUST, the Director of Nursing Quality and Patient Experiences and the Head of Learning and Development. From the middle level, I selected a General Manager of adult mental health services, as well as clinical directors and a modern matron in the adult mental health service for the interview.

From the frontline staff I selected a team leader who is also the chair of the equality and diversity committee within the adult mental health services. The HR Head wrote an e-mail regarding the study, attaching a participant information sheet, to all these organisational members, and urged them to cooperate with the me. These people responded positively and asked me to contact them to arrange the research interviews. Meanwhile I was also able to arrange an interview appointment with the Chief Executive (CEO) of the TRUST.

In the middle of December 2012, I met with the chair of the equality and diversity committee in the adult mental health services. The chair agreed to be interviewed and facilitate the data collection process at the adult mental health service

level. The chair wrote an e-mail to all the team members in the adult mental health services and shared the study details, along with a participant information sheet, and urged the team members to contact me directly with their details if they were interested in participating in the research. However, due to Christmas timing, I received very little response. I discussed the issue with the equality and diversity committee chair, and the chair agreed to write another e-mail at the beginning of January 2013. A few more staff from the frontline category working in the adult mental health service responded to the e-mail with their professional roles and interest to get involved in the research. Through this response I was able to select a variety of people from different professional roles, as is evident in the table below. I proposed February-to-June timing to these prospective participants, and we agreed dates for the interviews.

In January 2013, at the strategic level, I was able to interview the CEO, the Head of HR, the Equality and Diversity Lead, and the frontline Team Leader, who is also working as chair of the equality and diversity committee at the adult mental health services. These interviews helped me to direct my focus on data collection on particular issues. For example, from the frontline category, the Team Leader I interviewed shared that equality and diversity training being provided by the TRUST does not provide enough skills to the frontline staff on how to provide good quality service to service users of BME groups, including Pakistanis. Therefore, during my interview with the Head of Learning and Development of the TRUST, I asked about content and delivery methods of equality and diversity training, and the challenges his/her department is facing in

providing the needed skills to the frontline staff. Similarly, when I interviewed the CEO, and the Director of Nursing Quality and Patient Experience, they mentioned the role of the Recovery College, which is significantly different in ethos and purpose from other parts of the TRUST (being explicitly recovery focused and educational in approach), so I decided to interview the Manager of the Recovery College, and an instructor.

I selected one participant from the TRUST after interviewing the members of the Pakistani ethnic group. One of the participants from the Pakistani ethnic group stated that in the Pakistani community, drug related mental illnesses are on the rise in the younger generation. Therefore, I approached a manager of the drug related services in the TRUST who had an organisational perspective on that issue. In summary, overall I adopted a purposive sampling approach in this research. In total I interviewed 20 participants from the TRUST. See table 4.1.

Table 4.1: Research participants from TRUST

Organisation level	Professional role
Strategic level	Chief Executive Officer (SL-1) Operational Director (SL-2) Director, Nursing Quality & Patient Experience (SL-3) Head of HR (SL-4) Head of Learning & Development (SL-5) Equality & Diversity Lead (SL-6)
Middle Management	General Manager, Adult Mental Health Services (MM-1) Clinical Director, Adult Mental Health Services (MM-2) Deputy Clinical Director, Adult Mental Health Services (MM-3) Modern Matron (MM-4) Manager of Substance Misuse Services (MM-5) Manager of Recovery College (MM-6)
Frontline staff	Team Leader & Chair of Equality & Diversity, Adult Mental Health Services (FS-1) Occupational Therapist (FS-2) Assistant Occupational Therapist (FS-3) Consultant Psychiatrist (FS-4) Community Psychiatric Nurse (FS-5) Staff Nurse (FS-6) Lead Professional, Assistant Practitioner (FS-7) Instructor, Recovery College (FS-8)

4.3.5 Research method

Qualitative researchers work with empirical information or data which can be verified and is accessed through human senses, including hearing (LeCompte and Preissle, 2003). However, the choice of specific research method depends on the nature of the research question being studied (Silverman, 2010). In social research, qualitative methods have an advantage of giving flexibility in gaining a variety of

perspectives and studying the phenomenon deeply from the point of view of the research participants. Keeping in view the over-arching research aim and objectives, I decided to use individual semi-structured qualitative interviews to collect the data from the organisational members. This is in parallel to interpretivist research, where researchers use evidence-gathering techniques that are focused on the intentions and subjective meanings contained in social actions (Gerring, 2007).

4.3.5.1 Interview

Interviews are found to be helpful in studying social phenomenon as they provide accounts of mental maps people have about social phenomenon in their heads (Luker, 2008). However, interviewees' accounts of their social experiences are considered an indirect representation of their experiences (Silverman, 2006). There is also debate about whether the interviewer is a knowledge excavator or a knowledge co-producer.

The social constructionist approach considers qualitative interviews as social productions where interviewer and interviewees collaborate to produce data (Holstein and Gubrium, 1995). This conceptualisation of interview renders both the interviewee and interviewer as an active participant in the process. This is in contrast to a positivistic view of the questionnaire type interview, where interviewer and interviewees are relatively passive in the process of the conduct of the interview.

However, interviews are highly subjective and therefore researchers using interviews as research methods should be aware of the subjectivities involved in the interview process (Bell, 2006), and be cautioned against taking interview data at face value (Benney and Hughes, 1956). The participant may conceal or reveal specific data intentionally. Concealment may be to avoid any negative social sanctions, whereas revealing can occur to attain some positive social sanctions. Interview data is mainly obtained through talk or text, which usually lack a non-verbal aspect of human interaction. Additionally, an interviewee may not be able to correctly recall their past experiences. Therefore the validity of the interview as a technique for collecting data should be carefully evaluated.

Semi-structured interviews are widely used in social research because of their flexibility and freedom in sequencing, wording and the amount of time to be spent on each topic (Robson, 2011). Face-to-face individual semi-structured interviews were conducted with the organisational members to explore their understanding and perspectives of the implementation of racial equality policy in mental healthcare practice, identifying how the policy is perceived, interpreted and manifested in their behaviour. Interviews were conducted in a place which allowed for confidentiality and was convenient to the respondents located in or near to the study setting, such as an interview room on the ward or their office for the TRUST participants. Data collection from the TRUST started by interviewing the CEO, progressing to middle level management, and then progressing to the lower level of the organisational hierarchy. I started from the top level of the organization because I wanted to know the vision of the CEO

on ‘race’, and usually vision comes from the top of the organization. The interview guide is placed in Appendix-C. Interviews were transcribed fully prior to the final analysis. Prior to the commencement of fieldwork, the researcher read books on ‘being English’ to know the norms of meeting and holding a conversation with English people. Also the interview was piloted with a research supervisor and the Head of the School of Health Sciences.

4.3.5.2 Interview questions

After asking initial questions about their specific role in the TRUST and how long they have been employed in this role, I asked all interviewees the same open question: How does the issue of race influence your role on a day-to-day basis? While the participants responded to this broad question, I made notes for further questioning. So the interviews were largely steered by the responses of the participants.

However, for each level of the organisation, I had several specific questions to ask. For interviewees working at a strategic level, I was interested to know about their vision, philosophy and strategy for responding to the mental health needs of the BME community in general, and the Pakistani community in particular. I was also interested in knowing their expectations from the staff. I also asked them how they define ‘organisational culture’ and what kind of culture they are trying to promote in the TRUST.

For the interviewees at middle management level, I was interested in their expectations from the frontline staff in relation to meeting the needs of people from BME

backgrounds, and in how they endeavour to ensure that these expectations are being met. I was also interested in challenges they face at the middle management level in meeting the expectations of the racial equality policy in the service provision.

At the frontline, I was specifically interested to know what staff do in a practical way to meet the needs of BME service users. What helps them? What hinders them? What are their values and practices in relation to the ethnicity of their clients? I also asked them to share their perception of the culture of the TRUST as a whole. In addition to these specific questions, I asked all participants about their understanding and interpretation of race equality policy, and their suggestions for better implementation of the policy in service provision. The duration of the interviews ranged from 40 minutes to 70 minutes.

4.3.5.3 Methodology for data analysis

The analysis of qualitative data poses both theoretical and practical considerations (Ziebland and McPherson, 2006). Theoretical considerations in the analysis include deciding on an interpretation level of the analysis, i.e. whether it would be purely descriptive or aimed to develop a social theory. Practical considerations include decisions related to transcription and coding. These include method and level of detail needed in transcription and decisions on using computer assisted programmes for storing, coding and analysing data.

Qualitative researchers are advised to interlink data collection and its analysis (Miles *et al*., 2013). This ongoing data

collection along with its analysis can be helpful in collecting better data and identifying missing links in the data. This practice is also known as preliminary data analysis.

Qualitative data analysis is wary of prescribing any single method in its analysis (Bryman, 2008). Rather, qualitative researchers have flexibility in choosing from a range of methods suggested in the literature. These methods include response patterning, cognitive mapping, content analysis, analytic induction, constant comparison, grounded theory, discourse analysis, and framework analysis (Holloway and Wheeler, 2013).

Usually qualitative data is in *word* form as opposed to numbers. These words can be spoken or in text format. If data is collected in the spoken word format, then these spoken words are transformed into typed words through transcription. These transcripts are read and re-read. Data is coded through a manual or computer assisted programme. These codes are collapsed into categories and themes. Findings are presented in the format of words and participants' quotes are added to illustrate the results.

However, all of the above summarised points are not straightforward and need further discussion. For example, in the case of transcription, there are considerations to be made on the part of the researcher about how data is transcribed, who transcribed it, and what level of detail is included in the transcription. Each of these points can influence the quality of analysis.

Codes are descriptive or analytical labels assigned to a chunk of data (Saldaña, 2012). These codes may represent conceptual and/or methodological issues relating to the study. Coding helps the researcher to manage a huge amount of data which the researcher has in the form of transcripts. These codes may be used to retrieve data, find patterns in the data and develop themes (Basit, 2003). Thus, coding itself is an act of analysis, as this process helps in categorising and summarising the data (Grbich, 2012).

At the initial stage a researcher might identify a large number of codes, which later may be collapsed into a smaller number. It is advised that qualitative researchers should not impose any pre-existing standardised codes; instead, they should be creative and construct novel codes to organise their big chunks of data into relatively smaller sections.

One of the ways to analyse and find patterns in the data set is to display data in matrix, called matrix display (Miles *et al.*, 2013). A matrix displays data in a visual format which helps in tabling or summarising the data along with their codes for analytical purposes. Matrix display also helps in organising and condensing a large amount of data that is easy to read or skimmed for drawing conclusions and other analytical purposes. Computer programmes can be used for matrix display, but Microsoft office programmes such as Word and Excel can easily fulfil this purpose (Miles *et al*., 2013). Analytical display can be developed during or after data collection. However, it is advised that the researcher should develop a rough format of analytical display during the data

collection format which can later be revised if needed (Miles *et al*., 2013).

Data display matrices are defined into rows and columns. Data is entered into each matrix in the form of a short summary; variables, codes, full quotes or even symbols are used for this purpose. The form of entering data depends on the aim of the researcher. Care is needed in entering data into matrix, because the quality of the conclusions drawn would depend on the quality of the data entered (Miles *et al*., 2013).

The usefulness of any data display is its ability to help the researcher understand and draw conclusions related to his/her research. Specific tactics which are found helpful in drawing conclusions include: noting patterns; identifying themes; comparing and contrasting; and clustering and counting (Miles *et al*., 2013). Thus, after reading the data entered in the display, a researcher can draw conclusions in his/her mind about what he/she found in the data in relation to the research. These conclusions are then put into written format as analytical text. The researcher needs to be open and careful in drawing conclusions.

Finally, the researcher is encouraged to provide some sort of data display to the reader, so that the reader can make sense of how the data is analysed and the conclusion drawn (Miles *et al*., 2013). This also helps in enhancing the validity of the research.

The above discussion indicates that qualitative researchers go through a long and systematic process of analysing qualitative data. However, usually qualitative research is criticised for its lack of analytic transparency and quality in analysis (Bryman, 2008). One of the ways to demonstrate rigour in qualitative analysis is systematically and conscientiously searching for evidence that contradicts or modifies the emerging analysis (Murphy and Dingwall, 2003). These contradictory or negative cases are actively searched, evaluated and used to refine themes evolving from the data. This approach of searching for negative cases is inconsistent with the falsification principle in social science research (Seale, 1999).

My approach to staff data analysis

Case study research has the flexibility of using a variety of ways of analysing the collected data (Gerring, 2007). However, the important point is that the form of analysis used should fit with the aim and research questions of the study. The aim of this research is to understand practical issues and suggest ways of addressing them; in this instance, a framework analysis seemed appropriate (Srivastava and Thomson, 2009). Framework analysis is appropriate for applied and policy implementation related topics (Spencer *et al*., 2013), and its usage is increasing in healthcare research (Smith and Firth, 2011; Gale *et al*., 2013; Thórarinsdóttir and Kristjánsson, 2013).

A thematic framework approach was used for analysing data which displayed data as suggested in a matrix display. Framework analysis has five interrelated stages (Ritchie and Spencer, 1994). These stages include:

i) Familiarisation;
ii) Identifying a thematic framework;
iii) Applying a thematic framework to the whole data set (Indexing);
iv) Charting;
v) Mapping and interpretation.

In parallel to the above cited suggestion, I interwove the data collection and data analysis stages of this research. During the data collection, I was actively listening to the participants' responses and making my notes regarding further data collection as well as its analysis. After completing an interview, I would transcribe it before conducting another interview. I would actively listen, transcribe and make my notes regarding data collection and analysis. Usually, I made data analysis notes on each transcript by **bolding** the text and inserting comments in colour. This practice of interweaving data collection and analysis not only helped me in the tailoring of the interview guide and the wording and framing of the questions, but it also helped me to have a preliminary understanding of the data and the development of analytical strategy. This practice is known as preliminary stage of analysis, and its main aim is to highlight emerging issues in data collection as well as offering an understanding of the data (Grbich, 2012).

Firstly, I transcribed all the digitally recorded interviews verbatim with annotations to record my comments, thoughts, observations about the tone, mood, expression of the interview, impressions that I was gaining, questions that I wanted to follow up and ideas about meaning and interpretation of what was being said. I had my own desk

provided by the university, helping me to work in a quiet place without intrusion to privacy. No transcription computer software or kit (e.g. foot pedal) was used. Only one participant asked to share the transcript, and later agreed to use it as it was. The participant was happy to continue without changing the data in the interview.

Then I coded the transcript of each participant in an Excel spreadsheet. I summarised the data underneath relevant codes, along with the line number from the transcripts. I attempted to retain the wording of the participants during this summarising process. I adapted an inductive process of coding in this research. I did not deliberately fit data into pre-existing labels or codes. However, most of the codes are identified from the words of the participants, also called *in vivo* coding. New codes were added as I was reading more transcripts. Some initial codes were changed and combined with other codes.

I was open to adding new codes and/or collapsing two or three exiting codes into one. I also identified powerful quotes at this stage with their line numbers, to be used in presenting findings. As I collected all the data, and transcribed it myself, and then coded and read each transcript a few times, I became quite familiar with the data.

Based on this familiarisation, I inductively developed a thematic framework, and piloted it on three interview transcripts from each level of the organisation. Each case was presented in a row, while the themes were described in columns of an Excel spreadsheet. This piloting led to some

changes in categories, mainly collapsing several themes into a single entity.

Identification of the thematic framework was carried out drawing flexibly on *a priori* issues such as research questions and the objective of this study, as well as new issues raised by the participants themselves during the interviews (Pope *et al*., 2000). I printed out the research aim and questions of this study and pasted them on my desktop. This helped me remain focused during the data analysis stage.

Then I applied this thematic framework to all transcripts populating the matrix, inserting the interview number and the line number with relevant quotes in the matrix. My tendency was to be inclusive, categorising most of the interview data, so several iterations were required to arrive at a reasonable summary of what was representative of all the interviews. I charted the data into relevant themes and sub-themes. In the final stage, I read the charted data and interpreted it, with demonstration of representative quotes. This was a lengthy process.

At the conceptual level, data analysis benefitted from organisational development and social identity literature. In order to demonstrate rigour, I carefully looked at and examined the contradictory data and used my findings in the analysis.

4.3.5.4 Ethical considerations

Ethics are a set of moral principles that aim to prevent researchers harming their participants (Dickson-Swift *et al*., 2008). Research ethics are a socially constituted and situated phenomenon. This suggests that ethics are relative and can differ across cultures and research environments.

Because of the close relationship of the researcher and the participants, ethical practice in qualitative research is a complex phenomenon. This challenge is added to when studying sensitive topics. Because of its political nature, race is a sensitive topic and undertaking research on sensitive topics raises a number of particular methodological and ethical issues for the researchers *(*Dickson-Swift *et al*., 2008*).* These particular issues cannot be addressed through a simple checklist of ethical standards.

While reviewing the literature and designing the study, and also living in the UK, made me aware that studying race is a sensitive topic in the UK context. Specifically, there are many ethical implications when interviewing staff in public sector organisations like the NHS on a sensitive topic such as race. Therefore, the nature of this research needed thorough consideration of all threats related to ethical issues.

Lee (1993) identified three kinds of threat involved in studying sensitive topics. These threats are summarised as:

i) *Intrusive threat*: This kind of threat encompasses areas that are considered private, stressful, sacred and

emotionally charged. Examples of areas where such threats exist include: sexual or religious practices, and mental illnesses.

ii) *Threat of sanction*: This kind of threat may occur in research studies where there is deviant behaviour, which research may reveal. As a result, participants may be stigmatised or receive a legal penalty. These threats of sanctions can be both formal and informal. Formal threats include disciplinary action or legal proceedings applied by a formal structure on somebody or an organisation. Informal sanctions might include peer pressure, ostracism by colleagues and so on.

The threat of sanction is highly relevant to my research, especially when dealing with data from staff on race issues. Talking to the participants, especially from the frontline, on race issues may increase their vulnerability to actions from the top. I may come across poor practices regarding race, which may result in applying formal sanctions by the regulator in the organisation being studied. Also, while giving interviews, the staff may express their opinions, which may be interpreted as racist.

iii) *Political threat:* These kinds of threats refer to situations where the vested interests of someone powerful in society are challenged, and this can result in conflict among social groups. The issue of racism is political in nature, where White dominance is sometime criticised and challenged by Black and other immigrant groups.

Murphy and Dingwall (2003) identified four guiding principles that a researcher should ensure in addressing ethical concerns involved in social science research. These principles include: non-maleficence (that the research participants are not harmed); beneficence (the research is conducted to provide beneficial results); autonomy (the participants' decisions are respected); and justice (human beings are treated equally and fairly).

Informed consent is one of the important ways of addressing the ethical issues raised above. Dickson-Smith *et al.,*(2008) cited a useful criterion for assessing informed consent, which consists of four elements:

i) Disclosure: The participant should be given a full explanation of the nature of the research and a forewarning of any sensitive topics to be discussed;
ii) Understanding: Participants must fully understand what they are consenting to;
iii) Voluntariness: Participation must be totally voluntary and potential participants are to be fully aware of this;
iv) Competence: Competence for consent may need to be discussed with a third party (e.g. parents or legal guardian).

Based on the above discussion, I acknowledge the ethical challenge of exploring an issue (equality and diversity practices) in which the TRUST takes great pride. From the start I had to acknowledge that the overall findings may present a less glowing picture of the TRUST. Indeed, it was always possible that this research may reveal poor practice in

relation to responding to the mental health needs of people from a BME background. The TRUST management may react negatively to this, and may not allow me to share negative findings publically through journal publication or conference sharing.

These potential issues were discussed with the organisational gatekeeper at the time of negotiating access. It was highlighted that there is a potential for me (Basharat) to hear about poor or racist practice, and as a result I asked the organisational gatekeeper for advice on how the TRUST would like me to respond to this. There was a dilemma: if I assured people that their accounts would remain confidential, then they are more likely to be honest, but this would prevent direct action in response to their allegations. If I said that I would report back but anonymise the source, then at least some action could be taken. I therefore asked the organisational gatekeeper to give clarity about this issue of the potential for exposing bad practice as an organisational risk.

The organisational gatekeeper raised three concerns:

Firstly, what the status of the final report would be and who would be able to access it - because if there were negative conclusions and this is published data then it could also have reputational issues for the TRUST.

Secondly, the organisational gatekeeper asked that if poor practice is reported how would these reports be balanced. The organisational gatekeeper cited previous examples, where there were such issues reported to them by the staff; however when they looked into the all circumstances the situation was not in reality as it was originally presented to them.

Thirdly, the organisational gatekeeper also asked about what perspective this was being researched from – was it patient experience or staff?

The organisational gatekeeper was told that the research was exploring the views and experiences of staff (managers and practitioners) and service users to investigate the implementation of policies relating to race and equality. It was not looking for poor practice but would consider ethical issues. It occurred to us that we needed to be clear that the research would preserve the anonymity of the people interviewed so that they could speak honestly. If they expressed concerns or showed examples of poor practice, these would be reported in a balanced and responsible manner. Also the research was more interested in positive examples and evidence of awareness of cultural needs in order that that the report can make recommendations for good practice.

It was shared that the final report will be the doctoral thesis – which will only be published if successful, and only accessible through academic library loans. By definition as a PhD it will be rigorous, good quality research.

The organisational gatekeeper was asked for any suggestions to reduce reputational risk or to ensure that accounts are valid. I wanted to both reduce the reputational risk to the organisation whilst retaining the potential for individual action.

The organisational gatekeeper found these suggestions sound and confirmed that the issue was being approached sensibly. The gatekeeper also suggested that the TRUST could be given anonymity in any public papers.

It was clarified to the gatekeeper that I would anonymise the TRUST in papers. It was also told that the research proposal would have ethical approval from the University of Nottingham Medical School's Research Ethics Committee (REC), and also approval from the R&D department of the TRUST. It is pertinent to mention here that ethical clearance from the University of Nottingham Medical School's ethics committee is required for all PhD research projects being undertaken in the School of Health Sciences. All PhD students including those who conduct their projects abroad are required to get ethical clearance from the medical school's ethics committee. Therefore, my reference to the committee here does not explicitly identify to the TRUST where I undertook this research.

My collaborative approach and clear communication with the TRUST played a helpful role in obtaining access to the participants (Moll, 2012). The whole process of getting clarity on ethics took around three weeks.

In April 2012, I submitted an ethical clearance application to the University of Nottingham Medical School's Ethics Committee, along with study documents (Study Protocol, Participant Information Sheet, and Consent Form). The committee in its meeting raised a few issues about the use of complicated terms in the interview schedule, how the participant information sheet would be disseminated, and the anonymity of the participants. These issues were addressed and subsequently approval was granted by the committee in July 2012. The Integrated Research Application System (IRAS) forms were completed during this time. The approval of the TRUST's R&D department was also acquired.

The ethical and security guidance provided by the University Research Ethics Committee (REC) was adhered to. Throughout the fieldwork phase, all arrangements detailed by the REC were upheld. For example, the digital voice recorder remained in the locked drawer at the university's School of Health Sciences, and all recordings were deleted before removal of the device from the establishment post-fieldwork.

Prior to the interviews, the Participant Information Sheet was reviewed verbally with the participant. The Information Sheet is attached in **Appendix-A**. The information sheet provided comprehensive information about the researcher, research aim, research supervision and ethical approval of the study. The participants were also encouraged to seek any further clarification from the researcher and the supervisors if necessary. This enabled the participants to give informed and written consent to participate in the study. The consent form is attached in **Appendix-B.**

The Consent Form was then signed by both interviewer and interviewee. All points on the Consent Form were discussed and understanding was acknowledged by the interviewee. The nature of the work was outlined by the interviewer, and then the participant was given the opportunity to ask questions concerning the project prior to commencement of the interview.

The study mainly involved interviewing TRUST staff and its members. Explicitly, this seems to have little potential for physical or psychosocial harm to the study participants, but implicitly the participants may have social or psychological harm because of the sensitive nature of the topic. Therefore, the participants were given a voluntary right to decide whether they wanted to participate in the study or not. This right was clearly noted on the participant's information sheet**.**

The participants were given the right to withdraw from the study at any time without stating any reason. The withdrawal from the study would not have any negative implications to their professional role and legal rights. Prior permission was sought from each participant to record the interview digitally. All the participants were happy to be digitally recorded. Privacy and anonymity of the participants and the data collected was ensured. Fictitious names of the participants were used to analyse and present study findings. The data collected was secured in password protected computers and locked cabinets provided by the School to PhD students.

Although my main aim was to interview staff on race issues for my PhD, many participants from the middle and frontline

categories expected me to give them advice on the cultural needs of the Pakistani community. I clarified with these participants that my role was to undertake research for my doctorate, and also I did not feel myself to be an expert on giving sessions on the cultural needs of Pakistanis in a mental health context. Participants from the strategic level category asked me to share the findings of my research with them. I would happily share my findings once this research project is approved as a PhD.

During the research interviews some of the participants from middle management and the frontline expressed their frustration, anger and hopelessness at their inability to address the racial inequality in the service provision. Although, it might be considered bit unethical to induce anger and frustration, at the same time I considered that this research project has given the opportunity to middle managers and frontline staff to give voice to their concerns.

Some participants from the middle management and frontline staff categories, after taking part in the interviews, realised that they were not performing their duties on the expectations of race as they should be. So, in a way this research has provided an opportunity for the participants to reflect on their own performance in relation to their role on race issues.

After completion of the study, all research data are secured as per the School of Health Sciences data archiving policy.

4.3.5.5 Researcher being insider /outsider

In qualitative research, especially in ethnography, the status of a researcher being an insider or outsider of the group being studied is important. In interview type research like this one, this did not seem much of an issue. I am not a TRUST employee, and do not have inside knowledge of the TRUST. However, my status being from a minority ethnic group member might have influenced the data collection from a White majority staff. In this case I might be considered as being from the minority ethnic group; hence participants might have shared socially desired data. However, the kind of issues raised by the participants at each level, especially frontline staff, indicates that participants were open and frank in sharing the data.

4.3.5.6 Reflexivity

Qualitative research being based on subjective epistemology entails researchers to be aware of their own role in the knowledge claims they are making (Dickson-Swift *et al.*, 2008). This requires qualitative researchers to be reflexive during the research process, and recognise the impact of any personal bias (Tong *et al*., 2007). Reflexivity is central to constructivist research. It requires the researcher to document the research process and locate themselves in that process because they are part of knowledge production. The researcher being reflexive means that he/she should have a conversation with him/herself while experiencing the experience. Reflection serves to identify any areas of potential bias of the researcher (Robson, 2002).

I recorded reflexive thoughts in my research journal, also known as a research diary. The research journal or diary serves multiple purposes (Hart and Bond, 1995). It provided me with a chronological record of the research process. It was a means for me to assess my own performance in relation to my annual research plan. The journal proved especially helpful during data collection and the analysis stage of the research. Thus the diary served to provide a practical and emotional account of my journey throughout the research.

4.3.2 Methodology–II: Narrative method

The benefits of using narrative methods to improve quality are noted in healthcare research (Greenhalgh *et al.*, 2005). As one of my research aims was to give recommendations for improving the quality of mental health services, knowing the perspectives and social identity of service users can help in providing a better quality service (Haslam *et al*., 2014). Therefore, I have used the narrative method to explore the views of people of a Pakistani ethnic origin in relation to their perceptions of mental illnesses and mental health services, and how they portray their social identities when they talk and reflect about mental illnesses in a UK context. In the next section, the theory underpinning narrative research, mental illness and social identity is introduced.

4.3.2.1 Narrative approach, mental illnesses and the construction of social identity

Self-identity and self-understanding is developed through narrative. We construct our identities through the stories we tell to ourselves and to others (Benwell and Stokoe, 2006). Narrative provides a means by which we can convey and

negotiate our sense of self with others (Linde and Linde, 1993). Narratives are helpful in understanding the relationship of agency and structure through personal experiences (Williams, 2008). Therefore, narrative is vital for the construction of identity (Ricoeur, 2010). The belief that a person could be known by examining his/her speech has a long history in the social sciences, including early ethnographic work of the Chicago School (Riessman, 2008). It is with this understanding of narrative and identity that I have used a narrative approach to explore how members of Pakistani ethnicity construct their social identities through narration of their views on mental illnesses and mental health services.

In a narrative approach, the construction of identities is a social, relational and continual process. It involves positioning the self through discursively creating self/other boundaries among individuals and groups (Ellis and Ybema, 2010). Furthermore, identity narratives are not single-authored, but are co-produced with other individuals on a continuous basis.

Narrative analysis focuses on the action and activities that are performed when people talk with one another (Silverman, 2010). In the context of the present research, there are two individuals, i.e. the interviewee and myself as interviewer. In addition to this, when participants share their narrative they give reference to their social surroundings. These may be their siblings, friends, neighbours and the social institution with whom they have interactions.

There are two perspectives on identity. One is an essentialist view of identity and other is the post-modern view of self. The essentialists view identity as a fixed entity (Nkomo and Cox, 1996). On the other hand, the post-modern perspective suggests that identity is in a continuous process of construction, being multiple and fluid rather than being a fixed set of characteristics or traits (Zanoni *et al*., 2010). Post-modern perspectives also view identity as relational and produced in the social interaction the person has in society.

If we take a post-modern view of identity, then quantitative methods of studying identity may not be helpful, because quantitative methods are structured and lack the flexibility required to study the fluid and multiple nature of identity. Quantitative methods ignore uniqueness and the reflexivity of the each individual participant (Elliott, 2005). This lends support to using qualitative research methods because they are un-structured, flexible, and focus on the everyday practices by which individuals constantly construct and re-construct their sense of identity.

Ontologically, this research has used a post-modern view of identity and qualitative methods to study the identities of people of Pakistani ethnicity. This is in contrast to much of the policy literature on ethnicity which considers ethnicity-related social identity from an essentialist point of view, which has stable and fixed entities. Specifically, this study adopts a narrative approach to identity. Such an approach challenges the traditional view of identities as fixed entities and understands social identities to be narratively constructed as individuals try to answer the question: 'Which social group do

I belong to or identify with?' This study also views identity as being grounded in the experiences of an individual in society.

Although most narrative research is ordered and sequenced in terms of time, and sequencing of the event that the narrator constructs in order to make sense or meaning and convey this meaning to an audience, this was not the case in this research because my interview data is not organised as a lifetime story; rather it is how members of the Pakistani ethnic group perceive and respond to mental illnesses and what their views are about the mental health services being delivered by the TRUST.

In a healthcare context, interest in social identity is growing (Haslam *et al*., 2009). Literature around social identity and healthcare contexts is focusing on the way people perceive and respond to illnesses. For example, research has shown that people's appraisal of physical symptoms is mediated by features of their salient social identity (St Claire *et al.*, 2008). Similarly, it is observed that how people respond to illnesses is also influenced by the social identification process (Adams *et al*., 1997). It is with this view that clinicians of many disciplines are being summoned to practice that recognises patients by receiving their accounts of self (Zarconi and Pethtel, 2008). Narrative medical practice serves many functions, including the transformation of caregivers to use broader ways of seeing and caring, better self-understanding for patients, and greater potential for healing. Therefore, it implies that understanding the social self of the patient is important; hence I collected data from members of the Pakistani ethnic group to understand how they construct their

social self in the context of mental illnesses and mental health services in England.

Narrative research has its roots in interpretive hermeneutics and phenomenology, and it attempts to locate knowledge about human beings and social phenomenon in societal, historical and a temporal context (Josselson, 2007). It also has a close association with postmodernism, and is always interpretive at every stage of a research project, i.e. from framing the conceptual questions through to choosing the participants, deciding what to ask them, with what phrasing, transcribing from spoken language to text, understanding the verbal locutions, making sense of the meanings thus encoded, and to deciding what to attend to and to highlight (Josselson, 2007:7-8).

4.3.2.2 Narrative interview method

This section examines the relevant literature relating to the interview process in the narrative approach. In most narrative projects, researchers conduct interviews (single or, ideally, multiple interviews with the same person) to learn about a process, such as identity construction (Riessman, 2008).

Research interviewing is considered to be a discursive act where interviewer and interviewee actively and collaboratively develop an understanding and the meaning of any event and/or social experience (Mishler, 1986). Here, the research interview is viewed as a narrative occasion and conversation rather than a question/answer mode of interviewing. The goal of a narrative interview is to generate a detailed account from

a participant, rather than receive brief answers or general statements (Riessman, 2008).

Narratives come in many forms and sizes ranging from brief, tightly-bound stories told in answer to a single question, to long narratives that build over the course of several interviews (Riessman, 2008). Most narratives are event–centred, which depict human action, but they are also experienced–centred, where participants reflect and narrate their experiences on any subject (Squire, 2008). Experience–centred narratives can involve interviewing a single person as well as several people on the same subject (Squire, 2008).

It is generally accepted that in narrative research, the more open the interview schedule, the better (Riessman, 2004). Hence, I used an open-ended interview method. After introduction to the research and signing of the consent form, with each participant I started the interview with a broad question, i.e. **"***My study is looking at the perceptions of mental health/illness of the Pakistani community in the UK as well as their perceptions and experiences of mental health services; I wonder if you could tell me your thoughts on this subject?"*

Thus keeping the wording of the initial question simple and more open, I therefore invited the interviewee to relate his/her extended narrative. So I did not adhere to any strict interview guide. This gave more control to the participants over the interview and encouraged them to speak and construct answers in their own way. Few questions addressing specific topics were asked if they were not

addressed by the interviewees themselves in response to the first broad question. These topics include: how mental illnesses are perceived, explained and responded to within the Pakistani community living in the UK.

Interview questions and probes inquired about the mental illnesses and how people in the Pakistani ethnic group might respond to these illnesses, along with their views about the services provided by the local NHS mental health Trust. Participants, rather than answering in a 'yes' or 'no' standardised answer style, told of their understanding of illnesses, and also include short stories in their accounts. These stories sharply contrasted with the usual conception of an extended biographical account. Rather, a story here refers to a brief and bound segment of interview text (Riessman, 2008).

The extent of the narration also depends on the expectations of the interviewers (Riessman, 2008). If extended accounts are welcomed, both interviewees and interviewers can develop, and extend one; but if brief answers are expected then the participants may give brief ones. I collected extended accounts by telling the participants at the beginning that they have the chance to give detailed answers, as well as observing body language, such as showing attentiveness and active listening.

All the interviews were conducted in English, so the challenges of working with a translated text were not there. I had questions at the beginning of the interviews that elicited factual and demographic information from each participant.

The place of the interview, how long the interview lasted and how the participants were accessed, is presented along with demographic information for each vignette. This information was used in developing causal links and interpreting the data

4.3.2.3 Access to the participants

It is typical to have non-random sampling in narrative analysis (Riessman, 2008). Therefore, I adopted a purposive and convenience sampling approach when selecting members of the Pakistani ethnic group. Because the main analytical goal for this part of the project was not to generalise the findings of the population, but to interpret the meanings of mental illness and mental health services for the Pakistanis living in the UK. Both purposive and convenience sampling are used widely in qualitative and exploratory type of research (Robson, 2011).

I did not follow any set criteria for selection of community participants. However, I endeavoured to have diversity in terms of migration history, gender, and role in the society. This commenced serendipitously whilst having a conversation with one of my neighbours, who previously worked with a BME volunteer organisation as a mental health support worker. I subsequently interviewed him/her. Through his/her experience of working with the TRUST, and the local Pakistani groups, he/she identified various issues, such as the role of the community development worker, the role of the Imam and the nursing staff of BME background.

Therefore, I purposively selected and interviewed people from the local area. In total, eight members from the Pakistani ethnic group living in the local catchment area, where the

TRUST is providing its secondary mental health services, were interviewed.

An individual profile of each participant is given in the vignette of that individual in the analysis section. It is pertinent to mention that I did not face any difficulty in accessing these participants, which is in contrast to previous literature indicating that recruiting participants from ethnic minority groups is challenging (Woodall *et al.*, 2010).

4.3.2.4 Ethical considerations

In case study methodology, I have discussed ethical issues relating to my research in detail. However, there are some specific ethical issues relating to narrative research and interviewing members of the Pakistani ethic group on mental health issues. The stigma attached to sensitive topics such as mental illnesses raises important ethical considerations (Dickson-Swift *et al*., 2008). The ethical implications are important in the context of studying mental illnesses among Pakistanis due to the high level of stigma attached. Interviewing Pakistani people on mental health issues is sensitive because people from this group consider mental illnesses to be a stigmatised subject for discussion. Participants might not feel confident to share their experiences in the community. Hence, here I discuss these issues.

Issues of ethics are important when studying sensitive areas which are emotionally demanding in terms of stress such as mental health (Dickson-Swift *et al.*, 2008). The researcher and/or the participants may become stressed when hearing and narrating the stories. I did not have any examples where

my participants showed stress during the interview. However, I was stressed and depressed myself when hearing stories of how mentally ill people are treated in the Pakistani community, and how the issue of stigma is so powerful that the whole family can be labelled as going through a supernatural test. Also, when hearing that people without adequate English language proficiency are left alone on the ward, where they usually do not have chance to speak to anyone.

I originate from Pakistan, but was not aware of the very high level of stigma attached to mental illnesses in the Pakistani community in the UK. I became aware of the stigma during my literature review, but it was during data collection and when hearing various stories and examples narrated by the participants that issue of stigma struck me more.

The ethical issues can also arise in cases where the participants might have spoken for the first time on the issue at length (Dickson-Swift *et al*., 2008). This might be the case for my participants, who may not have been interviewed on this subject before because of their ethnic and social background. Some participants even wondered about my role of being a psychiatrist, and also asked me questions about funding and ownership of my research project.

It is argued that the listener's identities and preconceptions come into play, particularly when interviewing across the divides of geography, religion, class/race and age difference (Riessman, 2008). Through our presence, and by listening and questioning in particular ways, we critically shape the stories

participants choose to tell. Also, as outlined above, narrative interviewing is a co-production of knowledge. Therefore, it might be the case that these participants constructed or developed their narrative/account (and their social self) for a particular listener for me, who is doing the research, from their own ethnic group, in a mental health context, which is a highly stigmatised subject. These participants might have developed their accounts in different ways when talking to a White British person working in the local mental health TRUST.

To address anticipated and unexpected ethical issues in this narrative research, after completion of the data collection from the TRUST, I submitted a separate ethical clearance application to the University of Nottingham's Medical School Ethics Committee. This application sought ethical clearance to collect data from members of Pakistani ethnicity. I acquired approval from the Ethics Committee. The Information sheet and Consent Form are attached in **Appendix D & E** respectively. The main ethical principles such as confidentiality, anonymity and privacy described in the Methodology-I for the TRUST was adhered to. Issues concerning legal capacity to consent are not directly relevant to this research, as the participants from the Pakistani community were not currently using the services.

4.3.2.5 Method of data analysis

In this section, the process used for analysis of the narrative interviews is introduced. There is no single approach to narrative analysis, rather a variety of interpretive approaches for analysing narrative data including spoken, written and visual texts (Riessman, 2008). Therefore, remaining within the

tradition of narrative research, each individual researcher may develop his/her own method of analysing data as per the need of the project.

I myself conducted all the interviews, so the interpretive process begins during conversations with the participants (Riessman, 2008). Unlike written documents and visual data, oral data collected through digital record requires transformation into a textual form. I myself transformed the taped conversations into transcripts. I formatted each transcript into meaningful chunks and brief phrases giving line numbers on the transcript.

The data I have recorded consists of participants' own experiences, their understanding and reflections about mental illness, which they recalled from their past and present experiences. In experience-centred narratives such as was collected in this research, data can be analysed thematically, rather than focusing on the structure of the narrative (Squire, 2013). I arranged this data in text format in a Word table suitable for thematic narrative analysis.

In thematic narrative analysis, the focus of the investigator is on the content of the narrative, i.e. 'the told' or 'what' is said rather than 'how' or 'to whom' and for 'what purpose'. The focus here is on 'thematic meaning', 'point', 'the act the narrative reports' and the moral of the story, rather than understanding the structural components of how it is said (Riessman, 2008:58-62). Thematic narrative analysis also has minimal focus on the participants of the narration and the local context that generated the narrative. In thematic

narrative analysis, the data is interpreted in light of the thematic framework developed by the investigator, which may be influenced by prior and emergent theory, the concrete purpose of an investigation, the data themselves, political commitment and other factors (Jupp, 2006).

Thematic narrative analysis has the potential to reveal social identities and group belongings of individuals as well as collective action (Riessman, 2008). With the help of a strong theory as a resource, an investigator can link everyday seemingly insignificant acts that people engage in to a larger social change process or identity structure such as assimilation (Riessman, 2008). Hence, I am using the social identity theory. I consider that individual participants in this research, while narrating their understandings of mental illness and mental health services, are revealing their social identities.

In response to my simple question to the participants, i.e. '*My study is looking at the perceptions of mental health/illness in the Pakistani community in the UK as well as their perceptions and experiences of mental health services; I wonder if you could tell me your thoughts on this subject?'*, the participants narrated long stories of their understanding of mental illnesses in the Pakistani community. We then expanded following the lead the participants raised in their responses.

Through their interviews and stories, eight participants I interviewed revealed how mental illnesses is constructed, responded to and how their social-self is demonstrated in the mental health context. It is pertinent to mention that these eight participants were not selected to be statistically

representative, rather to develop a theoretical argument about how mental illness is perceived and responded to within the Pakistani ethnic group living in the UK.

I analysed this set of the data in an eclectic way (Lieblich *et al*., 1998; Czarniawska, 2004). My unit of analysis is a particular act of perceiving, explaining mental illnesses, and raising issues in the NHS services. During analysis, I passed through the following stages:

First, I transcribed all the eight interviews verbatim. Then I manually coded each transcript separately in a Word document as a table. I summarised quotations with relevant line numbers from the original transcript to help me locate the quote in its context. During this coding and summarising process, I noted my reflections and thoughts in a separate column. I also highlighted my notes in the summary of the data. Additionally, I added demographic data on each transcript. This process helped me to identify the main themes originating from each transcript.

In presenting findings for the community data, I developed eight vignettes of these participants. These vignettes consist of demographic information and the main themes identified. Vignettes have been used as a tool for exploring the cultural identity of ethnic groups (Crafter *et al*., 2015). At the end I presented an overall summary of the findings, keeping in view the aims of my research.

In parallel with a more holistic approach (Lieblich *et al.*, 1998), I went through the all interview transcripts individually, looking for important patterns; I interpreted these in light of the story as a whole and indicated my initial ideas next to parts of the interview. I paid particular attention to the ways interviewees talked about mental illness, and how mental illnesses are responded to within the population of Pakistanis in the UK, and their views about the mental health services provided by the TRUST. Focusing on these issues also allowed me to identify the social identity claims made by each individual participant in their narrative.

Next, in line with a more categorical approach (Lieblich *et al*., 1998), I compared the different themes found in each narrative. While doing so, I went through a process of 'dialogical listening', moving back and forth between the voices of the interviewees and using relevant literature on social identity, ethnicity, and mental health, while always trying to be reflexive of my own interpretations, which may be potentially influenced by my cultural background and my critical and non-essentialist approach to social identity.

My thinking has been informed by the social identity theory. The authors include Tajfel (2010), Jenkins (2008) and Hogg (2006). This does not imply any agreement among these authors, and their work is used as a starting point for my own thinking. The above process provided me with a general insight into the important themes for the interviewees as a group. These themes include:

i) Perceptions of mental illnesses;

ii) Explanations of mental illnesses;
iii) Help-seeking behaviour;
iv) Views about mental health services;
v) Social identity claims.

After this phase, I again contextualised the different themes within the individual interview and further explored the individual narrative informed by these themes, in order to understand how the different themes relate to each other and to the narratives as a whole. I used these identified themes as a main framework, to which I then added further relevant information. In summary, I used a theme-based narrative approach to analyse this set of the data.

In terms of social identity claims, my aim was to explore which explanatory model of mental illnesses each individual associates with, and which model of mental healthcare the participant is finding helpful. In terms of relational aspects, I was interested in how each participant relates himself/herself with mental health services. At the end I have presented a summary of the main findings. To help illustrate the views of the participants on mental illnesses, I have quoted the interview material extensively.

4.3.2.6 Trustworthiness of narrative research

This section focuses on the issue of validity or trustworthiness of narrative research. There is a long debate in the philosophy of social science about the 'trustworthiness' of the evidence and the interpretations derived from these evidences (Riessman, 2008). Therefore, narrative researchers need to

address two important questions related to validity and trustworthiness. Firstly, a narrative researcher needs to demonstrate the validity and trustworthiness of the story narrated by a research participant. This issue relates to the quality of the evidence. Secondly, a narrative researcher also needs to demonstrate the validity and trustworthiness of his/her interpretations of the evidence.

Like other qualitative types of research, fixed criteria based on a positivistic model of evaluating the validity of narrative research projects is considered inappropriate (Riessman, 2008). This is because it is noted that research projects are situated within the parameters and debates of the particular social science discipline, and by the epistemology and theories that ground the empirical work. Consequently, ways of thinking about validity and ethics are products of the paradigms that spawn them (Riessman, 2008).

At the beginning of this chapter, I made it clear that this research has used interpretive epistemology. So I approach the issue of trustworthiness from a perspective which considers narrative research and its epistemology to be fluid. Hence, the validity of this research should be assessed according to the epistemological perspective in which it is situated.

Furthermore, factual accuracy of evidence is important for research projects which are situated in realist epistemology. For example, researchers doing a historical kind of research would seek to validate their evidence as being consistent with other evidence on the subject. Another way to strengthen the

validity of the evidence is through the idea of correspondence, which means triangulating given evidence from other sources.

Both of the above points to establish the truth do not seem appropriate to apply in my research. Firstly, the focus of my research was not on collecting historical events; rather my interest was to explore how members from the Pakistani ethnic group perceive and respond to mental illnesses and how they relate to NHS mental health services in this context.

Secondly, and more importantly, my research is informed by interpretivist epistemology. In interpretivist epistemology, a narrative is not simply a factual report of events, but instead an articulation told from a point of view that seeks to persuade others to see the events in a similar way (Riessman, 2008). Thus, the narrative does not establish the truth of events or experiences, rather they are reflections *on* those events and experiences (Denzin, 2000). Therefore, emphasis on verifying the factual accuracy of the evidence I have collected does not seem of much importance to me. These kinds of validation may be more relevant with an oral history type of research. Also, I did not have access to information from other sources such as medical notes or personal stories of the participants. For me, understanding the meaning of mental illnesses and the NHS mental health services for the members of Pakistani ethnic group is important. My role in this research was to 'interpret the interpretations' (Riessman, 2008:188) of people in relation to mental illnesses and mental health services. Thus the meaning of the narrator was my focus rather than the truth or reality of the story told or the experience shared. In my case, the emphasis of validity is on

how I have interpreted the narrative, rather than the narrative itself.

Acknowledging that narrative truths are always incomplete and partial, Riessman (2008) suggested that narrative researchers can persuade their audiences about the trustworthiness of the data they have collected and the interpretations made through the following:

Coherence: identifying coherence in the narration of the participant and the interpretations of the researcher. Validity can be strengthened if the analytic story the investigator constructs links pieces of data and renders them meaningful and coherent theoretically. Instead of trying to find coherence and factuality in individuals' stories, investigators might search for coexistent realities: selves and communities that are pulling together and pulling apart at the same time. For example, my narrative analysis identified points where individuals' accounts converge thematically (creating a community of experience), and other points where they split apart. Making sense analytically of both convergence and divergence would support trustworthiness.

Persuasion: A good narrative researcher persuades readers. Narrative researchers can present their data in ways that demonstrates that the data are genuine, and analytic interpretations of them are reasoned well and convincingly. Persuasiveness is strengthened when the investigator's theoretical claims are supported with evidence from informants' accounts, negative cases are included, and alternative interpretations considered.

To validate the genuineness of the data, I have tape-recorded all the interviews. During analysis, I have presented descriptive evidence of the precise words spoken by the narrators in the form of participants' quotes. I kept a diary to record my notes and reflections during this process. I have detailed not only the process of data collection, but also its interpretations.

Presentation: The trustworthiness of narrative research can also be strengthened through presenting the way data is transcribed and analysed. The narrative researcher needs to be detailed in transcription, with attention paid to language and contexts of production.

In order to establish the validity of the narrative research, Riessman (2008) suggested a few guidelines which are summarised below:

Data collected is original, and not simply made up by the researcher.

I have digitally record of all the eight interviews which I collected from my participants. I also have transcripts of these recorded interviews which may be presented if required. This can also be validated through the diversity of the participant's quotations as presented in the findings.

Establishing that the researcher had followed a methodical path in undertaking the research.

I chose the narrative method of interviewing rather than a questionnaire because my aim was to have the perspectives of

the Pakistani community members on mental illnesses and the NHS services in their own words. I wanted to understand the unique perspective of each individual participant. This is in line with the ontological and epistemological underpinnings of this research.

Establishing that research was guided by ethical considerations.

I thoroughly considered the ethical dimensions of a narrative research on mental health in the Pakistani and NHS context. The ethical clearance was obtained from the REC of the Medical School, University of Nottingham before starting the data collection. This clearance required sound processes to be in place to ensuring that the research is carried out in an ethical manner. I fulfilled all the requirements and during my data collection also actually practised analysis and presentation of findings. This included sharing the Participant Information Sheet, obtaining informed consent, respecting confidentiality and privacy of the participants.

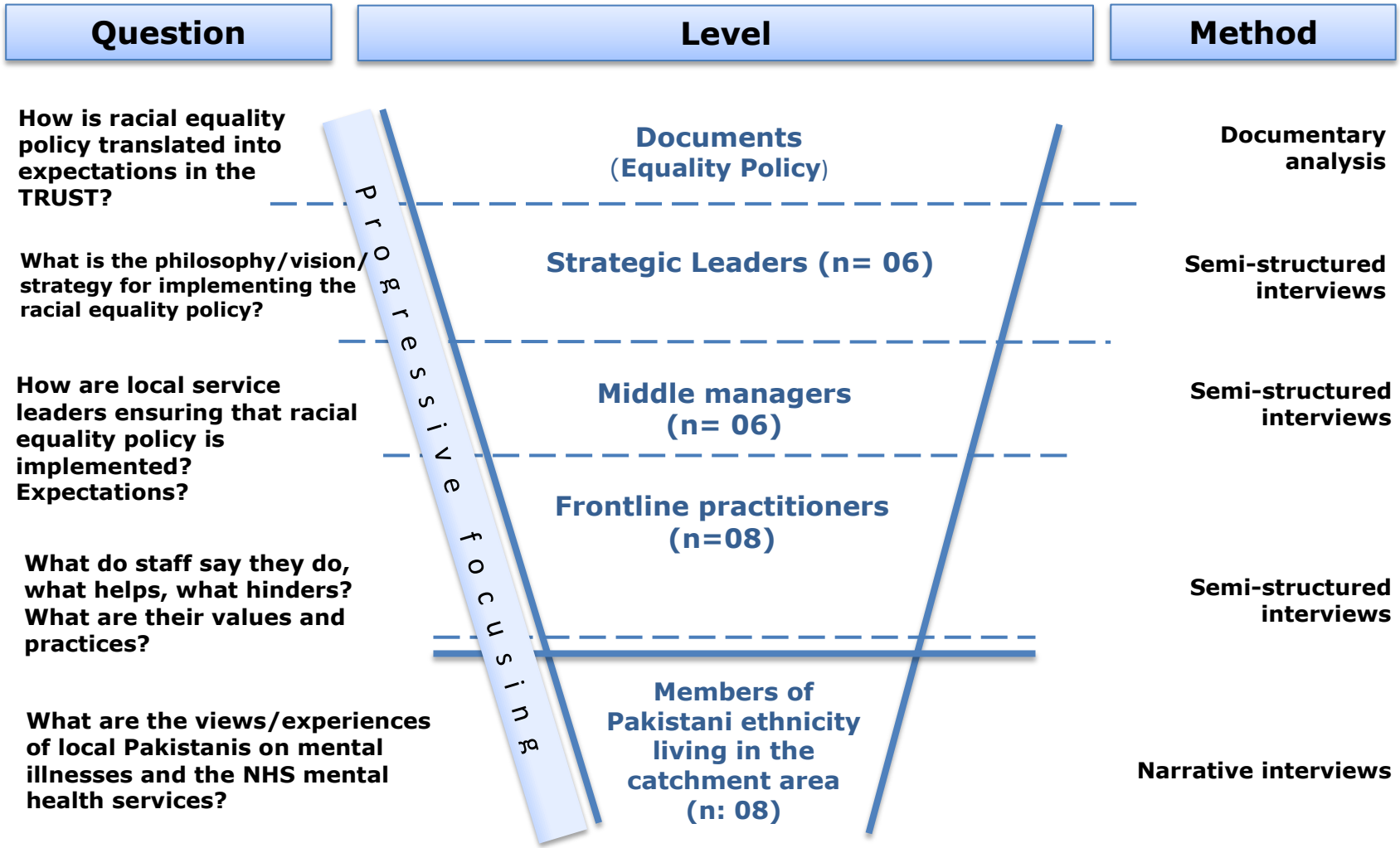
Use of relevant theory to analyse the data.

The final element which may help a narrative researcher to establish the trustworthiness of their knowledge claims is to use theory (Riessman, 2008). Hence I used the social identity theory to analyse the data collected from the members of the Pakistani community. Because of the above cited reasons, I would agree that there are no formal rules for validating qualitative research. I would also argue that the data I have collected, and the interpretations I have made, are valid.

4.3.2.7 Summary of the chapter

This research uses a constructionist ontology considering that there are multiple realities; an interpretivist epistemology suggesting that researcher and respondent co-create understandings, and a naturalistic set of methodological procedures providing flexibility to address the research questions and their aim. The findings are presented in terms of the themes and patterns identified in the data.

Fig. 4.1 Case study process



CHAPTER FIVE: FINDINGS

Part-1: FINDINGS OF TRUST DATA

5.0 Introduction

In the findings I am presenting what I have found in the data, and not discussing relationships to the existing literature. This will be done in the discussion chapter (No. 6).

It was striking that all participants at all levels of the organisation had a sound understanding of the expectations of the race equality policy. The strategic leaders were, however, markedly more positive about the extent to which the organisation is achieving these expectations. In contrast, the middle level management discussed the challenges of providing high quality services for BME service users, and the practitioners provided many examples of needs they were unable to meet due to a range of challenges that they were able to articulate convincingly. This pattern is seen repeatedly in relation to many different issues. One example relates to the provision of the interpreting services.

The strategic leaders stated that they provide full support to staff around race issues. For example, one of the strategic leaders shared that:

'[the TRUST] has a full interpreting service clinically, that links to broader strategy.' (SL-3)

However, the middle management identified issues in managing and providing this service. All the middle level managers I interviewed were unanimous in the fact that there is a range of challenges when using the interpreting services to address the communication barriers and meet the language needs of the patients. These issues relate to funding the interpreting services: getting it on time, having appropriately trained people, and issues of privacy and confidentiality.

'We do have a process where we get interpreters in, but in the community it is much more difficult because you rely often on families to act as an interpreter because we cannot always take an interpreter with us. It is easier to get the interpreter for someone as an in-patient than in the community … We have got a statutory duty when somebody is in hospital, they can have an interpreter … which costs us a phenomenal amount of money.' (MM -1)

The practice staff said that even then if they get interpreters there are issues:

'Generally working with an interpreter can be difficult because you are not completely sure that what you said is being translated and what is being said back to you is accurate; so there is always that concern, and of not hearing things the first time. You do not pick up body language or non-verbal communication as well. So you could miss things, and sometimes people just do not want to talk at all because they do not want to; they are worried about confidentiality.' (FS-2)

The overall picture of the data described above repeatedly indicates that there is a pattern in responses from the different levels of the organisation. The strategic leaders are aspirational in their vision, with middle managers identifying some challenges relating to funding and quality, whereas practice staff describe very basic and practical challenges on a day-to-day basis. The above description is plotted graphically as (fig 5.1):

Fig 5.1: Overall pattern of findings from TRUST data



Within this overarching pattern, a number of themes and subthemes were identified.

Presentation of Findings

I am presenting findings thematically. A number of overarching themes emerged from the data, reflecting the interviewees' interpretation of race policy in the Trust, such as the challenges which they percieved and the factors hindering implementation of policy, as well as organisational change and the culture relating to race policy. Finally, there were many suggestions regarding ways in which BME groups could receive an improved service. The findings are structured utilising these themes and the sub-themes identified within them as follows. In reporting the findings, I have selected typical illustrative quotes from each level to demonstrate representitiveness and not for their differences to elicit findings from the analysis.

Table 5.1: Themes and sub-themes from TRUST data

S. N.	Theme	Sub-themes
1	Interpretation, expectations, vision and strategy on race policy	○ Interpretations of race equality policy for organisational change. ○ Expectations of race equality policy for organisational change. ○ Usefulness of race equality policy for organisational change. ○ Vision and aspirations of strategic leaders for organisational change on race. ○ Strategy for implementing race policy and organisational change.
2	Challenges and barriers to organisational change and meeting the needs of BME service users	○ Language differences among the service providers and the service users as a challenge in bringing about organisational change. ○ Cultural differences among the service providers and the service users – a challenge for bringing about organisational change. ○ Organisational development interventions for improving the understanding of different cultures.
3	Perceived hindrances in bringing about organisational change and addressing BME issues	○ Organisational hindrances. ○ Community–related hindrances. ○ Racist attitudes. ○ Race being nobody's priority.
4	Organisational change	○ Perceived organisational change on race. ○ Perceived quality of services. ○ Perceptions of overall performance to organisational change on race.
5	Organisational culture and its role in organisational change in providing person–centred care to BME service users	○ Defining the organisational culture concept. ○ Organisational culture being promoted. ○ Interpretation of existing culture.
6	Facilitators and suggestions for change and delivering a good quality service	○ Individual commitment. ○ Reflecting the local population in the workforce. ○ Effective training and learning opportunities on race. ○ Thinking strategically. ○ Research evidence. ○ Individual staff level cultural sensitivity. ○ Diversity in the environment of the organisation. ○ Flexible practice. ○ Having an individualistic approach. ○ Using an educational approach to manage mental health.

Theme-1: Interpretation, expectations, vision and strategy on race policy

5.1.1 Interpretations of race equality policy for organisational change

All interviewees had similar levels of understanding of race policy and they used similar language and terminology to describe it – closely reflecting that used in policy documents on race equality.

All interviewees were aware that the organisation has a single policy which covers all the protected characteristics identified in the Equality Act (2010). The participants described the scope of the application of the policy, both in the service provision and in recruitment. This was a simple statement of intent about the equality of access and treatment. It applied equally across all the protected characteristics. It has no particular mention of any single protected characteristic, let alone any condition within each characteristic (such as a specific disability or specific ethnicity):

'[The TRUST] now has a general statement which applies to each of the strands which is to make sure that we treat people with fairness and equity and considers everybody's needs, inclusive of race, gender, disability. We do not have a specific statement for a specific strand.' (SL-6)

'It is just about the policy statement from the organisation, which says that we respect the individual needs of the people from different ethnic minorities; do not tolerate racism, those kinds of things.' (MM-4)

'[The race equality policy is] that people should be treated with respect and they should have equal access to services, and you should not discriminate against them, and give them a lesser service because of their race; they are the key things.' (FS-1)

In summary, the participants were aware of the fact that the TRUST has a generic policy on equality. This equality policy covers nine protected characteristics, and is drawn from the Equality Act 2010. The interviewees' awareness of more detailed expectations of race policy is described in the following section.

5.1.2 Expectations of race equality policy for organisational change

Interviewees were asked how they expected race policy to be implemented. Their responses reflected their position in the organisation.

The expectations of the strategic leaders were expressed, once again in the language of the policy documents. The driver for meeting expectations seems to be a wish to achieve compliance to legal and policy obligations.

'There is an absolute requirement to ensure that we provide direct support to people with varying needs.' (SL-3)

'I expect them [the practitioners] to be accessible to all. Treat anybody who they need to treat with the same level of respect

and competence and to be sensitive to the individual needs irrespective of what the need is.' (SL-2)

Responses from the middle management represent the expectations of the professional standards for the practice staff:

'I expect them to be 100 % professional on everything, not just race.' (MM -1)

'I expect them to provide a level of service that anyone would get, with sensitivity to the needs of that individual, and sensitivity to the needs of the individual is understanding their social and cultural context, but also trying to meet some needs around the interpreter if that is needed, making sure that it is in place, and people can access services properly, and get the same level and quality of care that anyone else would get, based around their individual needs.' (MM -3, with clinical role)

The responses from the practice staff affirmed the above-mentioned expectations from them. They acknowledged the importance of providing sensitive and individualised care.

'[The practice staff] are prepared to work with people from a wide range of backgrounds, that they are willing, even if they have a different perspective, to be respectful of the other person's perspective, and not enforce their own, and they would not deliberately say things that are or do things that are hurtful or putting down or disrespectful of other people and

that they have an openness to learn and to see things from a different perspective.' (FS-1)

'[We are expected] not to discriminate. To abide by the law and not to treat everybody exactly the same, but everybody should have same opportunities, and be treated fairly, equitability, rather than exactly the same. Because everybody's needs are different.' (FS-2)

Responses on the expectations of race equality policy from all the levels of the organisations are that service users from all ethnic backgrounds should have good quality mental health services. Whether and how interviewees' perceived the racial equality policy to be useful is addressed in the next section.

5.1.3 Usefulness of race equality policy for organisational change

All interviewees perceived that the quality and diversity policy in the TRUST is useful for many reasons. The reasons stated include compliance to the legal and policy requirements, being moral, and addressing the issues of discrimination and racism within the organisation.

'Because the NHS is a universal concept, it is going to work for everybody; it cannot just work for a selective few.' (SL-1)

'We value everybody, and it is very good actually.' (MM-3, with clinical role)

'Race policy is very important. It is a multicultural society.' (FS-6)

It can also provide a framework for detecting poor practice:

'It [race policy] does influence our practice of work really, how we treat people, you know, you do get some professionals who look down on the clients. People do think about status.' (FS-7)

Participants suggested that a variety of benefits derive from the racial equality policy. They described these benefits to be moral, political, legal and practical. So, it seems that participants I interviewed have a theoretical understanding of the racial equality policy. This leads to the question of the vision of change that the studied TRUST aspires to in order to meet the expectations of the policy. This is an issue that was asked specifically of strategic leaders rather than middle managers and practice staff.

5.1.4 Vision and aspirations of strategic leaders for organisational change on race

Strategic leaders have an idealistic but non-specific vision for the organisation in relation to race. Their wish is to change the 'whole-culture' of the organisation to achieve good quality service provision for the BME people.

Furthermore, the vision on race seems integrated within their overall aspirations for the organisation. It is about promoting a culture of equality and diversity in all aspects of the

organisation, which means giving equal opportunities to people from BME backgrounds in the workforce as well as meeting their specific needs in the service provision. Both of these aspects reflect the recommendations of national policy documents.

'It [racial equality] should be a culture thing. It should be the way we do things around here.' (SL-1)

'We want to be a world class organisation for all our patients, which meets the needs of the BME patients.' (SL-6)

5.1.5 Strategy for implementing race policy and organisational change

The strategic leaders stated that race is an important issue for them and that they have good organisational governance structures around that. The significance of race is demonstrated by their statements indicating that it is an important objective in organisational governance at the board level.

'It [the law] sets a legal framework. We have to set a cultural framework around that as well, so it is not just around, you know, very clear legal compliance. It is also encouraging a culture of openness and diversity which is really important to us and it is a key objective for us as a board.' (SL-3)

'We should be intervening as early as possible, and the services we are providing should be completely population-based and accessible to all and focus on those people who

have need of our services; and we therefore will make services available to those who need them.' (SL-2)

Strategically, stating future priorities on race, the Chief Executive focuses on mainstreaming protected characteristics and prioritising success on the Stonewall index as a way to demonstrate the cultural sensitivity of the organisation in relation to race.

'I think to integrate our office so the people get the choice within mainstream services. I do not see creating separate services … I am not sure that it is the right thing to do. I think it is quite discriminatory, actually. I think it creates stigma. We need to make sure that the work force is culturally sensitive to people's needs … So for me it is about a mainstream thing. It is about the Stonewall index.' (SL-1)

This strategic leader further stated that the strategic action plan on Equality and Diversity captures the voice of BME people and so works from the 'bottom-up' as well as 'top-down'; so all documentation is easily accessible.

'We got people from BME organisations, disability, sexual orientation organisations, gender organisations, and they come and they scrutinise us as critical friends. The other thing is that each of these action plans are available on the internet, as are our workforce statistics; they are there for people to see and inform and put us to question, if they want to question'. (SL-6)

In terms of organisational level mechanisms to monitor staff, the strategic leaders said that they make expectations on race clear to staff, and there are effective mechanisms in place to identify loopholes:

'Right from the very start, at induction, we make it very clear, this is the TRUST policy and if this is not the policy you agree with, then you should leave the organisation, it is not the right organisation for you.' (SL-6)

'And the whole system, the management appraisal system, supervision process, the work which you do with the carers and communities, all can pick up these issues, which is why there is such a robust framework. If you were a member of staff and you've got a specific attitude and it does not come out at your appraisal or your supervision session, we will find out from community complainants, from involvement centres, all those sort of things.' (SL-6)

In terms of community engagement, the views from the strategic leaders seem to be optimistic. From their perspective they have good engagement with the local BME communities:

'We comply with the race relation, kind of, you know, the legal construct, but we go further than that. So we also have communities of interest programmes. So we work directly with communities of interest across X area around race and equality. So we have those direct links back into the community.' (SL-3)

Strategies for achieving the vision on race include: developing cultural sensitivity in the workforce; diversifying the workforce; being open in organisational business: involving BME communities in organisational governance; the service planning, and being strict on race-based discrimination. The thinking is that service users from any ethnic background should have a choice and his/her needs met from the mainstream services. The challenges that the organisation is facing in meeting the needs of an ethnically diverse service user group are described in the following section. These questions were asked to the participants of middle management and frontline staff categories.

Theme-2: Challenges and barriers to organisational change and meeting the needs of BME service users

Interviewees talked about the challenges to meeting the needs of BME service users. The participants from the practice staff mentioned that they face two main challenges in meeting the needs of BME service users. The first and main challenge identified is the different languages of the practitioners and the service users. The difference in language presents a major challenge for practitioners. The practitioners face this challenge at various stages of the care cycle. This includes assessment, diagnosis, charting the care plan etc. The second challenge is a lack of understanding among practitioners about the culture of the service users. Firstly, I will describe the findings related to language and then to culture.

5.2.1 Language differences among the service providers and the service users as a challenge in bringing about organisational change

Language is critical when dealing with mental health issues. In mental healthcare, being able to describe your symptoms as well as your feelings and emotions are an important part of conveying your needs, and yet many people of a Pakistani background do not speak English, and many staff do not speak Pakistani languages. Most of the people interviewed identified language as one of the biggest barriers to getting their needs met. One of the ways of crossing the language barrier is through the use of interpreters. As already mentioned in the introduction to this section, interpreters were a major issue for interviewees because of the critical importance of language and the personal description of feelings and experiences by people using the mental health services.

'In psychiatry … there is a lot about communication skills. [Communication skills] are one of the most essential things … because all of your tools are your communication … As a surgeon, you very much rely on your technical abilities; you do not have to talk to the patient that much. In psychiatry that is the main thing.' (FS-4)

In order to address the language needs of service users, interviewees described a number of practices being used. These included: hiring interpreters from an outside agency; getting language support from colleagues of similar background; and using family members as interpreters. However, managers and practitioners identified a number of

challenges with each of these types of interpreters. The managers viewed organising and funding the interpreting service as a big challenge. This is described by a middle level manager, who is also an experienced psychiatrist:

'Funding it. Getting somebody quickly, in urgent times, or whatever the situation. I think sometimes families feel a bit of an invasion of privacy, and feel a bit sensitive, especially if they are from quite a small ethnic group.' (MM-3, with clinical role)

During the interview this participant mentioned that a suggestion has been made by the senior management of the TRUST to use family members as interpreters to avoid spending financial resources. The participant did not feel that this was a reasonable suggestion:

'Personally I do not think we should use families because I think it is difficult to get things like risks and safeguarding, and openness.' (MM-3, with clinical role)

Further identifying the practical challenges associated with using interpreters in the mental healthcare context, the participant echoed:

'Unless we get quite good quality interpreters, you can really struggle to actually judge what you are being told is right … I think it is very, very difficult in psychiatry to understand something like delusions or hallucinations or thoughts or voices, those kind of things; you really need to tease out

quite carefully. It can be really quite tricky through an interpreter. So deciding how sure you are whether someone is psychotic or not can be very difficult I think [depend with which interpreter?]. How well you understand the social context and needs, the cultural context as well, which sometimes they can, sometimes they cannot; it is not always that easy to get a really good interpreter at the level that you really need.' (MM-3, with clinical role)

While the managers prioritised funding and organising good quality interpreting services being available to the practitioners on time, the practitioners identified many practice challenges in delivering quality mental health services even when formal interpreting support was available to them. These challenges relate to indirect communication between the practitioner and the service users, lack of skills and lack of confidence on the part of the practitioners to work with the interpreters.

'I think it is probably much easier and kind of more direct to understand the patient if you speak the language. Because I think what sometimes happens with the translator, you kind of impose a third person. Sometimes something can be missed, lost in translation, and you also do not know exactly how, what exactly the kinds of skills of the translator are, what their knowledge is … Obviously they have to be, kind of, proving this and that. But something can be missed in that process and the consultation also is obviously different.' (FS-4)

Another participant from the frontline indicated lack of confidence while working with an interpreter as:

'I have to admit, if I know I am going to work with an interpreter, my heart sinks because I know it is going to make things more difficult … It makes me worried that I am not going to do a good enough job.' (FS-2)

The practitioners cited many examples to make their points in relation to the challenges when using interpreters and how the use of interpreters can influence the quality of the service. For example, a consultant psychiatrist shared an example from their own experience:

'[There] was a Polish person … and the assessment was in the presence of a translator. The issue was that they [colleagues] were not sure if the patient was psychotic, because certain things he said sounded a bit bizarre or could be interpreted as psychotic statements. But on the other hand he was not sure, if he was just kind of playing around and talking a kind of, bit of nonsense. Not in a psychotic way.' (FS-4)

As this participant was acting as a consultant for the colleague who did the assessment of the patient in the first instance, this colleague brought the case for supervision, and it was found that there was an error in the assessment due to interpretation:

'[The colleague] brought his case for supervision and he told me, a few kind of phrases which the patient stated which were then translated into English and on face value, yeah, it

sounded a kind of "oh, it is a bit of a strange thing to say". However, me knowing the language, these were the kind of common, you know, like kind of idiomatic expressions, which are commonly used in Poland and they do not mean that you know that somebody is bizarre-thinking or psychotic. These are kind of common sayings which all Polish people understand because it is commonly used; however translated in a different language sounded kind of odd and possibly bizarre; so that can lead to misinterpretation, because just the fact that you translated it word for word, then you can lose the meaning in a context'. (FS-4)

Getting interpretation support from a family member is also challenging for the practitioner when delivering good quality service. These challenges relate to issues of both misinterpretation in the communication and also stigma:

'It was the client's CPA review. They usually get the sister of the service user to come in and speak the language, so to communicate with us … but it was a challenge. We did find it very difficult … the sister sometimes put her own personal opinions and views on things on the feelings … It was difficult because the things happened in the family, they found it difficult to communicate, because it was quite private to people; certain things happened in the family, and how that impacted on the poor mental health of this person, but it was almost swept under the carpet, like something we do not talk about. It was very hard trying to help this person, and the family, who knew a lot about this, was not able to share or just gave limited information.' (FS-7)

This example, along with others relating similar experiences, demonstrates how families may feel shame or embarrassment about events, or even about the very existence of mental health problems in their own family, so they may be reluctant to interpret fully and openly. Similarly, the person who is using the services may be reluctant to share their experiences with a family member because of shame, embarrassment or an unwillingness to let family members know what is going on for them.

The quote below indicates the challenge of diversity in language. It indicates that it is not only about the main languages; rather that the different dialects of the language also matters.

'I worked with a young man from Afghanistan who had no English at all and relied on his family and asked to use an interpreter. I think he found the experience of an interpreter quite difficult, uncomfortable … The nurse brought in an interpreter, a Pashtu speaker, but the issue there, I think his dialect was different and I think it confused the situation somewhat.' (FS-5)

In this case, a family member eventually provided interpretation and again, this led to difficulties for the service user who was reluctant to speak openly with a family member present:

'… I think his uncle , who also had been there, ended up stepping in and talking more and the young man who was the

service user felt very uncomfortable so after that occasion they said they do not want to use any interpreter.' (FS-5)

Participants also reported that the provision of the interpreting service is not consistent or regularly available; rather it is provided in special circumstances, such as a review. So, if there is a service user on the ward, and he/she does not speak English, the challenges which the staff and the service user face can create numerous difficulties.

'On the ward we do not get interpreters. They are called for reviews.' (FS-3)

In summary, strategically if needed, there is the provision for interpreting services to meet the language needs of BME service users. However, middle management has identified many challenges in terms of financing and organising this service. Interesting insights came from the practitioners working across a range of mental health professions; the practitioners gave many examples of how things can go wrong in diagnosis and treatment because of different ways of expressing experiences and the possibility of misdiagnosis. There are sensitivities around speaking openly in front of members of their family or community because of the shame or stigma of mental health problems. Added to this, day-to-day communication is seriously hindered by the lack of interpreters available on a routine basis. In conclusion, although the provision of an interpreting service is sometimes necessary, it is not straightforward and the policy of providing interpreters does not fully meet the language needs of service users.

5.2.2 Cultural differences among the service providers and the service users -a challenge for bringing about organisational change

The second important challenge that practitioners face while working with service users of a BME background is not having enough cultural understanding of the service users. Culture is defined in various ways in the literature (Hunt, 2007). The people I interviewed had a good understanding of what this meant as shown by one interviewee:

'[Culture includes] everything really ... probably start with what is the religion, what are the traditions, families, how people kind of, what type of life, what are the priorities, and attitudes and values in that society, any customs, traditions, diet, food; quite wide really'. (FS-4)

The importance of culture in mental health is identified by another participant as:

'In mental health it is all your culture and, you know your spiritual beliefs, how you can think and feel directly effects on mental health and how you perceive that.' (MM-4)

The practitioners identified their own lack of cultural and religious understanding of different groups.

'My knowledge of different groups is broadly the same in each group; it is a little understanding of everything but not a deep understanding.' (FS-6)

The little knowledge of the participant is clearly identified in many instances. For example, the same participant when talking about the Islamic faith used 'bible' and 'temple' for Muslims, instead of 'Quran' and 'Mosque/Masjid'.

'I have very little knowledge of the Islamic faith. All I know about the Islamic faith is that they have their own bible. They have their own way of cultural dress. They have their temple and they have the duty that they believe in. They worship, and I am afraid that is my knowledge of the Islamic faith.' (FS-6)

'I remember going [on training] from the TRUST. A guy what it called, priest is … telling us about Quran, the faith, if people are poorly and things like that … I find teaching very interesting. At the end, I want to say 'thank you'. I stood up to shake his hand. He looked at me. It was not until the British lady [said] 'he would not shake your hand because you are a lady.' (FS-7)

'I do not know the difference between the issues for a Pakistani person as opposed to an Indian person. I do not know what the difference is. So, I would not know what their particular issues are.' (FS-2)

The practitioners considered a lack of cultural understanding as a challenge for them in providing good quality services to BME service users. They were of the view that less understanding about cultural issues can have a deleterious influence on service provision in many ways.

'I might be ignorant of saying something offensive. I do not know what the gender issues might be around a woman working with an older man. I do not know if there are any issues in that. I am guessing. It might be that I could be completely wrong there. I do not know about the different ways of doing things, which I might not appreciate … for example, with psychosis, I know in BME communities, I have noticed that lot of people attribute it to angels and religious reasons for their voices, for their hallucinations, you know, so those kind of issues as well that I can be ignorant of, which would affect the way someone receives the treatment options.' (FS-2)

Practice staff found it difficult to apply routinely used assessment tools to the Pakistani context:

'There is a particular standardised assessment which can be difficult to apply to Pakistani service users because it is extremely standardised … for example … shopping. you have to buy at least four things and one of them has to be heavy and if somebody does not normally you have to travel to at least 100 metres to get to the shop. If the person does not normally buy that many things or buys heavy things like a bag of sugar or a bottle of pop. They do not normally do that. When they go for shopping that is not a suitable task. So that assessment is only really suitable if the activities that people normally do in certain ways that fits that list. So, therefore, translating that to somebody with a Pakistani origin is more difficult because I do not remember there being any specific Pakistani activities going on there.' (FS-2)

'[not understanding culture] can … impact on your relationship with the patient and you, without knowledge you might offend somebody because you might come across something which is sensitive but also you might misinterpret certain ... and your assessment might not actually be correct because if you misinterpret certain body- language.' (FS-4)

'People's beliefs can be seen as unusual if you are not familiar with their beliefs, for example, parents of an African Caribbean man who was speaking in tongues; that is quite normal practice in their faith community but if you are not aware of that you think they are responding to hallucinations or something. I do not know … but more everyday things as well … but also what people want to do to achieve in their life is influenced by their faith and whether someone wants to live or not whether someone commits suicide all those things can be influenced by someone' s faith.' (FS-5)

Understanding and meeting the cultural needs of ethnically diverse service users is a big challenge for practitioners. The participants identified that understanding the culture of the service users is important in providing a good quality mental health service. How the studied TRUST is attempting to bring cultural understanding in the practice is the focus of the next section.

5.2.3 Organisational development interventions for improving the understanding of different cultures

The participants identified both formal and informal ways for gaining cultural understandings of different BME groups. The formal arrangements include: working collaboratively with the

BME third sector; seeking advice from BME colleagues; and attending training courses on cultural issues. The informal learning is obtained through friends of BME backgrounds, the media, personal reading and research.

Developing an alliance with the BME third sector

Across the three levels of interviewees, participants recognised the important role which the BME third sector can play in helping NHS services deliver good quality services to BME service users. It is also evident that participants no longer have access to these community groups or community development workers and this has resulted in a poorer quality service for BME service users. The participants identified funding cuts to the third sector and the new funding arrangements for the third sector as an important reason for this:

'No matter how culturally capable your services are, how culturally appropriate they are, how fantastic your staff are, that does not always meet everybody's needs and the cultural specific services, either the services done by the third sector and the community have a very important part to play.' (SL-6)

'We are actually partnering with an organisation who are specialists in BME drugs organisation, and I think what they bring into the partnership is the sensitivity and sophistication and understanding of some of the issues, that we may not necessarily have the same sophistication and depth, so that partnership is really beneficial. Because we kind of share experiences, we probably have got experiences and expertise in different areas.' (MM-5)

'There used to be lot of specialist services and groups and support networks that I think their funding is going and I will be worried about that, that is not all we want, and then the danger would be that the generic services will do their best, but they miss things and people would not feel entirely comfortable with that.' (MM-3, with clinical role)

The funding arrangements from commissioning bodies for the voluntary sector have limited the opportunities for statutory services in engaging with small community groups. The new arrangements are reported to be through bidding processes, and BME groups, especially smaller ones, are reported to lack capacities to get money through the bidding process. This has resulted in a gap in the quality of services but also with the engagement with the community.

'They [BME community leaders] are telling me that the gap is widening now. Because people would not accept certain services because they do not trust them, and where commissioners have put the money, they do not trust them either. So this is almost a gap in terms of how we engage with different groups.' (MM-1)

The practice staff identified the absence of the support from the BME voluntary sector and also it is a challenge for them to provide culturally appropriate services in the absence of the support from a BME volunteer.

'Support from (X Asian BME VSO) is not there.' (FS-3)

'I worked with a specialist Asian service. We did a lot of joint work that does not exist anymore. So there are less specific services for us to refer people on to which are culturally appropriate'. (FS-2)

The participants identified the role of the third sector in bringing cultural understanding for the practitioners as important. However, the participants also identified that due to funding cuts this support is not as available to them in practice as it used to be in the past.

Managing workforce diversity in the organisation

Another way practitioners could get further understanding of different cultures is through having specialist BME posts in the team/service. However, it seems that this support is also not available to the practitioners. Middle management and practice staff specifically viewed these community development workers as a useful link between the service and the community. However, commissioners are no longer funding these posts. The middle management and practice staff participants found the current situation affecting provision of quality services challenging:

'If you want to disadvantage people, you know, if you take the link between statutory services and them out, we are going to have a gap.' (MM-1)

'When I was working closely with an Asian colleague, she can tell me things that will be helpful around common cultural issues for families to do with mental health issues, and I might

not have that practice now because, I do not have that advice on tap.' (FS-2)

Since the accounts of practitioners and middle managers repeatedly referred to the recent loss of specialist BME posts, I interviewed the Head of Human Resources to know if there is any targeted plan to recruit people from BME groups. The response was not encouraging.

'I am not aware that we have got any particular sort of targeted recruitment initiatives as a plan.' (SL-4)

The existing recruitment practices in the organisation test the competencies of the candidates, instead of any deliberate effort to recruit with an aim to diversify the team:

'We interview for the best person, the person who scores best against the questions we ask and appoint that way. So we do not say "oh, we have not got anyone of an African Caribbean background in our team, we need somebody", so we only, only advertise and attract people of African Caribbean origin to apply to this post, we do not do that.' (MM-4 with nursing role*)*

Even in the recruitment process, the emphasis does not seem detailed, rather only limited questions are asked to assess the cultural capability of the candidate. For example, when a team leader was asked how the cultural capability of the candidate is judged, the participant responded that candidates are asked only one scenario question about any of the BME group,

bearing in mind that the person being judged for the post would be working with diverse communities including the white majority:

'We tend to only ask one cultural question because obviously we have a range of things we have got to assess so they tend to only be, sort of like, we might ask about a Pakistani gentleman but if we are doing that there will not be for an African Caribbean person, so there will be only one question.' (FS-1)

However, having BME diversity in the team might not always be helpful. The issues of stigma within the community might influence here:

'One of the things that really interests me: for a while we knew that we were not really offering the service that we wanted to offer to Asian communities in X area, and we employed a woman to work specifically supporting families around their community needs, and we actually found a bit of naivety and what was actually interesting was that it did not work, and it did not work because that woman came from within the community, and that community then became concerned about whether or not they would be known and talked about within their community, and so there was concern about their level of shame and things like that.' (MM-5)

The participants identified that ethnic diversity in the workforce is helpful in bringing cultural understanding for the

practitioners. However, the participants also indicated that ethnic-matching may not be helpful due to the high stigma attached to mental illnesses in the Pakistani community.

Training and development

The third important way of generating cultural understanding of different BME groups in the workforce is through formal training sessions. The main training provided by the TRUST on the subject is Equality and Diversity training, which is mandatory for all the staff. Any staff member can access this training online, and they have to refresh it every three years.

Despite the fact that the TRUST has mandatory training on equality and diversity, a number of participants from middle management and the practice level considered this training unhelpful in their practice with BME service users. The practitioners are of the view that the content of the training does not provide them with an in-depth understanding of different cultures.

'In terms of training … I think it would be touched on. I do not think it goes into sufficient depth to make people confident that they would understand and even if you took the major groups.' (MM-1)

Thus, practitioners think that the training provided is not helpful in practice and through their language of compulsion (e.g. 'have to do') they indicate that they do not choose to attend the training. All the participants from the practice staff expressed non-satisfactory views about the usefulness of the

training. As the sample of the staff is from a range of professional disciplines and geographical backgrounds, this indicates the full breadth of the experiences about the Equality and Diversity training.

'Every three years you have to refresh the things like that. It is not a very kind of detailed training. It is not that it tells you in this ethnic minority these are the things you should do. It is more kind of legislative, corporative responsibility about what you need to be aware of and respect and that kinds of things and just informative really. It is not effective.' (FS-4)

Another participant from the frontline commented on the quality of equality and diversity training as:

'I do not think it [E & D training] is [helpful]. Because I actually cannot remember it (laugh). I know I did it last year. I was due to do it and I did it. And I passed it but I cannot remember what was in it as now when I am talking to you so it cannot be that helpful unless it confirms things I already know. Maybe that is the reason I cannot remember it. I have not come across any specific training for healthcare professionals in this TRUST about working with Pakistani service users specifically.' (FS-2)

'The Equality and Diversity training, I think we can do that on e-learning now which seems very tokenistic.' (FS-5)

'Equality and Diversity training gives a very basic level of understanding.' (FS-6)

'Equality and Diversity training is very boring.' (FS-7)

The possibility of understanding various cultures is also viewed as challenging:

'I think it is difficult because there are so many. And I think people with a little bit of knowledge jump to conclusions ... It is a bit worrying really, that is we should use an interpreter for specialised advice, not just jump to conclusions … especially when it gets to first, second and third generation. Then it actually is a whole mix of culture, is it not? It is not simplistic.' (MM-3, with clinical role)

'I think it [learning about different cultures] is a hard thing. It is impossible to know all the different nuances, different issues and dos and don'ts of each cultural background.' (FS-1)

One of the participants from middle management stood out as different (a negative case). Contrary to others, he/she considers that Equality and Diversity training is useful. However, when describing its usefulness, the scope of it seems limited to just making people aware of the broader policy of the organisation in relation to equality and diversity. This is ruled out by the participants from practice staff as they do not seem happy with this level of awareness; rather they expect more in-depth training on how to meet the needs of different cultural groups in their everyday practice. This also highlights the rhetoric of the clinical director.

'I think equality and diversity training is quite good. That has been a real shift over the years. I think it is a real shift in culture: what is acceptable, what is not acceptable, people's behaviour generally, that does move things forward, because the expectation changes, then the mass starts to shift and the people who are not behaving properly become more and more outliers and get pulled back into that. It is about keeping on going forward, but I do think it is good, useful.' (MM-3, with clinical role)

This raises the question for me of why generic rather than specific training? I took this question to the Head of Learning and Development. I asked about the reasons for not doing specific training; the response from this participant points to a lack of priority at the strategic level:

'It is the case of priority. I have a budget, an annual budget ... but you cannot train everyone in everything, and sometimes when we do not deliver, it is because the government says this, and local people say they want that. And we have to give what the government is saying.' (SL-5)

It could be the lack of training that result in practitioners making assumptions about BME clients. These assumptions relate to different aspects of the service users such as gender relations among a specific community, responses to illness and coping behaviours. The participants recognised that a lack of specific knowledge about ethnic background hinders their ability to meet individuals' needs.

'We may be in danger of making assumptions about certain clients, through ignorance of their individual culture … I know with a common perception of some Asian women, who perhaps focus on physical healthcare, need is often misunderstood and misinterpreted and not really understood as part of their culture. There are some assumptions that people want to speak to someone of their own culture and that is not the always the case.' (MM-4, with clinical role)

'I think assumptions can lead us to interpret certain behaviours or responses as meaning that a person is ill when they are not and getting that label. I think that happens quite a bit and just general misunderstanding, I think it can lead us to either mistrusting of people and sometimes to be frightened to relate to people to come along alongside them to try and understand people. Because you are trying to fit in, they're saying the wrong things and … making an assumption of people's needs, or wanting to be treated in a certain way when that might not be the case. I think it might lead to people not actually getting to know that individual or taking into account that person and individual needs because … it is easier to not go there really.' (FS-1)

'In fact I have just found somebody, one of my service users who is originally from Jamaica is down as Asian on RIO (electronic patient record system), and I have to change that. That is wrong. They got the name and made an assumption of it.' (FS-2)

'I think there are a lot of quite subtle prejudices and assumptions. For example, the black Caribbean men, "The big,

black dangerous stereotype" ... When I was working in X area where there were more Pakistani service users, there were some assumptions made about the way people present their symptoms or complain about them, somatise them. There were such perceptions that Pakistani people complain more, unlike a very strong English/Irish man. They never go to the doctor, they might get cancer, they do not think about it whereas a Pakistani person might complain all the time about more things. I think that was a perception.' (FS-5)

In the absence of support from the BME third sector, and also lack of diversity in the teams, the current coping practices in the organisation to address the needs of the BME communities are shared by a middle manager as:

'I think we are just having to do what we can do, just provide the care as best as we can through our own services through our own outpatients clinics. Sometimes if there is a particular need we sometimes move doctors, we sometimes try to get somebody with a particular interest from the community team, that is not always available.' (MM-3, with clinical role)

In the absence of any effective arrangements for having an understanding of cultural needs of the BME service users, the current learning practices are varied:

'On the [TRUST] intranet there is multicultural, multi-faith information and that is what most staff use. They will go on there and actually look up the information. That is one way. And so I think that is our main source of information and also

contacting where we know we have got support groups like Asian women, we ring them and ask them for information and advice or the spiritual leaders and also asking the client themselves if we can contact their relatives if they are able to communicate with information they are the main sources … I think they (staff) tend to use a lot more word of mouth, actually speaking with somebody who they know.' (FS-1)

'I would talk to any colleague that may have more experience than me, and we do have couple of Asian staff left (laugh) after the dismantling of the services, so I might seek their advice and probably Google as well (laugh), use the internet … colleagues probably [are most frequently used].' (FS-2)

'[If I want to understand about Pakistani culture] I would not go to the TRUST (laugh); maybe internet, books, family. I will just keep my ears open; I know people from Pakistan so I will ask the client actually.' (FS-7)

The method used to bring cultural understanding in the workforce is through generic equality and diversity training and a few ethnic-specific sessions. However, this intervention is not helping the staff at the frontline to provide good quality services to people of Pakistani ethnicity.

Theme-3: Perceived hindrances in bringing about organisational change and addressing BME issues

The participants across the organisation identified various hindrances to bringing about change in the organisation at the grassroots practice level.

5.3.1 Organisational hindrances

The barriers to shifting organisational culture include staff attitudes towards change, organisational history and its local context, and existing organisational culture (Powell *et al.,* 2009). In interviews, different reasons were cited by participants at different levels. Where strategic leaders identified the practitioners' resistance to change as a hindrance, participants from the managers and practitioners' categories viewed organisational culture as an important hindrance. Factors such as reduced resources and increased workloads were identified by all the participants. It appears there is a 'blame game' between different levels of the organisation.

'People do not like change; people like to do what they have always done. Stick to that routine, there are a lot of things to do, lots of demands, lots of volume and workload for people to deliver.' (SL-1)

'The problem is, it is permitted, and fashionable … we might invest in having different specialist workers [interpreters] and things like that. It costs plenty of money, but we have not got

plenty of money. They say "Oh, we do not need those people. We do not need people from the Asian population, Caribbean population, or East European population".' (MM-1)

'It is about where do you focus your time and we have got waiting lists. So we focus our time trying to do the work with the people who are referred to us. We aspire to make the service better and reaching the population we might not be serving very well is quite difficult under those circumstances. It needs to be on the list of things to do. I just do not know how we are going to do it considering the stresses at the moment.' (FS-2)

'I think wards, they are so busy and there is so much paperwork to do. There is so much risk management, regardless of ethnicity of the service user. The service user does not get enough time and attention, and individualised support.' (FS-5)

'I feel that people are tired. The nurses, they do their job very efficiently; but, are they going beyond what they can do. I do not think they are. I think they are just doing the basics. They do not feel appreciated. They feel that they are given more work … People do not have time. It is just tick box now.' (FS-7)

'OT time is limited to go to the ward to each group, it is not about time management, time is already less, and we rush in doing things.' (FS-2)

Although the strategic leaders said that they are trying to promote an open culture, and they provide good support to the practitioners, the responses from middle management and practice staff do not seem to affirm this:

'[Culture of this organisation is] not entirely open, I think there is a bit of a disconnect between the organisational ... the bigger sort of organisational structure and clinical area … when we go higher up in the organisation … there are certain things, you know, which managers do not want to hear, … they want to hear positive feedback, about meeting the targets, and they do not want to hear the reasons, why a clinical team is struggling to meet the targets. So I guess they would not want to hear that we may not be meeting the needs of the clients from ethnic minority groups … There is lot of fear around race and racial policy and … a lot of people fear that. They cannot talk openly … racism is there … There are a lot of strands of policy … a lot of policy legislations, legal framework around … racial abuse is a crime, so there are lots of things that inhibit people's speech sometimes, and speaking freely.' (MM-4, with nursing role)

'I think people, certainly from African Caribbean backgrounds, are not sure about you know some from Asian communities but they do get, I think we have got better at it but they can get misunderstood and misdiagnosed and have a certain illness label put on them, and I do not think we talk a lot about that enough and understand enough.' (FS-1)

'My immediate manager is supportive, [but] if you look at the TRUST as a whole that might not be the case so much.' (FS-5)

The research also found that the middle managers have a limited role in ensuring that practice staff is meeting the needs of BME communities; ensuring that needs of BME service users are being met is also viewed as challenging in actual practice:

'The only thing we can do is we make sure that people have the training.' (MM-1)

'I guess through supporting policies and procedures of the organisation, but I understand that is what you are going to come to, what that means in practice is, very, very difficult, so I guess I may be approached to support staff individually if they are struggling to, say, access interpreters, or if there are issues around language and diet, promote things through the Essence of Care standards.' (MM-4, with nursing role)

It is pertinent to note that both the middle management and the frontline practitioners have identified a number of challenges in addressing BME issues. This is in contrast to the perspective of strategic leaders who seem to be positive and aspirational, and do not identify issues within the organisation.

5.3.2 Community-related hindrances

Participants identified a few hindrances which relate to the Pakistani community. These hindrances include mental health stigma, complex family structure and its functioning, and unreasonable expectations.

'There are so many stigmas around mental health despite it affecting one in four people in this country and it is going up as well. And we actually know that in certain communities there are no words in their languages, first language, there are no words for mental illness. So sometime there is a double stigma in certain communities; South Asian community would be an example of that.' (SL-1)

'There are still some issues where we know that because of family structures, Muslim culture, that some issues are not discussed and talked about but also the way family works in terms of looking after individuals within family, this is something traditionally Scottish as well. Where you do not want other services to get involved, family will be able to look after that individual, but the problem is when it becomes too much, carers of that person often end up having issues such as depression or mental health issues. So for us, it is a bit of a problem getting people involved. There is also an understanding that, that is a cultural issue.' (SL-6)

'It is often quite complex family dynamics … So it can be quite difficult meeting everybody's desires because the family might want something which is quite different from what the service user wants, and there may be unrealistic expectations. So that can be quite difficult.' (FS-2)

It was felt that the community-related barriers are not just related to stigma and culturally specific expectations of services, but the organisation also struggles to engage with local communities because of the internal dynamics of the community. The quote below, from a strategic leader,

identified issues in engaging with the local community. It indicates that funding is not the only challenge for the organisation to getting engaged with local community groups. There is some kind of internal politics involved as well:

'In the past, organisationally we have built partnerships with particular third sector organisations and because we built with these organisations, these organisations here would not talk to us ... in the past that element of our cultural sensitivity has not been tuned in … [so] getting a neutral and clear landscape, it is very, very difficult, very difficult indeed. Who you go to. How you find a neutral route.' (SL-2)

'I have done some work, for example, teaching with the Sikh centre around drugs and things like that … you try to talk about things breaking down, stigma and recovery … and I think within those communities, the sense that actually perhaps recovery and reintegration into the Sikh community, or whatever is more difficult, because you almost get shunned by that community because of the shame associated with it. So it is very difficult to have the same sort of conversation when you are with carers or families, that you might have with other families, be they Polish families, English families, whatever … it is something about the tight nature of those communities, that sometimes can appear to be exclusive'. (MM-5)

The prevalence of stigma attached to mental illnesses within minority ethnic groups is identified as a main barrier to providing good quality mental health services. Why there is more mental illness stigma in the minority ethnic groups and

less among the white community is in itself an interesting phenomenon to study.

5.3.3 Racist attitudes

People at the strategic level talked about racism, but they said that there used to be racism in the workforce in the past, and it has gone now and also that racism is completely not tolerated in the organisation. However, people at the middle and practice level have different views. They mentioned the existence of racism both at the staff and the population level. As the nature of this racism is hidden and subtle, the participants found it hard to tackle:

'You can never be 100 % sure because I will always accept that we do have people that for whatever reasons do not offer the necessary requirements in terms of all people being treated equal.' (MM-1)

'Racism does exist; it exists in our staff group. I am naive to think that it is not … I am sure it probably does, but in a hidden way and certainly racism within the community, so the racism within our client population.' (MM-4, with nursing role)

'I think people certainly from African Caribbean backgrounds are not sure about, you know, some from Asian communities but they do get, I think we have got better at it but they can get misunderstood and misdiagnosed and have certain illness labels put on them … I think there is, you know, racial abuse. Certain service users are abusive racially towards our staff and that is not tackled particularly … I think that is still happening.

So I think those sorts of subtle bits of racism; that is going on.' (FS-1)

'You know you do get some professionals who look down on the clients. People do think about status.' (FS-7)

'There was a request, the patient was on the ward here and wanted a Muslim doctor, a Muslim doctor and you know what my feelings are about that. I found that this is rather an unreasonable request, because religion should not really be a criterion for choosing your doctors.' (FS-4)

A racist attitude is something which is inside a person, and is not overt; hence it is difficult to tackle. It is seen as an individual act of meanness, rather than systematic (Tatum, 1992). Therefore, in the long-run, racist attitudes may not be addressed through policies and guidelines alone, rather that more education may be needed to win the hearts and minds of staff to eradicate racism from practice.

5.3.4 Race being nobody's priority

This was an interesting category which identified that race does not seem to be on any agenda when it comes to doing something real and meaningful. This is reflected from the responses of participants across the three levels of the organisation. The views are expressed by those participants who hold key responsibilities in their role in relation to race. So, if things are working that way with these participants, it is likely that this is passed down to the other people who look to them for leadership and support. For example, the response

below from a participant who is involved in learning and development activities in the organisation clearly identified race as not being a priority.

The quote below from a strategic leader involved in recruitment indicates the priority in terms of the future, but it also shows that until now there is no such thinking or planning in the organisation:

'[We need] to think about how the population will change. How we are to shape the workforce that will be able to respond and reflect that; but also, is it going to give us some recruitment issues? Is that all the communities that are bringing up in the local geographical area? Are those people who will be from a whole host of different ethnic and cultural backgrounds, will those people come and work within an NHS mental health TRUST? I do not know the answer to that.' (SL-4)

'What is hindering? I suppose it is competing forces, because money is too tight, you know, that the NHS is no different to anybody else and, you know, we need to take 20 billion out of the kitty and I suppose where does managing the needs of people from different cultural background sit on the agenda? They would say we have appropriate investment but I would say there is a lack of investment.' (MM-1)

'It's made me think, that I am not paying as much attention to this, having a conversation with you today, has made me, want to go on the wards I am responsible for, find out exactly

how many clients we have got, find out what we are doing specifically for those clients, I have not got any specific routine, it is more a kind of global approach, I think, I probably should do so'. (MM-4, with nursing role)

'You are making me think now, maybe we should be asking our equality and diversity committees to actually be collecting some information, and then you can feed up, so that when you ask me how we are doing, I can know that bit more. I do not know; I do not have data to hand to know that, so that is sort of locally we do that, through governance. I think that would be … it is in any way … it just does not report much back, I chair and say anything from equality and diversity on agenda, and they would say no … they do not put anything forward for it.' (MM-3, with clinical role)

'I think there is nothing like being able to talk to somebody, to whom you feel comfortable with to ask questions and say, you know, I am sorry, I really do not know this, can I just ask you … which is making me think that actually a list of staff you know who are of different cultures and faiths who are willing to be emailed or rung up to ask to act as a sort of like a verbal resource, would probably be very helpful.' (FS-1)

'There were a number of community development workers just lost because of the cuts. It is a shame that happened. May be it is a signal that it [addressing ethnic disparities] is not given sufficient priority.' (FS-5)

Although the strategic leaders above indicated that race is an important issue for them, here it does not appear to be like that. Race does not seem to be a priority in terms of allocating resources, i.e. financial and human. It is these two resources which have the potential to be the greatest influence in determining actions and practices.

Theme 4: Organisational change

5.4.1 Perceived organisational change on race

This theme presents participants' responses relating to perceived change in the organisation and daily practice of the practitioners in relation to race.

It seems that there are variations in the perceptions of the participants with regard to change in organisation and practice in responding to the mental health needs of BME communities. The strategic leaders seem to be claiming that positive change has occurred in the workforce as well as the service provision components of the race equality policy.

The Chief Executive stated that when he joined the organisation, there was racism and under-representation of BME groups in the workforce.

'I noticed when I came here, a few things, and a sort of racism. I did not like this for my staff. I felt we were under-representing certain groups in our workforce.'(SL-1)

Similarly he acknowledged the negative perceptions and experiences of local BME groups in the mental health services provided by the TRUST.

'I have complaints about some of the services from the BME communities when I came here that interest some of the services, X area in particular. So we had some real issues; … I have a lot of feedback … that the BME community is not trusting both the Asian, South Asian community and the established African Caribbean Communities, both saying we do not quite know what happens when somebody gets in touch with the services. Do you section more people from a Black background? Do you section them to keep them in longer? What happens to them? Do they have culturally sensitive services offered? And the answers were not great, when I first came here. I think we were very hard on that.'(SL-1)

Comparing the above with the existing situation on race, the Chief Executive stated that now there is increased diversity in the workforce at different levels, and the initiatives taken are nationally recognised.

'I noticed in induction sessions that there is more difference in the room. If you look at our staff we have more people claiming themselves to be from BME communities, different communities in the workforce. I promoted various junior, middle managers into more senior management positions through a BME mentoring scheme which again has been nationally commended.'(SL-1)

The Chief Executive speaks on behalf of strategic leaders in claiming that currently the organisation has a good reputation and is culturally sensitive. This claim is seen to be confirmed by a high rating on the externally judged Stonewall Index.

'[The Stonewall index] is really important to me because it is a great measure. It is not about gay and lesbian issues, it is about cultural sensitivity and I have been doing this about three or four years now and we have moved you now right into the top 15 of the Stonewall index and that is very challenging index, very systematic as well.'(SL-1)

However, the above claims of the strategic leader on cultural sensitivity and diversity in the workforce are underplayed by the middle management and practitioners, when sharing their perceptions about the quality of the training and lack of diversity in their team.

'I think we do not understand the sufficient depth, the depth of diversity across cultures and the communities we serve I think, I think it is just played at that a bit.(MM-1)

'All the staff are white, middle class, one man as far as OT staff in my team. So it is not ideal … because it does not reflect the population that we serve.'(FS-2)

The organisational change claimed by the strategic leaders is found in terms of enhanced workforce diversity, increased cultural competency in the workforce, promotion of BME background staff into leadership positions and addressing

racism. However, those providing management and practice observe that for these same indicators, the performance of the TRUST is not great.

5.4.2 Perceived quality of services

In terms of quality of services being provided to BME clients, there are again opposing views among different levels of the organisation. The participants at the strategic level appear to rate the current quality of the services very highly. However, the majority of the participants from middle management and the practice staff group had a different view. The participants at the strategic level claimed:

'We have been audited by the Care Quality Commission, and these reports are saying as well that we are providing really good services. So I am very confident that we are providing very high quality patient centred services.'(SL-6)

'We have a lot of … really affirming good feedback. It is a very high quality equitable service. It is a very sensitive service as well … I would not say that people from a BME background would find difficulty in engaging with our services meaningfully. There is no blockade there.'(SL-3)

However, the perception of the middle level of management is different. Their views indicate the various barriers which BME service users are still facing

'We have to accept that it is particularly difficult for some groups of people to engage with statutory services. It is very

difficult for some young groups to engage with statutory services, and they do not see trust there. They do not feel safe with them. They often see mental health services almost as an extension of the police … If somebody from a group has got some mistrust and they see how it is managed, is to get hold of them and, you know, something is missing somewhere, is it not?'(MM-1)

'I think it is complex. I think the idea of providing to diverse communities is not quite as simple and straight forward as some people think.' (MM-5)

'What that [race equality] means in practice is very, very difficult. It [race equality] is something that I think there is a gap and can easily be issues around; race equality can easily be missed.' (MM-4, with nursing role)

However, one of the participants from middle management was of the view that the organisation provides good quality services to BME people. The participant seems to contradict what she/he said earlier in the interview. But in her view-point on the quality of the services, it is not based on any evidence, rather upon guessing, and she seems to be struggling in responding to the question on rating of current quality of the services.

'I think we are just having to do what we can do, just provide the care as best as we can through our own services, through our own outpatient clinics.' (MM-3, with clinical role)

'Umm ..... I ..... I think ... I think we ... we meet that, we do, I do not have [real?] concern that we are not meeting it. It is an interesting question. I am trying to think, are there any audits or studies or pieces of work to prove that? But we certainly do not get many complaints to suggest, or service user's feedback to suggest that we are not being sensitive, and we are not meeting needs.... yeah, that is as far as I know, I guess, I do not know everything that is going on in all services. I have certainly never seen any complaints around that.' (MM-3, with clinical role)

However, most of the participants from the practice level endorsed the view that the current quality of the services for BME is poor.

'Right …… (Long pause) ……. I think it's …… em ……. I think it [quality of service] is patchy. I do not think it is consistent. I think some areas have really good services and for certain individuals, but I think we have still got more we could do in terms of understanding how to make our services more accessible and more user friendly to different faiths and cultural backgrounds.' (FS-1)

Stating reasons for being not able to provide good quality service the above participant said:

'I do not think we necessarily understand how our services are perceived and received by people from a range of cultural backgrounds. I think we need that information, so we can be more accessible; I think we are not good at it in generally

thinking about how we, how we make our services more attractive to a range of different cultures.' (FS-1)

'We probably are not providing the best service we could be.' (FS-2)

A good quality service is one which meets the needs and expectations of the user. Quality of service in a healthcare context as described by the Donabedian framework consists of structural, processes and outcomes (Donabedian, 2005). In the context of this research it seems that managers and service level practitioners lack trust in the quality of services provided by the TRUST to people from BME backgrounds.

5.4.3 Perceptions of overall performance to organisation change on race

There was unanimous agreement from strategic leaders that they are not claiming that the organisation has addressed all race issues, rather it is an on-going work, but the organisation has definitely made some progress on it. They appeared to be somewhat tentative about the rhetoric they shared with regard to achievements on race issues.

'I am not saying it is perfect but we have moved forward … you can see some of the advancements we have made. We track them in our figures. I am trying really hard to do it. But still there is so much more to do. There are certain examples; I think we can put on the table.' (SL-1)

'We are not perfect. We have still got a lot of work to do. And I think that is one of the important things that we are realising; much more we can do … Unfortunately we cannot put a cross on race equality and say that we have done that because that is not the case.' (SL-6)

One of the participants from the middle management also seems to endorse what the strategic leaders have to say on the organisational achievements on race. There is similarity between this middle manager and the people at the strategic level. This is what was said:

'You can never say that there is no inequity and unawareness; it is a journey, is it not, if you constantly challenge? It is ongoing.' (MM-3, with clinical role)

The above view is contrasted by a middle manager and a staff participant in terms of actual change in practice on the ground:

'Lots and lots of work has been done but I am not sure how much of it is in the thinking of everybody in terms of daily positions. It will be a surprise if nurses come on duty as part of hand over; they would say Mrs so and so, she is of Pakistani origin etc. etc. Her special needs of the day are … when we talk about where are we in terms of our direction of travel. We are probably very good organisationally and nationally saying we recognise this and that but in actual fact how much of that do we put into practice.' (MM-1)

Another participant from the practice staff also seems pessimistic about the change in actual practice:

'A few years ago, you know the inquiry into the death of David Bennet; there were a whole raft of recommendations that came out. We all thought that it is going to be a very big issue, and create lot of change in practice in the TRUST … It did not change things very much; on paper and on literature … the TRUST pronounced all around the messages I think around the BME agenda, but also around LGBT agenda. We got Stonewall and so on, but I think the TRUST is good sometimes in making things on paper, but it does not always translate to the practice on the ground.' (FS-5)

The strategic leaders are projecting that the TRUST has achieved much on addressing race issues; however, participants from the middle management and practice staff are pessimistic about the real change on the ground.

Theme 5: Organisational culture and its role in organisational change in providing person-centred care to BME service users

This theme is based on categories around the conceptualisation of organisational culture, the organisational culture being promoted, and the interpretation of existing culture by the participants. This theme is important as it helps in explaining the facilitators and barriers to providing person-centred care to BME service users.

5.5.1 Defining the organisational culture concept

There are many definitions of organisational culture in the literature. Most of the definitions include concepts such as values, beliefs and norms amongst staff. However, I asked this question of participants at the top and middle level to see how they define this concept, because it is the strategic leaders who play a significant role in setting the organisational culture. The participants defined culture as the 'way of doing things', and conceptualising organisational culture as a metaphor, 'what we stand for', 'deep rooted staff values', and attitudes. All these dimensions and elements are also included in various definitions given in the literature. This endorsed the view given in the literature that there is no single definition of organisational culture. Here is what participants at different levels said about the organisational culture:

'The way you do things around here; and sometimes it is the way you should do things around here.' (SL-1)

'It really is the tone of what we want, kind of stand for and provide … [it] provides a benchmark for what we believe as an organisation.' (SL-3)

'I think that there is a lot about staff attitude and values … deeply embedded in the system and have been for many, many years.' (FS-1)

5.5.2 Organisational culture being promoted

People at the strategic level shared that they are promoting an organisational culture which encourages 'openness',

'innovation' and 'excellence' for the staff, and it is 'safe; and 'sensitive' to the individual's needs.

'This TRUST is not about ticking boxes. This TRUST is about making real meaningful change; the culture of this organisation is about making sure that BME patients get their needs met; for me the organisational culture is one that puts the patient at the centre of everything and that patient is very much inclusive of BME and Pakistani patients, their particular needs and everything this organisation involves around that and the leadership team model that behaviour; they practice what they preach.' (SL-6)

5.5.3 Interpretation of existing culture

These claims that the organisation is very much practical and open were not confirmed by the participants at the middle and practice level.

'We are probably very good organisationally … saying we recognise this and that but in actual fact how much of that we put into practice?' (MM-1)

The views below from the practice staff indicate that the organisational culture is not conducive to being open and they do not feel well supported by higher management.

'I think people are uncomfortable to talk about it and I think they are frightened of upsetting their colleagues. They are frightened of getting isolated themselves and they become the person who is persecuted … I might just be going to be seen

as a trouble maker, embarrassment, feeling that you are a bit stupid; you are ignorant, because you do not know these things and you should do those sorts of reasons.' (FS-1)

In response to the question about whether practice staff felt supported by higher management, the response was:

'I think, the Chief Executive, his photographs appear everywhere, and he talks up the organisation. The organisation has a good reputation. But I do not know, I think there is a gap between the frontline staff and the senior management, the Directors, the General Manager, Directors, and the Chief Executive. I do not think they know how quite hard it is at the moment.' (FS-2)

'On paper and on literature those things, the TRUST pronounces all around the messages. I think around the BME agenda but also around the LGBT agenda. We got Stonewall and so on. But I think the TRUST is good sometimes in making things on paper, but it does not always translate to the practice on the ground. And I think the culture of the TRUST is becoming very much corporate like, and it is losing touch with public service values somehow in doing that. There is a lot more attention paid to the business plan and bids and tenders and policies on the window dressing, rather than caring for the people on the ground, if you like on the everyday level.' (FS-5)

It is also found that there is a lack of trust among those higher in the organisation and people working at the frontline. There

is a view from practice staff that those higher up are doing micro-management.

'One example of that is the senior admin staff used to do all the inputting of sickness, annual leave on an electronic staff record. Now only managers are allowed to do that and you just feel you like that no one is trusted by the senior management. So they want to give power more and more to the managers because they do not trust anyone else to do the job. It does not lead to much faith in the senior management really that they do not feel trusted.' (FS-2)

'I do not think managers have personal experience of some of those things. I know they are not really supposed to … We know what box to tick … personally when I look at the people I worked with, I do not say that my colleagues are not working hard I think, sometimes morale can be low … They do not feel appreciated. They feel that they are given more work … people find it hard to work with [BME] … People do not have time. It is just tick box now.' (FS-7)

Knowing how organisational culture influences the way the TRUST is responding to the needs of Pakistani service users is one of the main research questions. Keeping this in view, it seems that there is a corporate style culture being promoted in the TRUST, and there is much emphasis on cost-cutting and less emphasis is given to developing a culture which fosters good quality services for members of Pakistani ethnicity. This type of culture is not conducive for maximising patient satisfaction (Bellou, 2008).

Theme 6: Facilitators and suggestions for change and delivering a good quality service

This theme is based on the categories of facilitators which the participants have identified are helpful, or could be helpful if available.

5.6.1 Individual commitment

The participants from all levels of the organisation described their personal commitment to race as an important factor in helping to provide satisfactory services. This commitment is about promoting values of equality and diversity, and recognising that there are differences among the communities:

'My own experience of seeing people feeling indignity because of racism, because I find it really alarming that individuals are not always treated as human beings because of the colour of their skin. I feel very angry.' (SL-6)

'I attached lot of value to treating people with dignity and respect and treating people equally and non-judgementally and trying to help people in a very pragmatic and humane way.' (FS-5)

'If it is something we truly believe in, then things will change, practice will change, our relationship with clients will change, if you are treating somebody truly as you would like to be treated, not just saying it, it sounds good, but you really mean it. You are treating that person as an individual you think, this

can be my brother, this can be my sister you know if you do have brothers and sisters in mental health service, how you would want to be spoken to. You do not want them to be looked down on, frowned upon, treated like second class citizens; you would not want to be thinking that this person is loved by somebody. They have worries and fears and joys like we do. I think once we start looking and treating people differently then things will change, definitely.' (FS-7)

5.6.2 Reflecting the local population in the workforce

Participants from both the middle management and practice level identified that if the service has representation of the local population in their workforce, it can be helpful in many ways. The presence of a team member from that community can help when addressing language and cultural barriers. Workforce diversity may be achieved proactively through positive discrimination.

'I do not think that policy actually makes it clear that you know sometimes positive discrimination is needed … when you are recruiting you need someone from a certain ethnic background or male or female you can actually recruit just for that group of people. But mostly you cannot do that. So I do not think the policy actually covers it. You know in fact we might need to positively discriminate at times.' (FS-1)

'I actually think that we do have to recognise and I am not actually saying that we can deliver for every group. We know that because we can get the data. We know roughly how many people from an African Caribbean background, we know how many people from the African continent. We know how

many from the Asian continent and we can break that down to Pakistani, Bangladeshi, Indian, Ghanaian whatever, we know because we collect that data to give or take a percent, and there will be some groups that there is no way we could provide specialist services for but we do have large populations where we should have some specialist workers.' (MM-1)

'If you have got a mixture of diverse, if you got diversity in your staff team, that really, really helps, because obviously, you got both understanding within the staff team, what it like to be a minority ethnic group and, and also if you happen to have a client of the same ethnic minority group then you have got some insider knowledge into that culture, first-hand expertise, and also, it is modelling the diversity in our communities and, promoting race equality in that way.' (MM-4, with nursing role)

'I think probably kind of reflecting what is the mixture of local population with some kind of acknowledgement and maybe having some workforce specifically who are from that background. And with that knowledge, who would have the part of the role of being consultancy or having to work with people from a given background … I think some may be identified posts, roles, where these people are, kind of consulting and supporting generic workers with regard to those issues and I do not think that more legislation is the answer (laugh).' (FS-4)

'I think having colleagues from those communities and our staff should reflect as best as they can the communities we serve.' (FS-5)

5.6.3 Effective training and learning opportunities on race

Participants from the middle and practice level groups specifically view the provision of effective training to staff as a way to help staff to meet the needs of BME service users. The participants identified various effective methodologies and contents that can be helpful in achieving the desired goals. These suggestions include: examples of practices that help; more ethnic specific modules and practical tips; written material on different cultures; face to face training; opportunities of hands-on training and mixing with the community, and being trained by Pakistani service users and colleagues.

'Maybe regular kinds of examples of practice that helps; that people can relate to, I know, I mean what is really inspiring and helps clinicians a lot is learning from lived experience. We try to promote across services so one of the things that is helpful is if we hear from people who use services from minority ethnic groups, if they talk about their experiences, it has a much better impact on staff, they tend to remember then and it is related to an actual individual person.' (MM-4, with nursing role)

'Rather than what we have, "you must do this and this and the other", more modules on different and main ethnic minority which are relevant in current phases; for example, in this area

we have some people who recently came from Sudan, or Somalia, I think I would not know much about what their history is, what their situation, so I think that kind of quick response to, might be useful, you kind of understand where these people come from and what the culture is. Obviously on a private level reading about the culture, that does help, but not everybody has a kind of interest to do so.' (FS-4)

'A few years ago there was a poster calendar with lots of religious festivals, faith groups on it, you do not need to refer to it in practice, and it was a good way of highlighting diversity … you learn about their culture, sometimes by looking at everyday life festivals and those kinds of things … and face-to-face training.' (FS-5)

'If somebody comes and works with us, maybe we can go out, maybe visit a [Pakistani] family for a day, have a meal with them. Or visit a mosque, or whatever, that is how I would learn – hands-on, and mixing with the community.' (FS-7)

'Maybe we need to do something trying to facilitate colleagues who come from diverse communities being able to bring their community's experiences, their own experiences to challenge.' (MM-5)

Having some material that can be circulated to the different units, on like a booklet on prayer, place of worship, dress, diet, cultural practices like the main headings for each different ethnic group, so when you have a person admitted to the unit, you can quickly refer to this book, and then you have

a superficial understanding of that person's cultural needs which can then, once talking to that person, inform the care you give, and we can write it down in the care plan. So that not only you know about it but everybody who comes across that person will then have a detailed care plan of what this person needs and they do not have to constantly explain them.' (FS-6)

5.6.4 Thinking strategically

The need to think and plan strategically and in a long-term way is also identified in a way that can be helpful in meeting the needs of BME communities:

'From an employment perspective, I think that actually, some of the things that we need to do are to look out to our data, look at what it is telling us, understand our workforce better in terms of the changing face of some of our communities and how that may impact on the changing face of some of our workforce … I think we need to think about what that means strategically then for our work force and how we need to reflect back.' (SL-4)

'A puppy is not just for Christmas, this community is here and here to stay and you have to invest; it may look expensive on Monday, but if you keep somebody out of hospital because of that intervention by Friday it is cheap.' (MM-1)

5.6.5 Research evidence

Participants at various levels of the organisation stated that scientific research, data and hard facts can be useful in

improving services for the BME service users. This data can be used as a form of feedback mechanism for improving existing services as well as bringing some new changes.

'I am pleased you are researching it; I will be very pleased to know what else we could do from your research'. (SL-1)

'It is great that you are doing research. That is a big influence. We talked about national policy and everything else. It will be nice to listen to your empirical research as opposed to political research (laugh). So I think the fact that this process is taking place is really affirming.' (SL-3)

'If you were to come to me next week and said the population of a Pakistani background need this and this in terms of best, I would say give me some data, let us have look on this and I will be more happy to take this to commissioners and say we need that and we start to fight to get it.' (MM-1)

'I think we should probably have regular feedback and research into, in specific clients from minority ethnic groups, like we have this XX organisation, but actually their role is of white British nationality, I think maybe we should have some specific work that is done annually or something to say, are we meeting the needs of patients from minority ethnic groups?' (MM-4, with nursing role)

'I do not think we understand why we are not doing it well enough and in order to know what changes need to be made. So I think we need help with that, and I think we need help

with what we need to do differently really. I think it is a lot about having more information … there is no point in just saying there needs to be a cultural change without defining why and what we need to do about it … why would a Muslim gentleman or a Hindu want to come into our services? What will make them feel safe? … I think we need to know that.' (FS-1)

It is pertinent to mention that different policy and research documents have also identified the need for undertaking research on ethnicity and mental health to inform better practice (Department of Health, 2011; Chorlton *et al*., 2012; Cooper *et al*., 2013)

5.6.6 Individual staff level cultural sensitivity

Staff participants suggested that they need to be sensitive with their communications and with eating and dressing while working with BME service users. The quote below specifically seems helpful when working with the Pakistanis service users:

'For a lot of people their faith is part of how they define themselves as a person, it is a large part of their identity. When they refer to themselves as a person their culture, their upbringing, their faith, their way of worship, their way of life is a large part of who they are as a person and to discard that or to gloss over it would be to be disrespectful to a large part of who they are. If you are expecting them to give you respect as a professional, then it is only fair that you should give them back the respect they deserve from the background they come from though that may be markedly different where you come from and you may have no prior knowledge of it.' (FS-6)

'I think you have to be sensitive, for example, with Muslim subjects to talk about sexual issues. You know in England, it is open and everybody talks about who they do what with and what have you and obviously, you know in other countries this is not kind of open and easy to talk about so I think you need to be sensitive when you start exploring and be led by a patient because these are much more sensitive issues. Again in some cultures people are more likely to complain of more kind of physical symptoms rather than talking "I am depressed I am this and this", because it is a different way of expressing distress, I think you need to be aware of those differences.' (FS-4)

'I think I am right in thinking that Muslims do not eat pork and meat from pigs and other things and it will be quite disrespectful. I am speaking as a vegan. I do not eat any animal products. If someone brings a bacon sandwich I will be a little bit upset.' (FS-5)

'[When meeting a Pakistani client] I probably would be more conscious of what I was wearing … because I would not want to disrespect their beliefs and offend them … I would be mindful that I am not really crude in what I say. I do not swear and things like that … I think I will be careful even cracking a joke, you know probably very careful and obviously the religion ... and you have to be careful of what you share really, even your own beliefs because I can see this person can take things to heart and get upset and affecting his mental health. So you have to be very mindful even if people want to ask about your faith.' (FS-7)

5.6.7 Diversity in the environment of the organisation

Physical features, such as buildings and their décor are found to be an important element in quality mental healthcare (Lovell, 1995). This research also found the importance of making the outlook of the organisation match with diverse cultures and service users.

'I always think that the way you look at our service, so do you use images of diverse range of people in the literature you provide? Do you have images in your clinics, in the room, some of the offices you use that are representative of the diverse range of services that you are providing?' (MM-5)

5.6.8 Flexible practice

Participants from the managerial and practice staff categories suggested having flexible practice in order to address the needs of BME patients. This flexibility relates to budgets and flexibility in assessment.

'[We need] flexible budgets, so you can access resources if you need to, if you need specialist equipment for somebody to meet the cultural needs of that client.' (MM-4, with nursing role)

'I think trying to make services more humanitarian, more flexible … I think sometime when assessing people, the assessment tools are not the important thing. Sometimes it is the human context and understanding and sometimes there are very simple practical things that you can do … There is not a box in assessment form about that.' (FS-5)

5.6.9 Having an individualistic approach

It is observed that avoiding generalisations about different communities is also important. It is suggested that instead of having a generalised approach, there is a need to have a person-centred and trans-cultural approach in understanding service users. It is also suggested that things may be improved if the team leader discusses the needs of individual clients and the ways of addressing them in supervision sessions.

'It is like saying all black people are same, but they are not, are they? You cannot just say all Asians are the same, you cannot just say, Pakistanis and Indians are the same. They are very different. It is really looking to that person, asking that individual, if they are willing to share little bit more.' (FS-7)

'I did trans-cultural issues if you like. I think it was important to have a holistic understanding of her [Pakistani service user] faith, beliefs and so on.' (FS-5)

'You can take everybody as an individual. Every single person as an individual and treat every case on a case-by-case basis … It should be [useful for recovery]. You should take everybody as an individual, no matter what their background.' (FS-2)

'I do not think it works to just to give people the policies and say "read" and expect them to just do it … We [team leaders]

have to sort of bring into life and live and breathe it. So when we are discussing clients, individual clients, we will discuss what their particular cultural needs might be? Do we need to get information from somewhere? Where is that going to be and we think about when we are developing services, you know are they going to be appropriate for a range of people. You also think when you are guiding and supervising about individuals'. (FS-1)

'In my experience there are different ways people can worship within the same faith; not everybody will embrace all the aspects of that faith. Like they may have a mixed ethnic upbringing, like they may have a British mother and the Pakistani father for example, a mixed cultural upbringing, and so they will have a very strong affinity with the part of the Pakistani faith for example, but they may also have important Church of England practices that they need to fulfil. And to make sure we embrace that and do not neglect a part of that faith.' (FS-6)

5.6.10 Using an educational approach to manage mental health

There is growing evidence to suggest that using an educational approach to manage mental health issues is useful. Following these evidences, the organisation had a recent intervention about a year before. This intervention is known as a 'Recovery College'. I interviewed the Manager of the college, and here I present the approach being used in this college, the challenges it has faced and the way forward from the perspective of the manager of this college.

Explaining the approach underpinning the recovery college, the manager described it as:

'I think in our model people work with us. And then deliver with … even though we have different backgrounds. So it is a very integrated way of working … we hope that the way we co-produce the courses, these are accessible. We have learning support. So each student will tell us what is needed. If the language is difficult or anything to do with their culture would impact on their study, they would talk to us, and tell us what would be helpful and we will support those learning needs they have identified.' (MM-6)

Further detailing the approach and methods of the working of the college, the manager stated:

'We do co-production and we would allow people to be the expert, that is, integral to a recovery college model. We do not see the professionals as being the experts. We see the individuals, and therefore the communities, to be the experts … It is like working with people … We are led by what would be helpful. What people are telling us is helpful … we do not think that "oh I think this would be a good course", and I design it, and I know what is the best. We automatically have a default setting of saying, "what do you think would be helpful?" Here is the TRUST expert in that area, here is some external expert, here is some research, let us work and design something together. You may call it our mission statement, or the way we work.' (MM-6)

Although the approach seems appropriate and in parallel to the current policy framework, the manager identified a few important challenges while working with people of diverse cultural and language background. In the words of the manager the challenges are:

'The first one is what people think about the Recovery College concept; whether they would like to come. We need to make sure that the concept is understood by the diverse group. Another challenge would be that once we have opened the dialogue with people and listening to what people might want, the challenge will be finding relevant people to produce the course, co-produce the course … finding some students to come and work with us because courses have to be co-produced. The challenge would be whether people would be interested to do that, because they might say, you should know why you are asking me; and then how adequately we advertised the college to communities and faith groups.' (MM-6)

The manager identified various future goals for the college in relation to BME communities as:

'Our future goal is to talk to the community, and know whether or not an educational approach to managing mental health as a part of a recovery journey would be helpful, and therefore, what would the curriculum look like, what the subject matter looks like, what people would like to learn about? And then going back and co-producing along those communities. That is very much on our agenda.' (MM-6)

Most of the suggestions made by the participants here are part of the proposed strategy for organisational change for the TRUST.

PART II: FINDINGS FROM PAKISTANI COMMUNITY MEMBERS' DATA

This data is analysed through a narrative analysis approach. The theoretical framework through which the data is analysed is social identity in the mental health domain/context. Thus, the data is presented in terms of a general summary followed by an analysis of participants' perceptions and beliefs about how mental illnesses are identified, along with the sort of help they (and their community) prefer and how they (and their community) access help for mental health problems. The final section of each participant summary relates to their social identity in relation to mental illnesses. In total, eight interviews are included. Pseudo-names of the interviewees are used to hide their original identity.

Participant -1

Summary

Tanzeela is 40 years old and of Mirpuri origin. She was born, brought up and educated in the UK to degree level. She has experience of working with a BME support organisation. She says that in the Pakistani community, there is a belief that there is 'no such thing as mental health problems', and people do not like to talk about it because of the stigma associated with diagnosis. She thinks that in the Pakistani community mental illness is associated with black magic and other supernatural forces. She perceives that there are variations between the generations in perceptions and responses to mental illnesses. The first generation is more likely to seek support outside the health service, compared with the 2nd and 3rd generations because of education and assimilation into the

host society, where they believe in more medical explanations. She is pessimistic about first generation Pakistani immigrants changing their ways. She observed problems of delay in help-seeking among the Pakistani community with mental health problems. She herself experienced post-natal depression. In contrast to her siblings, she prefers to accept medical explanations. She has suggested to the community that mixing an alternative route with a medical route can be more beneficial for the service user. She considers most of the Muslim holy people fraudulent, and only a few are genuine, who are gifted by God and are pious. She thinks that staff in the NHS are very supportive. However, they need an understanding of Pakistani culture through lived experiences. She also recommends having more staff from a Pakistani background in the local TRUST.

Analysis

Perceptions of mental illness in the Pakistani community:

Stigma

Tanzeela observed that in the Pakistani community, people do not consider mental health problems to be an illness, and it is highly stigmatised. She observed that people associate mental health issues with supernatural beings. She used the category of ' Asian' ,'people' and 'they' to discursively position members of Pakistani ethnicity distinct from others, and herself, and who hold different views about mental illnesses. As such she constructs her identity as a more contemporary Pakistani, not bound by traditional views and values.

'There is no such thing as mental health within the Asian community. People does not like to talk about mental health.

'People think it is shameful thing to ask for help, and for other people to find out about it, even to talk about it openly.'

'They feel that if there is a problem then it is because somebody else has done black magic on the family.'

Another issue which Tanzeela has observed among the Asian community is that they socially exclude the mentally ill. In social identity terms, this means that mentally ill people are categorised as 'out-group' members when it comes to developing relationships with them. There is a perception that 'if anybody goes and sits with them or if anyone has a conversation, maybe they are going to catch the same disease'. She thinks that this kind of perception is more prevalent in the older generation, and the comments made by them might be:

'Oh do not talk to that person, because they are mad, they do not know anything.'

In contrast to the above, Tanzeela positions herself as sympathetic towards mentally ill people:

'I really, really do take my heart to the family who has to live with somebody like that. Who has got mental health issues and especially for someone who suffers from psychotic

episodes, and especially children growing up in a household like that, it can be really, really difficult.'

Temporally, she observed that a lot of progress has been made with regard to addressing mental health issues, but even today *'some people fear for the fact that they are going to be labelled and therefore, do not want to talk about it'*. She identified that in the past, there was a perception among Pakistani people that if you are mentally ill then '*You are going to be locked in a mad house. Because you are mad and that is it'.*

She identified that there are generational differences among Pakistani community members regarding perceptions of mental illnesses. She said that in her parents' generation, causes of mental illnesses are not well understood, and causes of these illnesses are believed to lie in supernatural things like magic:

'*Say for example if my mother is not well. Somebody comes around or friend of her comes around. And she just said "oh I am feeling a bit low. I am feeling bit down". Then it is a case of "oh well so and so went to go and see this person and they gave him some stuff to take. And you take that and you will be all right". No one talks about "oh how you are feeling? Why you are feeling like this? Have you sought help from the doctor? How long this has been going on for?" They do not go into depth of it .It is just straight forward thing. "Oh someone is jealous of you or your family. So that is why you are feeling like this. Because it is a black magic going on".*

According to Tanzeela, the second generation of the Pakistani community is more aware about mental illnesses, and these illnesses are not as stigmatised. The quote below also indicates that Tanzeela is identifying herself with the second generation Pakistani immigrants group, who are more educated and open about mental illnesses than the first generation:

'But I think within our generation, or my generation, I think a lot has changed now because of we have become more aware of mental health issues and this is through education. Through sort of reading about it or talking about it openly. Seeing adverts on the TV or watching programme which involve mental health. So we are more educated.'

Tanzeela has worked as a mental health support worker for the Pakistani community. Her role was to create awareness about mental health and illnesses in the Pakistani community. This awareness was aimed at changing traditional beliefs and engendering a more western approach towards mental illnesses. However, she identified difficulties in persuading the older generation of the Pakistani ethnic group:

'I do not think that they will have a shift away from their own ideas of you know people can suffer from mental health issues, and it can be related to something that happened in the past or it can be something that is happening now, you know a trigger factor. But I do not think that our parents' generation that they will ever get away from this.'

Tanzeela observed that in the Pakistani ethnic group, particularly older people, disregard the medical route and prefer alternative or traditional methods to treating mental illnesses. However, she believes that western medicine can play an important role in improving poor mental health conditions. In a way she is suggesting the adoption of an integrated approach based on both traditional and western models of addressing mental health issues:

'I understand people want alternative remedies and do not want to go down the route of medicine and stuff like that. I appreciate that but some time what people do is they overlooked that and that is something that they need to focus on as well. Because sometime you need to take these drugs in order to start feeling better.'

Although it is generally stated that mental illnesses are highly stigmatised in the Pakistani ethnic group, and people do not like to talk about these, Tanzeela positions herself to be different from these people, and during the interview openly shared that she herself suffered from depression in the past. So, in this way Tanzeela constructs her positive identity in relation to mental illnesses.

'I suffered depression myself and this was after when I had my daughter.'

Tanzeela thinks that there is a positive relationship between the provision of social support and addressing mental health issues of the people. She a thinks that she was fortunate to

have such support, and it performed a positive role in treating her postnatal depression:

'*Support is so important when it comes to having mental health issues … I was fortunate because I had support of my partner. I had support of my work colleagues. And they helped me get through it.'*

Tanzeela narrated that although she suffered from depression after giving birth to her daughter, this was not associated with the female gender of the baby. This position is in contrast to the normal expectations in the Pakistani ethnic group, where women are expected by in-laws and partners to give birth to a male baby to carry on the family name. If this is not the case then these women can be categorised as 'no good', and this can cause depression among mothers. Tanzeela identified this cultural problem in the Pakistani ethnic group from her experience of working with women in the local area:

'If you do not give birth to a son then you are classed as no good … and that was the pressure on the women in order to give birth and especially if you got pressure from the in-laws, you have got the pressure from the partner. You know people do not understand it is not the women that decide whether it is going to a male or female. But it is just this thing of that she got to give birth to a son to carry the family name on. And that is pressure in itself and you know that can be a cause for depression.'

Tanzeela identified the prevalence of poor intra-family relationships as another social problem causing mental illnesses among the people of Pakistani ethnic group, especially people who migrated to the UK as a 'spouse'. According to Tanzeela, women who migrate to the UK in order to marry are trapped in the traditional Pakistani ethnic group. On the one hand, the families of these women in Pakistan expect that they should tolerate ill-treatment from in-laws and partners, and should not come back to keep the family status intact. On the other hand, their in-laws and partners do not support them and they do not have any awareness about accessing the services.

'This poor person is trapped, because she is neither here nor there. She does not know where to go, what services to access. Because she is not allowed to leave the house on her own. She is never good enough in order to do anything with regard to trying to keep in-laws happy and everything. And partner, majority of the time, there is always about "Well I do not want to marry you, and I was forced to marry you". Of course these poor women are going to suffer mental health issues.'

Tanzeela thinks that having mental health issues is a normal thing in life. She thinks that people are different. They have different circumstances, and diverse ways of coping with these issues. Here she emphasises an individualised approach when viewing mental health issues:

'Every single person is individual. That is what I keep telling everyone. Your circumstances are different to mine. What you

can deal with, I might not be able to deal with and vice versa. Something that I can deal with, you might not be able to deal with.'

Tanzeela affirmed that she treated her post-natal depression through a medical route. In the quote below, Tanzeela clearly identifies herself with the medical model of mental illnesses and disregards the alternative route:

'Yes, I did go to the doctor and I did take the medication for it. Yes, I went down that route but I did not tell my parents about it, because I knew that my parents are going to be worried, and secondly, they are going to go down this route of alternative medicine. And for me I don't believe in things like that. But that is me.'

Tanzeela thinks that people from the Pakistani community go to priests to seek help for mental health issues because:

'They think it is all to do with black magic. Somebody is jealous of my household, and it is all black magic being done on me. So, therefore, conventional drugs are not going to do anything, only the priest can help us.'

However, she questions the genuineness, and healing role of the priest saying that '99% of the time the priests are there just for money purposes. It is just a money-making scam thing that the priests do'. She observed that people from the Pakistani community have trust and faith in priests and think

that *'oh if the priest gives something then everything is going to be all right* '

She is not completely distancing herself from alternative explanations; rather she thinks that alternative medicine is useful if used in combination with medical advice.

'Do not get me wrong. Our Quran is a Holy book, and I appreciate that. And I understand the fact that yeah you know some verses yes they do help you. I am not saying that. What people do is they just rely on this method. This method is a good method if you take conventional medication as well.'

Her lack of trust in priests to performing a healing role is obvious, when it was suggested by her dad for her to get treatment from a priest:

'I said to my dad, "I do not trust him. I do not want him to give me anything". And if I do not trust someone, I am not going to take something from someone whom I do not trust.'

As she does not believe in the priest, she is aligned to the medical model when she said, '*I will just stick with the doctors'.* According to her, the benefit of going to doctor is that: 'if you feel medication do not work, there is always an alternative, for example counselling. Sometimes it the case of just speaking with someone who is neutral'.

Although she said that priests are there to make money, and they are unable to help people, later on in the interview she was more cautious about this:

'*For me I think the only ones I believe in are those that actually do this for a good purpose, people who do not take money. Do not take me wrong, I appreciate there are some people like this that are blessed, who are gifted at this kind of thing, like healers for example, they have a gift or a sixth sense.'*

At the beginning of the interview, Tanzeela reported that there are generational differences in the way Pakistani people living in the UK perceive and respond to mental illnesses. Later on in the interview, however, she also identified differences in the mental health perspectives of second generation attitudes as well. She shared a story of manic depression suffered by her sister-in-law, and how her own brother, who is also from the second generation and was born and brought up in the UK, responded differently. It also indicates that she had not adopted the normative framework associated with the general Pakistani community with regard to treating mental illnesses through traditional approaches. It indicates that she is identifying herself with medical explanations:

'I remember I spoke to my brother and I said "look, go to the doctor", and he said "no, doctors cannot do anything. She is not taking any anti-depressant, because that is not what she needs". And then I thought … if you have got that mentality, then that is up to yourself. And I am not going to intervene because maybe they thought that I was wrong by going to the

doctor, and taking medication for it. And I should have taken alternative route. But I do not believe in things like that.'

A quote below from Tanzeela's transcript further strengthens the above point, which suggests that even siblings from the same family in the Pakistani ethnic group may identify themselves with different models of responding to mental illnesses:

'This is my sibling we are talking about, he has got this mentality that you should go to the alternative route and not use medicines. And yeah this is me who says there is nothing wrong with going to your GP and speaking about it and actually asking for help.'

Tanzeela considers the combination of following individual and social characteristics important in order to deal with mental health issues:

'For me the biggest thing is being strong; knowing that the help and advice is available, and what kind of services to access and how to educate you on something like this.'

Being someone who has suffered mental illnesses in the past, and recovered now, Tanzeela views her role to be as an educator which can have a positive influence for other people experiencing mental illnesses.

'For me if I can educate someone else through my experience, then for me that is positive thing, because I am trying to get the message across.'

Tanzeela thinks that there is gradually becoming more awareness among people about mental health issues. She is optimistic that '*the next generation would be definitely more aware of it and would deal with it sooner rather than later'*.

She thinks that although it is difficult for her to change perceptions of mental illnesses, behaviours can change:

'(When they were) physically and mentally exhausted, some people were sort of willing to do anything in order to get themselves better.'

She identified another problem with the Pakistani community. This relates to the fact that people are unaware of the services and delay seeking help. Due to this:

'Some people do get admitted into hospital, because they have ignored the problem for so long, because they do not know who to turn to, who to talk to and what services to access and that are the shame.'

She also identified other challenges within the community, where there are over-expectations and a 'dependency attitude' among the service users. She narrated an example of a service user, where she was given lot of support:

'*But still that was not ever enough for her, there was still something always wrong. Every time you went, it was like "you got to pick me from my door. You have got to drop off at my door. You have got to do everything for me".*

Tanzeela found this 'over dependency' among Pakistani service users frustrating. She thinks that there are a lot of services and support available for the people with mental health problems, and Pakistani people here should consider themselves to be fortunate. Now it is up to the individual service user to access these services.

'*If you are not willing to help yourself, nobody else can help you and that used to annoy me, because I used to think of myself. You know you should be so fortunate that you got access. You got services here that you are able to access. And people want to help you, but you do not want to help yourself. And with people like this, there is not much you can do.'*

Tanzeela thinks that there is lot of material out there, and much depends on the willingness of the individual to learn from it. She thinks that Pakistani community members are unwilling to learn, and *'that is the problem'*.

She views it problematic in the Asian community when '*the parents suffer or a mother suffers from depression, then all of the sudden, the children become the carers'.*

Issues in mental health services and suggestions for improvement

Through her experience of working with the statutory services, Tanzeela identified cultural differences among white and Asian communities:

'For example, you can have mix sex wards. The white community do not have a problem with that whereas the Asian community, which is huge problem … Language barrier, is another big problem. Because again it is how you communicate in order to get your message across, this is how I am feeling.'

She discourages NHS staff from making assumptions about the social identity of service users based on physical group prototypes such as their skin colour, as this may play a negative role and lead to incorrect judgements.

'Because you have got brown skin does not automatically mean that you are Indian or does not automatically mean that you are Pakistani.'

Tanzeela views ethnic-matching among service providers and service users playing a positive role. She thinks that if the services '*have the right staff there, then of course that is going to make it easier*'. Which means '*having people who speak the language'* of the service user.

She thinks although having an interpreter is helpful, it cannot address the barriers of time. But:

'*By the time you wait for the interpreter to get there. You know this person is distressed as it is. Then have been admitted on the ward. Do not know what is happening. No one is telling him anything. Because no one is there to tell them, because they cannot communicate, because there is a language barrier there*.'

She thinks that *'it is a tough job'* to perform the role as a mental health worker in the Asian community, but as she has her own mental health issues she *'therefore was able to relate to people'*. She thinks that if you want to work in mental health, then *'You got to love it. You got to have a passion in order to be in it'.* She further said *'You got to have the empathy. You got to be sympathetic in order to be in this role'.*

She suggested that the '*staff, they need to be more sort of trained and educated about the Asian community'.* She further identifies that staff should have an individualistic and person-centred approach and avoid making judgments.

'If someone has a certain way of thinking, then you have to respect them for that. But if you go on to judge and tell a person how to think, what to do, then you are in the wrong profession.'

She thinks that the biggest issue is that *'there is shortage of the Asian workers within the mental health services'.* She thinks that current recruitment practices in the local TRUST are qualification-based and not experience- based, which

results in fewer people from an Asian background joining the service. She is of the view that if recruitment was more experience-based then definitely 'a *lot of people would be willing to work within these services*'.

Social identity claims

It seems that Tanzeela is associating herself with a more western model of perceiving, explaining and responding to mental illnesses. She also positions herself as an open person who can share her own story of mental illnesses without feeling stigmatised by the community.

Participant -2

Summary

Mehnaz is in her 50s, and originates from Punjab. She is a first generation immigrant to the UK. She has 12th grade education (up to age of 17/18) from Pakistan. She is working with the NHS chaplaincy department. I came to know this participant during my visit to the mosque in the chaplaincy department. From her name and attire, she could be identified as Pakistani. While I was collecting community data, I went to her office and introduced my research project. She also read the Participant Information Sheet. She agreed to participate, and we agreed on a day and time for interview. I interviewed her in her office. There was not anybody else in the office, as she alone occupies this office. The interview lasted for an hour.

She observed that in the Pakistani community people perceive that mental illnesses are caused by supernatural as well as

genetic factors. She considers spirits and magic to be part of the Islamic belief system. She thinks that the Mirpuri community do not understand mental illnesses. She identifies that there are variations in the perceptions about mental illnesses in second generation Pakistani origin people and acknowledges the diversity among service users throughout the Pakistani community. She thinks that spiritual healing works if taken with medical interventions. She identifies the stigma attached to mental illnesses in the Pakistani community, which not only affects the individual, but also whole families in terms of their social status in the community. She thinks that the Pakistani community needs greater awareness that mental illnesses are recoverable. She also suggests that services should understand the spiritual needs of service users and meet those needs. She thinks that having staff from an Asian background, addressing cultural needs, and having in-depth understanding of the issues of the Pakistani community can be helpful in meeting their needs.

Analysis

Perceptions about mental illness in the Pakistani community:

Stigma

Mehnaz made comparisons between the Asian communities and the host society regarding the stigma associated with mental illnesses. She observed that '*in western society it is not a big stigma. But in Asian community it is a very big stigma'.* She thinks that the stigma is so strong that families with a person diagnosed as mentally ill will want to keep it as a secret because of the fear that *'if anybody knows that we have a mental son or daughter, and then people might not*

come to our houses. They might not take their daughter's hand for instance'. She narrated an example of a mother who was worried about finding a suitable proposal for her daughter because of having a mentally ill son. People think that it might be genetic, and '*if one child is 'paagal', all of them might be 'paagal'.*

Perceived causes and responses to mental illness in the Pakistani community

Mehnaz identified a lack of understanding in the Pakistani community regarding mental illness:

'[*Mental illness*] *is a very misunderstood concept. People do not understand what is happening. They might not think proper cause of it. They might think something else like this person has been possessed by a devil, has been possessed by an evil spirit … maybe somebody has cursed them. They have cursed the whole family. And maybe this is only the beginning. One son is, one daughter is, maybe now we will all catch it. Some even blame modified food causing mental illnesses.'*

She thinks that, because people explain mental illnesses as being caused by supernatural beings, therefore *'instead of seeking medical advice or medical treatment, they will take the person to the spiritual healers, molveess and mulanas for tavveez ganda and all that'.*

Stating the other reasons for people going to the spiritual healers, she thinks that people have brought this approach to mental illnesses from Pakistan where there are not enough

psychiatric facilities. She stereotypes the largest Mirpuri group of the Pakistani community for not having much knowledge of mental illnesses, and not having had exposure to mental health services. As she belongs to the Punjabi group of the Pakistani community in the UK, she is, in a way, self-enhancing her group by stereotyping the Mirpuri group of the Pakistani community.

'*[Mirpuri] do not really understand what the nature of illness is. They have not seen psychiatric hospitals anywhere*.'

Also, medication makes people drowsy and disjointed in their thinking. Therefore, people '*think that they are not receiving the right treatment, because of these symptoms'.*

Usefulness of spiritual healing

She considers that spiritual healing is derived from the Quran and it is very useful in some cases. She narrated two stories to make her point:

'*There was one young boy who was aged 16/18. He was admitted in a psychiatric hospital. He was in the institution for a long time, maybe 7, 8 years. I think his problem was that he never wanted to face anyone. He wanted to hide in his bedroom, and would do nothing. He will draw the curtain in the morning, and he will just shut himself in the room, and will not come out. And the same happened while he was having treatment in the Hospital. But after sometime he went back home and he seeked treatment. Then he got married in Pakistan. Now, I mean he does get some of these like odd*

days, you know, when he is not feeling too well. But he is much better, and his mother says that it is all the miracle of the spiritual healings. They do not believe that medication has cured him. They believed that spiritual healers had cured, or these verses from Quran he was reading and he was with ablution all the time, 24 hours a day, he was with ablution. He was pure. He was clean. His mind was more receptive to good things. Good spirits if I may say. So devil left him at the end of the day. He is too good for angels.'

She narrated another story which she came across recently:

'I learned quite recently. This is another son of somebody I know. He was fine. Had a lovely job. He was graduated. Got married and then they have a little girl. Somehow he lost his job, and he started going under depression. Everybody thought that he is not having job. He is recently married. He got a little girl, more responsibility, but his depression became quite severe. He went to Pakistan. This is something I really, really admire, whoever this molvi, or spiritual healer, whoever he was. He must have been an excellent member of the community because he said to this boy, "well look there is nothing wrong with you. I do not want you to go through any healers and spend a lot of money. Do just two things; one is, you just clean your house, should be very, very clean, either you do it or your wife does it or you hire cleaner to clean the house, house should be immaculate, there should not be little dust on it. Very, very clean house, and the second thing is stay in wuzu [ablution] all the time, so when you think that your wuzu is broken, do fresh one" and that worked, that worked.'

She believes that '*the treatment of every ailment is in the Quran'*. But suggests '*that does not mean that you do not seek medical advice or medication. If we take everything side by side, we will be all right. Probably, we will get better quicker'.*

Authenticity of spiritual healers

Characterising the authenticity of the spiritual healers, she said there are some who advertise themselves in newspapers. However, in the first instance people should ask the Imam of the mosque as:

'They [imams] know where the good people [spiritual healer] are. They know who the best spiritual healer is. They do not necessarily have to advertise their services in the paper and they do not charge. If anyone says that I will charge you £100, I think they are not the people you should go to because it is wrong, and it is sinful in Islam to charge for verses of Quran.'

Mehnaz observed that compared to first generation immigrants, second generation people '*are more aware that what mental illness is. And if it is there, we will get better. I need to have a psychiatric help … but the older generation has very much in their own world'*. She considers it very sad that people in the Pakistani community '*believe that once you are paagal, you are paagal for ever. You can never get better'.*

Issues in the Pakistani community

Narrating issues in the community, she said people in the Pakistani community are not open about mental illnesses, and *'they keep sweeping it under the carpet, and things go really bad to worse'.* Therefore, she thinks that *'we do not have to only work with NHS authority, we have to work with the community as well'* to raise awareness about mental illnesses and that it is recoverable, and also assure the community that the NHS would be sympathetic to their spiritual needs.

Narrating issues in the services, she observed that language is a big barrier for the service users:

'If anybody has a language problem, how can they be more relaxed in a psychiatric ward? That person must be very lonely, who cannot understand your language, who cannot understand your culture. That must be a very scary place for that person.'

Issues in mental health services

Referring to the facilities for language support in the hospital where she works, she said:

'*We do not bring enough interpreters in the hospital. It is because the service is costing a lot. They sometimes rely on the relatives, the relatives are doing the interpreting or they might in extreme cases, they might bring the interpreters from the agency*.'

She also thinks that the hospital does not make an effort to publish material in the languages that are understandable to Pakistani service users.

One of the solutions she suggests to address the linguistic and cultural needs of the Pakistani community are to:

'Have pure Asian mental institution psychiatric wards, just for Asians. You can achieve that target if you want to. Because if we say that there is one Asian mental hospital in X area then people from Y, Z, all Asian people with mental illness could be gathered in one hospital where there will be same culture, same language, and same creed.'

This suggestion is contrary to the future priorities of the Chief Executive of the local TRUST, where he/she is interested to offer choices to Pakistani people within mainstream services rather than establishing separate services for them. Indeed, given the variation in language, culture and beliefs among participants and the people they describe, it may well be an equally large challenge to meet their cultural, language and mental health needs in an Asian-specific resource.

Social identity claims

One of the distinct social identity claims made by Mehnaz is that she does not associate herself with the Mirpuri group of the Pakistani population living in the UK. The Mirpuri group is the largest in terms of its population of the Pakistani community in the UK. This social identity claim indicates that people within a single defined 'Pakistani' ethnic group category

may identify themselves with different sub-groups. Mehnaz seems strongly to identify herself with those groups of Pakistanis who believe that spirituality plays an important role in healing mental illnesses.

Participant -3

Summary

Muhammad Javid is male and 35 years old. He is a first generation immigrant, and came to the UK 10 years ago. He is a law graduate from a Pakistani university. He originates from Punjab. He works as a teacher, but occasionally as a lead for Friday prayers in one of the local NHS Trusts. During my PhD, I sometimes used to attend the prayers. In one of his Friday prayer sessions, he referred to his background from Pakistan. During my community data collection, after one Friday prayer time, I met him and verbally introduced my research project. He agreed to be interviewed. I interviewed him in his school after school time. The interview lasted for approximately an hour.

He thinks that mental illnesses do exit in the Pakistani community, but accepts that some people think that they do not. He said that people have a 'poor belief system', and they hastily jump to explain mental illnesses in terms of supernatural beings. He reported that people in the Pakistani community respond to mental illnesses in different ways, and the majority prefer to favour spiritual healing.

As a Muslim, he believes that Jinn and supernatural beings are part of this religion. He believes that supernatural creatures can harm a person and there is spiritual treatment for these. The main thing for him is to find out the actual cause of the mental health problem, and establishing whether the illnesses are being caused by a supernatural being or a medical problem.

Analysis

Perceptions about mental illness in the Pakistani community:

Stigma

Muhammad Javid presents himself as an open person, a person who considers mental illness as an 'illness' and accepts that it does exist in the Pakistani community. This approach is in contrast to what most others in the community think about mental illness:

'*If somebody is mentally not well, it is illness really to be honest. But people do not seem to be accepting it as a problem. It is like you have any health problem. Your stomach is not well. Your back is hurting. Same is with mental illnesses*.'

The reason behind this denial according to Muhammad is '*purely because of the social stigma attached to it'.*

Muhammad observed that mentally ill people are de-humanised in the Pakistani community. He told me of an example from the community where a young man was

suffering from mental illness and '*his parents push him out from the door. They do not want to know him … it is viewed as something that makes somebody inferior. They are kind of untouchable*.'

However, Muhammad positions himself as a compassionate person with mentally ill people and said '*I felt very sorry with that young person'*.

Perceived causes and responses to mental illness in the Pakistani community

In terms of explanations for mental illnesses, Muhammad thinks that '*in Pakistani community especially, there is this belief of jinn'*. He identifies himself with the Muslims and said that '*we as a Muslim do believe that there are jinns'*. However, '*if the belief is poor, then you would associate everything with jinns'*. Muhammad narrates a story from his recent experience as a Muslim Chaplain to make his point:

'I was visiting a child in paediatric section, and they were twins actually. They were both struggling to sleep. And then I was called and I was told that perhaps they are possessed. But in fact these children could not sleep properly. And when I went to see them, they did not have socks on. Because I am a father, and I am a father of two children, and I saw, there is cold. They are feeling really cold. And if you feel cold, you would struggle to sleep. So I asked them to put the socks on, and within half an hour they went to sleep. But their parents think that there is some kind of jinn or other things. So that happens quite often, when you have different problem, you associate something else.'

As people are uncertain about the actual causes of mental illnesses, in order to reduce uncertainty, they readily associate these illnesses with supernatural beings. Muhammad contrasted this approach of associating everything with Jinns with a personal story of the importance of knowing actual causes of illnesses as:

'I came from Pakistan about 10 years ago. I felt down, lots of the time. I felt down. And somebody told me "did you get your vitamin D checked"? And this was first time, it struck in my head. There is some problem. When I do not see the sun, feels down. When I am out in sunshine, I feel happy. And when I went to the doctor, and ask that I want to get my medical check done, including all, you know including the vitamin D, the level of vitamin D. And I was really shocked to find out, and it was about 0.13, and average is over 40 or something. So I was feeling down for something else. It might be something else. But it was a medical problem. I am lacking vitamin D. And that is the case with majority of our community, who come from that climate, where you have sun belt for majority of your time. So you do not lack this. So when we are lacking that, we feel down. But if somebody does not get that check, they will think that there is something else. And that can lead to them then believing something else, might be Jinn or all sort of things.'

Muhammad thinks that in the Pakistani community, people are unaware of the causes of mental illnesses:

'I think the main problem is diagnosing whether the person is actually having the mental problems or that person is being

possessed by some spiritual being or Jinn. So that is where we struggle.'

Muhammad observed relationships between perceived causes of mental illness and the resultant treatment choice.

'In majority of cases, everything is associated with Jinns, or Jadoo or magic or black magic whatever you call. If it is associated with them, then obviously, the doctor would not treat that. They will be looking at the physical signs of those things.'

This indicates that as the causes of mental illnesses are not physically visible; people in the Pakistani community associated these illnesses as being caused by supernatural things

Muhammad observed variations among the generations in responding to the mental illnesses. He particularly sees the influence of the host culture and assimilation to the host society playing its role in changing the perception of mental illnesses among people of the Pakistani community:

'If you talk about the generations, then in first generation, definitely they would not go to the doctor. Second generation, they are somewhere in middle. Some of them, who are aware of those things, they will go to the doctor. Otherwise, they will just follow their first generation. The third generation obviously is more aware, would say they would be more inclined to go to doctor than going to any spiritual guide,

because they are brought up in this culture, which is very kind of physical. Everything is physical. So obviously there is influence of it and they will go to [doctor], and get physical treatment. Get some medicine.'

Muhammad aligns with medico-spiritual healing, and thinks that '*If somebody is practising religion, then whatever the words they say, they will have influence … because these words have been sent by our creator. So they will have influence'.* However, Muhammad emphasised the need to first identify the actual cause of the mental health problem, and cautioned '*that does not negate that we should not be seeking the medical treatment, and wherever there is medical problem, then we must. Our religion encourages seeking medical treatment first'.*

Challenges in mental health services

Muhammad identified many challenges within mental health services. He thinks that although he works with the NHS, even he is not aware of what kinds of mental health services are on offer. Even if the people were aware that there was a mental health hospital, there is a lack of trust among the Pakistani community about the service provider:

'*They [Pakistani service users] will think "oh do they understand what these problems are". So there will be question of credibility. Can they identify [causes]? Would they understand the problem? Would they believe me? If I said that I am being possessed or would they just declare me that I am just crazy?'*

Muhammad positions himself with the Pakistani community, and thinks that the values of the Pakistani community are different from those of the service provider:

'Our values are different. One of the most important is that we believe. You believe in something, they [White majority] would not believe. For us religion is important. Our religion is our value. They would not consider it as something important. Value such as family life is considered important in our community. It is very important. But it is not given its due importance in the wider society.'

Muhammad clarified the relationship of Muslims and non-Muslims with the Holy Quran in the quote below. This also indicates the power the Holy Quran has for Muslims:

'*We believe that our book is very important. Our Holy Quran is very important. So we get guidance from it. We get treatment from it. For someone who does not believe in that must look very stupid. How you get treated with a book*.'

He suggested that the local TRUST should have people from the Pakistani community working for them. According to Muhammad, there is a relationship between having a workforce from the Pakistani ethnic group and having an understanding of Islamic values.

'If somebody is from our community, they would understand those values. And they would understand that this is important for Muslims.'

Muhammad challenges the position that people from another ethnic or religious background can be sympathetic to the service user of Pakistani background.

'Somebody who does not know [our values], somebody who does not appreciate or does not care about those values, how they can sympathise with you?'

Social identity claim

It seems that Muhammad is positioning himself with contemporary Pakistanis, who have a good understanding of mental health issues. He is not bound by the traditional explanations of mental health issues, but also thinks that people in the Pakistani community should consider scientific or western models of mental illnesses as well.

Participant -4

Summary

Shafique is in his mid-40s. He has a postgraduate qualification in a discipline related to healthcare. He is a second generation immigrant and originates from the Mirpur region of Pakistan. He has experience of working with the local mental health TRUST. During my interview with a frontline staff member in the TRUST, I came to know about him. I asked this staff member for Shafique's contact details, which he/she gave me after getting permission from Shafique. I contacted Shafique through e-mail, introduced my research project, sent him a Participant Information Sheet, and asked him to participate. He agreed to this, and we fixed a day and time for the

interview. I interviewed him in his car in a car park. The interview lasted for 70 minutes.

Mr. Shafique considers himself to be accomplished in terms of social relations, but complains that he was a victim of racism while working in the local mental health TRUST. He observed institutional racism in the organisation, and claims that it failed in meeting the needs of the service users from a Pakistani background. His narrative orientates around what he perceives to be institutional racism.

Analysis

Giving the historical overview of the types of ailments experienced by the Pakistani community, Shafique said that, in the past, depression was the main mental health issue but it was considered taboo to talk about mental health problems. Nevertheless, over time the community has become more open discussing such matters.

Shafique said that currently, in the Pakistani community, there are more drug-related mental health issues. He thinks that it was easier for the community to deal with depression than with issues of substance misuse. With the emergence of drug-related issues, which he considers as *'real hard-core'* mental health issues, the Pakistani community is struggling to deal with these issues itself and has once again become *'introverted'*, and lost the openness about discussing mental health issues. Shafique asserted that there are two reasons for the current situation. Firstly, the Pakistani community finds both substance use and mental illness both *'big, big taboo subject'* associated with shame and consequently treated with

secrecy and denial. Secondly, discriminatory treatment from the service provider side, i.e. *'the apprehension of services to actually become engaged proactively in providing that service for the Pakistani community'.*

Shafique blames service providers for not providing the necessary resources needed specifically to tackle this new challenge. According to Shafique this happens because of a negative image of the Pakistani community because of religious and terrorism related issues. Due to internal stigma and the negative image in society, the Pakistani community is less vocal, and:

'*Historically we have seen that the communities that are less vocal are the ones who will always lose out*.'

The above quotation also indicates the socio-political powerlessness of the Pakistani community within the UK. Shafique thinks that Pakistani people, particularly those living in the suburbs of a city, do not get 'specific services'. Shafique thinks that the move towards a service user led NHS (Department of Health, 2005a) might have worked to some extent for the general population but not for the service user of a Pakistani background:

'There is a vast dichotomy there. Where service providers have a particular angle on things and it does not and has never clicked with the actual needs and expectations of the Pakistani community, the two have not as yet ever come together, and has been the opposite.'

Shafique thinks that there is a lack of representation of the Pakistani community in the local TRUST, and due to this *'there is lack of awareness of the needs of the Pakistani community, and until we get that equality of representation within service providers, there is always going to be that vast difference of opinions'.* Additionally, due to the recent funding cuts in the ethnic minority services, '*Pakistani community without a doubt has been hit the hardest'.*

Funding cuts have not only targeted the clinicians of Pakistani background, but also the services provided by the local third sector *'has also been just totally wiped out'.* Shafique thinks that cuts in ethnic-specific services have resulted in poor services for the service users*:*

'Due to cuts in ethnicity-specific services, we have now actually gone 20 years back, where services are now been almost centralised again. So the whole thing has gone back 20 years.'

This observation is very much in contrast to what strategic leaders in the TRUST think. They think that the current situation is very much improved. This also contrasts with what some participants have alluded to that there has been an improvement in services. It also suggests that different people in the community have different perceptions about the quality of the services.

Depicting the current situation of the Pakistani community, Shafique said that:

'I think the Pakistani community is almost at a stage where it is walking away from the table. It does not see that it has a valid seat at the table.'

Shafique thinks that one of the excuses given by the service provider in cutting the ethnic-specific services is that now, because there are 3rd and 4th generations, this community is assimilated and integrated with the culture of the host society. Shafique considers this as 'a complete fallacy'. According to him:

'If you look at the kind of emergence within the younger generation of people turning much more back to their faith, and turning back to their faith means that there is a re-emergence of a strong faith within, particularly, the Pakistani community and with that comes a strong adherence to their cultural roots.'

Shafique blames institutional racism in the TRUST when it comes to recruitment and employment practices:

'If you look at the data from the recruitment and employment practices, right down to the top of the service providers, there is institutional racism all through the system.'

Shafique further said that policies are not discriminatory; rather their *implementation* is discriminatory, and the reasons for this are:

'The mind set of those in seniority in the organisations who come from very privileged middle class white male backgrounds, and their level of understanding, particularly of the needs and challenges of Pakistani community, is extremely limited, and since those people are the drivers behind these type of the policies, then the implementation is always going to be discriminatory.'

In making his point on institutional racism in the organisation, Shafique said that the organisation has gone to the extent that now:

'You *do not now have any workers within an organisation, which is one of the biggest service providers across the whole country. You do not have any clinicians that are working specifically with ethnic minority communities, and that is an absolute kind of shameful description of the organisation. A shameful reputation of the organisation then carries and it goes without challenge. And then one has to question well why it is not challenged, and it is not challenged through fear … that is being through fear of discrimination. Fear of backlash on people's employment.'*

Shafique considers the Delivering Race Equality (DRE) programme as a milestone in delivering ethnic-specific services to the black and minority communities, including Pakistanis. However, he criticised the implementation and sustainability of the programme at the local level. At the end of the programme time period (2010), the Community Development Workers (CDW) were made redundant and were not replaced with people from BME communities. He said that

due to unemployment and poverty, the mental health needs of the Pakistani community have increased in recent time, but the CDWs who were the link between the community and the statutory services, are not there. He blamed the local TRUST being engaged in discriminatory practices:

'The sad thing is the community is still there. The needs are still there. If anything, the needs are growing and having grown, but the service provider has refused to engage with those needs, and a lot of that has to do with particular philosophy that the organisation has recently engaged in, which in itself is discriminatory.'

Shafique gave an example to demonstrate how the local NHS mental health TRUST is involved in discriminatory practices in the service provision, with regard to meeting the public sector equality duties enshrined in the equality Act 2010:

'Public sector entities are legally obliged to conduct equality impact assessment on any service change. The only service change where equality impact assessment was not categorically carried out was in the cutting of ethnic minority services, decreasing services to the Pakistani community. So that in itself was unethical, was immoral. It was illegal. And the organisation has not been held to account for that.'

Shafique thinks that under-representation of the Pakistani community in services is not due to factors related to the community, such as qualifications and aspiration to work in the mental health field. He observed that over a period of

time, the educational profile of the Pakistani community has improved and now there are people from this community with the relevant academic qualifications to work in mental health services. He also dismissed the perception that people from the Pakistani community do not like to work in the mental health profession. He blamed discrimination in the recruitment process of the local TRUST, resulting in the under-representation of the Pakistani community at all levels of the organisation.

'It is actually seen as a field, as a service that within kind of cultural and religious ethics of the Pakistani community is holding in very, very high regard. Because it is a caring profession, and anything which is caring profession, within Islam and Pakistani culture and so forth will and has been always held with high regard. So it is not that the community is not coming forward. It is that they are not getting the opportunities, the equality of opportunities.'

Shafique believes that the Pakistani community is not powerful enough to challenge the discriminatory treatment by the local mental health TRUST. He identified political reasons behind this powerlessness:

'With such a vast organisation, what can individuals within the Pakistani community do to challenge that, particularly when they are already being beaten into the ground through the harshness of the society in general? Because the extreme reaction of Islamic phobia and kind of being labelled as terrorist and so forth.'

Personalising the racism, Shafique said that although he himself considered himself very much Westernised, educated, and had a good grasp of the English language, even he experienced racism while working with the local mental health TRUST:

'I myself experienced backlash of racism and so within the organisation, and within society in general. And I regard myself someone who is extremely confident, extremely self-aware, have extremely good grasp of the English language. So I come across fairly westernised, but it does not make me immune to the discrimination, because of the colour of my skin. That is something that I cannot and would not choose to change. So that is a factor that often goes totally unrecognised.'

According to Shafique, an ideal service for the Pakistani service users would be one which is competent in meeting the linguistic, cultural and religious needs of Pakistani service users. This service should have a collaborative approach with the Pakistani service users, their informal carers, and the third sector:

'What that ideal service would look like is employing people with the right cultural competencies, people who have the language skills, who have the understanding and the credibility within those communities to be able to break down the barriers and reach out to individuals.'

Shafique argued that the mental health needs of the Pakistani community are different because of differences in their presentation and explanation.

'The kind of rationalisation and presentation of illnesses is vastly different, particularly within the Pakistani community; it is very different. There is a different philosophy of that kind of representation of mental illness.'

Evaluating the cultural training provided by the local TRUST to its organisational members, Shafique found that the training is irrelevant and does not help the staff to meet the needs of Pakistani services users. According to him, the training providers do not have a clinical background, and secondly, they are not from the Pakistani community. He further added that the training is generalised and very short; hence it does not address the fast changing diversity of the local population. According to him, the training meets the needs of the organisation and not the service users:

'The training is completely irrelevant to the needs of the service users; it is relevant to the needs of the service. It tick boxes the policy element of the organisation, but does absolutely nothing for creating awareness, and understanding of the Pakistani community.'

Shafique made suggestions to improve the effectiveness of the training

'They need to be objectified. They need to be resourced. They need to be revisited on a regular basis with regard to the assessment of those cultural competencies, whether they are actually meeting the needs.'

Shafique thinks that as formal services are not meeting the needs of the Pakistani service users, they are turning to the informal services like Hakeem and faith healers. This, according to him, is not helpful and adds to the distress and suffering of Pakistani people with mental health issues. His statement suggests that he is not positioning himself with traditional spiritual-healing as a useful method for treating mental health issues.

According to Shafique, Britain is a multi-cultural society, exhibited in communities with different cultural and religious identities. Resultantly, NHS service users would have different cultural and religious needs. Therefore, the efforts to have a service user led NHS also needs to recognise this diversity, instead of visioning a single identity group:

'If we are to truly have a service user led NHS, then it has to be within the recognition that service user is a quite a diverse and quite a dynamic entity, rather than being a static generalised entity.'

Shafique refers to the social and political consequences of disengagement for the Pakistani community and society at large:

'Because of that lack of access to services and lack of engagement of services proactively with our community, and through that, we are at the moment probably the fourth generation, fifth generation. It is becoming a lost generation. Because of all the different factors that are impacting on the health of the community, the physical health and also the psychological health are just being absolutely destroyed.'

Ending the interview, Shafique pointed towards an important issue related to the relationship of the Pakistani community with the host society: The most important political manifestations of the unequal treatment of the Pakistani community:

'The government themselves are allowing organisations to conduct their business in such a discriminatory manner, and then it questions why the community are withdrawn within themselves and extreme elements within those communities then are borne.'

As Shafique has worked as a mental health nurse, he considers this as a 'privileged position'.

'I think my experience of working in at times quite a privileged position. Because there are very very few qualified Pakistani nurses if I can share that. Actually when I say very few, there is none within this area. So it is a privileged position.'

The above statement indicates the practical challenges in achieving workforce diversity at different levels of NHS

organisations. This issue has been dealt with in detail in the discussion section of this thesis.

Social identity claim

Being a mental health nurse, Shafique positions himself as somebody who has worked in a 'privileged' position and aligned to the western model of mental illnesses. In the whole interview, Shafique reported that due to his minority status he has experienced 'institutional racism' from the mental health TRUST, where predominately the White majority is employed.

Participant -5

Summary

Shamim is a 41 year old female of Mirpuri origin. She is a second generation Pakistani immigrant, and has GCSE level education from the UK. She is known to me through my extended family. She also knew a little about my PhD project. I contacted her on her mobile number, and asked if she was happy to be interviewed on the subject, to which she happily agreed. I interviewed her in her house. Her husband and children were also present in the house. The interview was conducted in the sitting room of the house. I briefed her that the interview needed to be conducted without disturbance. She informed her husband and children of this, and urged them not to make any disturbance and intrude on the privacy of the interview, so we did not experience any disturbances during the interview.

Her previous role involved working as an interpreter in healthcare settings. Currently she is working with the

Pakistani community as a support worker for a volunteer organisation in the local area. Her role seems to have influenced her social identity in terms of being more westernised in explaining mental health issues. Compared to the majority of Pakistani community members, where she considers they stigmatise mental illnesses, she sees herself to be an open and accepting person about mental illness. She narrated to me her own story of postnatal depression. She thinks that most of the Pakistani community members associate mental illnesses with supernatural things, but she aligns herself with the medical model and sought medical help. She presented herself as sympathetic to people with mental health problems, and is interested to work in the field. She narrated her own story of losing her childhood, as she was caring for her siblings due to her mother's mental illness. She has a positive image of some of the services being provided by the local TRUST, but also suggests improving the cultural competencies of the staff, and recruiting people from the Pakistani community to improve the quality of the services.

Analysis

Perceptions of mental illnesses in the Pakistani community:

Stigma

Shamim is open about mental illnesses as she accepts that mental illnesses exist in the Pakistani community. Her position is in contrast to most of the other Pakistani community members, who perceive these illnesses negatively, and do not talk openly due to fear of being labelled. This negative image of mental illnesses, according to Shamim, is particularly significant among Asian communities living in the UK. Shamim

thinks that this closeness among the Asian communities has negative repercussions:

'My perception [of mental illnesses] is that obviously they exist. It is a stigma, especially for the Asian community, not to talk about it. They think that if we do talk about it, we will be labelled. We will be judged. And so it is best to keep it in you. And I think the more they keep it in you, the worse it gets.'

Shamim felt that relationships between Pakistani community members with a mentally ill person are not healthy. Mentally ill people are avoided because of the perceived magic upon them. This de-humanising treatment results in damaging the self-perception of a person with mental health problems:

'Instead of supporting them [the mentally ill],.they [community members] make it actually worse. The patient is getting more paranoid. That when sitting down, "Oh she is looking at me. They are looking at me like this. They are doing this. They are talking about me". So it actually makes them [mentally ill] worse. It escalates the situation more.'

She pointed to the difficulties she has while working with people of a Pakistani origin. This relates to issues of confidentiality*:*

'The first thing people ask me is: whose daughter are you? You know that confidentiality. People think right "Ok she knows so and so", because it is a small community. They feel afraid sometimes that they cannot talk about it. I think they

[NHS TRUST] should have people from other local areas coming in and building that trust.'

Explanatory model of mental illnesses

Shamim narrated her own experience of having post-natal depression. She aligns herself to the medical model of mental illnesses when explaining the causes of her own post-natal depression. Her explanatory position is in contrast to what most of the people in the community think about it:

'I mean I had children myself. I think there was a bit of post-natal depression. You cannot share that because people will think, you had this happiness after such a long time, why you would be depressed about it. But obviously hormones are all over the place, and that is something you cannot control.'

Mental health help-seeking behaviour

Shamim said that because of the closeness among the Pakistani community about mental illnesses, people *suffer in silence* when they experience mental health issues. They are not only fearful of the negative image of the other community members, but they also hold a negative image of social services:

'You have to hide and suffer in silence, and cry in silence and you do something, but not tell anybody, although there is a lot of help there. When health visitors come and when midwife talk about it, you think that you should not talk about it, in case they take the child away from you. You know social workers get involved, they might take the child off you,

because you are not mentally capable of looking after your children.'

She thinks that, as compared to the first generation, the second and third generations are more aware of mental health issues. However, even second and third generations still prefer traditional methods of treatment. This is due to following the cultural practices of their parents, and less assimilation into Western culture:

'It is not only the first generation; I think the second and third generations even think that [mental illness is caused by black magic], because it has been put in their heads, when they were growing up … so they go for that [traditional] help first.'

Shamim thinks traditional ways of treating mental illnesses are ineffective, and thinks that people in the Pakistani community trust word of mouth from within the community:

'I heard it from somebody: "We took our daughter there. She got better. We took our son there. He got better". Our people, they are just so naive like that they will pay their ticket money and they will do everything and they probably give them [traditional healers] something as well, and I do not think it is going to get them better.'

Perceptions about NHS mental health services

Shamim thinks that most Pakistani community members do not use NHS mental health services. The reasons for this are primarily cultural and relate to widely-shared traditional

mental health beliefs. Additionally, there is scepticism regarding prescribed drugs and if they are offered sleeping tablets they fear becoming addicted, and the most fearful thing for them is that they might get sectioned because of their mental health issues. She thinks that the experience of being sectioned is not only damaging to the family identity, but also to the patients as well. She thinks that NHS professionals are insensitive to the cultural identity of the Pakistani service user in their practices while sectioning a person:

'To have the police standing on your street, a police car at the bottom of the road; it is not nice. You know I do not think it should be there unless they have to have it there; if they do not agree with the doctors and nurses then, yes, call them but, it is like, I mean your neighbour would not have known if they are criminal or they are mental health patient. So I think they need to be a bit sensitive around that.'

It seems that Pakistanis are very sensitive about societal respect (*Izzat*). Having the police outside the house is seen as damaging to the reputation of the family in the community. This may be more marked than for the White British, who have a less communal life and have a more individualistic way of life.

She questioned the effectiveness of a coercive approach of getting people to recover from mental illnesses.

'I sometime see when they [patients] go to the hospitals. Are they going to get better or they are going to get worse than they already are? Because when you look at people all around you, there are some people who are much more serious than them, and they are sitting in there, and they are not as bad, and there are other people who have been there for long, long time, and just by looking at them and seeing them, that person who is already not mentally well think they are going worse. And they have gone worse. I have seen it.'

Shamim narrated an example from her work, where staff have shown a lack of cultural understanding and as a result the service user is labelled as dangerous or risky, and thus needs to be kept longer in the mental health institution:

'I go to X hospital quite often, and there is gentleman that I interpret for. And he gets up and he holds everybody's feet. Now when they [NHS practitioners] are on ward round, and when they read his reports, they say "he attacks people". But he is not attacking people, he is asking for forgiveness. Because they have got no cultural awareness, they do not know what he is doing. Or he will go up to somebody's chin. But they think he is going to strangle their neck, but he is only begging them, "Can you do this for me …?" He is just begging and getting out of here and things like that. But in the reports they have put, he is attacking the person. He is strangling the neck.'

Shamim has a positive image of the staff, and thinks that it is not their fault:

'I mean staff is brilliant. They are lovely, lovely staff there. You cannot fault them. But it is not their fault. If they have not got awareness on the culture, and they need training on that.'

Shamim observed that the local mental healthcare TRUST is White dominated. Consequently, Pakistani service users have communication barriers. NHS staff cannot even talk about simple things with the patient:

'They [professionals] know he [service users] is not going to understand me, and I cannot understand them. So they are just left there, and it is mainly "have they had their breakfast"? They have been washed and changed. "That is done. That is ok, let us leave them there".

Shamim asserts that the service provider has a generic approach towards Pakistani service users. She gave an example from some communication material being used by the local TRUST to help engage with Pakistani service users. Shamim emphasised the need for an individual approach while treating service users of Pakistani ethnicity.

'We got to remember there are lot of first generation, even second generation, who are illiterate. You know we got to put that in mind that everybody does not read Urdu. You know all my carers, 75% of them do not read Urdu. I know, they say we got leaflets. We got this. We got that. But they do not read, they are illiterate; so it does not really matter. So I think first hand talking with people. I think that is really important.'

She considers that reaching out to communities at the grass-root level is important, and hence the role of Community Development Workers is crucial:

'[Service provider] will have one conference at X Conference Centre. Look really nice and posh and everything. But what are these people are supposed to do there. And that is mainly for professionals. It is not for the community. They need to have community events, where they [community members] can pick up information, and it could be community development workers … I think that is really, really important to reach the community, instead of the community looking for you.'

Narrating her own experience of using the services when having post-natal depression, she aligns herself with psychosocial ways of treating mental illnesses.

'I prefer the therapy instead of medication. Because I was as a professional, I was somebody who was educated in this country. Even I thought, "Oh gosh I do not want to go on medication, in case I get addicted". So I prefer the therapy route.'

Shamim thinks that over a period of time, a lot has changed and now there is a range of services available, but Pakistani community members struggle to take the initial steps on their pathways to care:

'There is help and it is your choice of which help you choose. It is not just medication. There is a lot of counselling. There is therapy. There is lot of support out there, and you can choose which one you want. But again it is taking that initial steps to get the help. Once you get the help, there is a big range out there. But our people just have not got the confidence.'

Shamim outlined that despite being from the Pakistani community, working with the Pakistani community is very difficult as service users from this community can start depending on the workers. This results in the blurring of professional and personal identities of the workers.

'It is really sad to say some time they think, they own you. They say, "You do this for me, you do this for me, you have to do this, you have to do that". And it is really sad, it is very sad. But they depend and demand, and you cannot switch off from work sometimes, because it is small community, they know you. So if you are walking in ASDA or somewhere, they will grab you. "Oh can you do this for me. Can you do that for me"? Or they will get your number from somewhere and you cannot switch off. You are always working 24 hours (laugh).'

Social identity claim

The narrative of Shamim indicates that she relates to a more medical model of mental illnesses. She is open in sharing details of her mental illness, and does not feel fearful of being labelled. In this way, Shamim is presenting a positive identity in relation to mental health issues. She is also presenting herself as somebody who is sympathetic to people with mental health problems.

Participant -6

Summary

Latif is a 33 year old second generation gentleman who has a degree in religious studies from Pakistan, and works as an Imam in a local Mosque where this research is carried out. He originates from the Mirpur region of Pakistan. During my first five interviews with the community members, I found that in the Pakistani community, the role of religion in relation to mental illnesses is very important. Many of the community members I interviewed referred to Latif in their interviews as a spiritual healer. Since the Imam in Islam and in the Pakistani community is considered to be a religious leader and a key opinion-maker, I purposively decided to ask whether he would be willing to be interviewed for the study. I went to the local community mosque during the day prayer time. After the prayers, I met Latif and introduced my research project briefly. Latif was happy to be interviewed and we agreed on a date and time. The interview was carried out in the mosque where he works.

Latif was very welcoming to me, and he was also forthcoming about sharing his perspective on mental illnesses. He shared examples of mental illnesses from his family and friends, and about spiritual healing being effective in treating mentally ill people. He gave personal examples where he treated people with holy verses from the Quran, and thus strongly positions himself with the spiritual model of mental illnesses. His definition of mental illness is '… a *disability of the mind or the brain'.*

He labelled mental illness as '*behaviour illness'*, and suggests that a person with mental health problem acts: *'differently, than the normal people'.* However, he does not have the same understanding of mental illness as Western psychiatry; for example, he considers people with head injuries and cerebral palsy would fall into the category of mental illness.

He supported his beliefs about the spiritual model of mental illnesses, referring to the verses of the Holy Quran, which is sacred for the Muslims, and hence to the Pakistani community. He also referred to Christianity and the Bible in strengthening his position on Islam and mental illnesses.

Latif is very much appreciative of mental health services being provided by the NHS. He compares this with the services being provided in Pakistan, and thinks that in the UK, mental health services are of a very high quality and that health professionals are also very caring.

This positive view of Latif on mental health services gives him a different position from most of the other participants who view the services poorly and as not meeting the needs of the Pakistani service users. Latif also has a good image of Pakistani community members with regard to their relationships with mentally ill people. Overall, this narrative is about a religious perspective on mental illnesses.

Analysis

Perception of mental illnesses in the Pakistani community:

Stigma

According to Latif, compared to other communities, mental illnesses are not stigmatised in the Pakistani community. This position is contrary to the findings of the research that mental illnesses are highly stigmatised in the Pakistani community. This may be due to the fact that Latif conflates mental illness with disability.

'Compare to a lot of other societies, our people are very, very welcoming for this. Many other people, they give up their disabled children, because they do not want a disabled child, but Pakistani people are not like that. They look after their disabled children themselves.'

According to Latif, the reason for this acceptance of mentally ill people in the community is explained in the context of their relationship with Allah and their religious beliefs. Mental illnesses are considered and accepted as a test from Allah, and the people in the Pakistani community would not complain about it and try their best to be patient and perform better as it is a test from Allah.

'Perception in the Pakistani community is that this is a test from Allah, just to test us that how we will react in these circumstances, and how we will treat the individual … so that is why we try to do best as we can in that test.'

Latif narrated a story of one of his relatives having mental health issues. He identified that the relationship of the Pakistani people with mental health problems are not de-humanising, rather that they are sympathetic. Latif also mentioned about the power and will of Allah in giving a mental infliction to somebody:

'Nobody has got any problem with it. They just think that it is from Allah. This is test. You know he can give a person some disability or a mental illness from birth or he can get it later on.'

Response to mental illnesses

For Latif, spiritual healing practises such as verses of the Quran are very effective in treating people with mental health problems. He shared an example with me where he personally cured a 'schizophrenic person' (this is his conceptualization of the person) with holy verses from Quran.

'*I written him verses and since then I have not heard in past seven years that he has episode again. They said he is all fine. So basically prayers do make a difference. Apart from this example there are many, many. I am giving you the examples which actually I have seen from my own eyes, not just heard.'*

Latif considers Allah to be very powerful, and believes that Allah has put power in the verses to cure the ailments:

'If a person has headache, you pray on him a verse of the Quran like Surah Fathea (first few verses of Quran) seven

times, that headache will straightway disappear. So you are not going to say "oh it disappears by chance". No, it is the verses which has taken the effect. How it takes effect, we cannot explain, because of spiritual thing. However, it is from Allah which has put the power behind that to cause change.'

In terms of performing the role of spiritual healer, Latif stated the process as:

'We blow on the water. We give them some water, which is blessed with some verses from Quran or some of the holy water from Mecca which is blessed. And we write some verses of Quran. We give them. They wash this paper. We do with special ink so that it is not bad for health, written with Zafran etc. They drink this and it makes a difference.'

Other practices within spiritual healing include asking pious and holy people to pray for the mentally ill person. For Latif, this is also useful in treating people with mental health issues:

'There are many, many stories that people who had gone mad has become all right again. When people have prayed for them, pious people, God accepts everybody's prayer. But some people we believe are closer than other. So when you go to such a person and they pray, there is more chance that your prayer will be heard more quickly.'

Another practice in spiritual healing includes visiting Muslim's holy places. For Latif, this is also an effective way to treat mentally ill people:

'People have taken them [mentally ill] to holy places like Mecca etc. and a change has been seen, and sometimes a person has made a complete recovery as well.'

According to Latif, God has the power to give afflictions to a person whenever he wants. Similarly, God has the power to cure or not to cure a person, even when medication is used:

'Allah has put cure into them [medication], whether he does it or not is in his hands. I mean Allah has the power to change the original functioning of anything, like we hear in the Bible and in the Quran that Allah when Ibrahim was put into the fire, it did not affect him. He (Allah) made the fire cold. Allah changed the power and the original function of fire which is to burn into cool. So Allah can make things which are cured, redundant and void, so that they do not work.'

For Latif, believing in supernatural beings and their potential to cause problems (including mental illness) is part of the Islamic belief system. For Latif, whatever Islam says is true:

'We are told in the holy book quite clearly … about what jinns are etc. and their types … So because of this reason we know about it. Because this is told by our religion and the English have not been told by their religion … obviously Islam does not go against anything which is a fact … anything which has been set by Islam has never been proved wrong.'

Referring to the archetype of social identity of the Pakistani community, Latif said that Pakistani people are mentally very

strong, and they do not get disappointed by the mental illnesses and disabilities:

'They [the Pakistani community] do not let anything get them down. They try to do what they can. If after that they find that "'Oh nothing is going to work", and then they sit and think "Oh this person is ill. He got illness. No problem and they carry on". So they do not let it bring them down. And this is one of the high factors of the Pakistani community … Number (1) they are very hard working. Number (2) they are mentally very strong.'

Latif further identified the archetype related to social identity of the Pakistanis as:

'They are very good at coping with things. Because if you ever meet a person who got a disabled family member, the people, who look after them, they have heart to gold. And they are very, very strong.'

Perceptions about mental health services

Latif holds a positive image of the mental health services provided by the NHS. He compares the quality of the services with what can be expected in Pakistan. The quote below also indicates that he considers Pakistan 'his' country, and uses 'our' to include me (the researcher) as well:

'The services which are provided by NHS in this country for mentally ill people are very, very good. I mean they are lot

better than our country, because in our country there is nothing. You know once you are mental, you are mental.'

Latif also has a positive view of the NHS staff working in the mental health services:

'The staff we have in this country, we are very lucky, that we have qualified people, and they are also very nice, the people who deal with the mental people and disabled people.'

For Latif, having an individualised approach in understanding and responding to the mental health needs can be helpful in improving services for the people of the Pakistani background:

'Everybody has different needs, according to the illness or the problems they have, or the set of mind, the frame of mind they are in. So ask each person what we can do for you.'

Social identity claims

Latif sees himself as a healer and associates himself with Muslims and those of Pakistani ethnicity. He is also open with regard to talking about mental illnesses within his own family, and thus positions a positive identity. In terms of mental illnesses and a help-seeking response, his association seems consistent with a non-Western model of mental illnesses.

Participant -7

Summary

Rasheed is in his mid 30s. He is a second generation immigrant, and originates from the Mirpur region of Pakistan, and has a postgraduate qualification in a scientific discipline. He has developed a western appearance and is clean shaven. He is, however a religious person who prays five times a day, observes fasting, and is planning to go to Hajj (a pilgrimage to Mecca) and he strongly associates with a Muslim identity. He can speak both Mirpuri and English fluently. I used to see him during our daily prayers in the local mosque. One day I introduced to him about my project, and told that I am interviewing members of the Pakistani community for my PhD thesis. He was interested in participating. We agreed on a date and time for the interview along with the venue. It was agreed that the interview would be conducted in Rasheed's office, after 5pm in order to have privacy. Accordingly, I interviewed him in his office after 5pm and the interview lasted for 60 minutes.

Rasheed does not have personal experiences of mental health problems, but one of his close friends has, and has been sectioned under mental health law. He refers to his friend when talking about mental health issues in the Pakistani community. He also refers to one of his aunts who also experiences mental health issues.

Similarly to others interviewed, Rasheed thinks that mental illness is stigmatised in the Pakistani community, and people explain mental illnesses as being caused by supernatural beings. He thinks that most of the people prefer spiritual

healing to treat mental illnesses. Rasheed believes that *'Tib-e-Nabwi'* (medicines of the Prophet (PBUH)) is more effective than medical science. The significant assertion from Rasheed throughout his narrative is that people in the Pakistani community do not consider mental illness as a 'disease', but rather as a spiritual affliction.

Analysis

Perception of mental illnesses in the Pakistani community:

Stigma

Rasheed shared the case of his close friend who experiences severe mental health problems. Rasheed considers his friend in a non-stigmatising and understanding way:

'We do not stigmatise him, or we do not look at him any differently. Perhaps the way I interact with him maybe slightly different, because I am showing him to have more positive thoughts, through my communication with him, but otherwise we [friends] treat him normally.'

Rasheed said that although the mental health issues in the Pakistani community are '*brushed under the carpet'*, when it is serious and people find problems difficult to hide, then they talk about it. He refers to his friend, where the family kept the matters hidden for a time, but then opened up:

'They kept quiet perhaps a period of time, and when it boils over. When people suspect, if somebody is banging on the door or saying strange things or cannot cope or been

sectioned, then the family have to just come in and admit. Well this is how it is.'

According to Rasheed, the issue of stigma relates to treatment as well. The issue of stigma is so strong in the Pakistani community that people do not even openly discuss the course of treatment. Referring to his friend, Rasheed told me that when he visited his friend, the family did not disclose much about the treatment options they had sought. For Rasheed, it is not something which is normal in the Pakistani community. This is contradictory to other type of illnesses, where people would happily share their treatment efforts:

'It has been like a black hole. They have not really talked about the services or treatment which they have received, but it is bit strange. Because if it was something else, "I have been to the doctor a, b and c ". You talked about the treatment, but because perhaps it may be a little bit stigmatised, they will just say that I have been in the treatment or I have been sectioned and that is it. They would not go into the detail or what the treatment was or how they felt about it or the services they came. They would say I have been here and that is it.'

Although Rasheed is a second generation immigrant who was born, brought up and educated in the UK, he is unable to identify various types of mental illnesses and/or their symptoms. This suggests that, having been born and educated in the UK does not mean that a person would automatically have a good understanding of mental health issues. The example below from Rasheed's transcript demonstrates that

he does not consider dementia to be a mental health issue. The dots (….) in the quote indicate the length of time he took in searching for appropriate words to describe the issue.

'Close to home, I got an elderly aunty, who is ..... suffering from ..... not mental illness. I think it is more probably dementia, where she would go out of the door and maybe become lost. You know just walking out or would complain to the family that I want to go back to Pakistan. I think that is probably more dementia than anything else.'

According to Rasheed, although generally mental illnesses in the Pakistani community are attributed to supernatural beings, there are social causes to it as well. He views Pakistani culture as a cause of mental health issues. He refers to the case of a Pakistani colleague of his, where he asked her colleague why she did not go to university:

'Her replies were something along the lines: "My family lives in the dark ages where they do not want the daughters to go out often and have education". These sorts of issues can lead to these stresses.'

Response to mental illnesses

Rasheed thinks that the responses of people in the Pakistani community at the onset of mental illnesses is not that of a 'disease', and they do not consider mental illnesses worthy of seeking help from the doctor:

'We try to keep it within the family. We do not like to seek help. We probably do not understand where the help is. What is available? Who to contact? What the reaction would be? Whether it is acceptable to be bothering the doctor about something which is mental illness. I think we perhaps would go to the doctor if we have a heart attack, or have a pain in the joints, something which is more tangible, something which is more of a disease.'

Rasheed gave an example of his friend's mother who was mentally unwell, and the doctor prescribed her tablets, which she did not take because she did not think that she needed medication to cure her illness:

'My friend's mother who had depression, she was prescribed some Seroxat [tablet name], I think it was, and it was difficult at the time to actually to take the medicine. The compliance was an issue … because she does not feel that she was ill.'

A quote from Rasheed's transcript below illustrates how the issue of diagnosis and response are closely intertwined:

'Perhaps in the mental health case, they might not be accurately diagnosed. They might perceive the mental illness to be as consequence of spiritual problems. You know, the attachment of jinn or something rather than physiological problems, which can hinder them. Because you do not go to the GP if you got a jinn attached to you. You know you go to a spiritualist (laugh) to relieve you of that.'

It is not only first generation Pakistanis who would go for spiritual healing to cure mental health issues; even Rasheed, who is well educated in a medical related discipline himself, considers spiritual healing more effective than the medical model:

'I mean, I myself has the Tib-e-Nabwi (medicine of the Prophet Peace Be Upon Him), and then I have a look at that, and I do not discard that. There is not any bogus issue there. Because that is part of our faith, our deen (religion), and that might actually be better than medical science.'

Although Rasheed seems sympathetic to people who experience mental health problems, according to Rasheed this is in contrast to the wider community, where most people are less sympathetic to such matters when compared to physical kinds of illnesses:

'There might be not enough compassion for these people. Whereas someone who has heart attack or someone who got cancer, we realise that there is proper illness there. And call it 'proper illnesses'. We do not maybe perceive mental illness as proper illness.'

Rasheed considers the delay in help-seeking behaviour as one of the elements related to the social identity of the Pakistani ethnic group:

'They [Pakistanis] will leave it until it gets to breaking point, and then they go and seek help … we [Pakistanis] are quite poor in seeking healthcare advice in general.'

This observation is in contrast to staff data, where a participant pointed out the prevalence of a stereotype among NHS staff that people from the Pakistani ethnic group complain about minor health issues instead of tolerating them like a *'strong Irish man'*.

Another significant cultural element to which Rasheed has referred is the role and power of parents in making decisions regarding treatment options. In the case of his friend, his parents made the decision to get treatment from Pakistan, from a spiritual healer, although his friend is in his 30s.

'If there is a significant problem then the parents will have more of a say, and they perhaps would be reluctant to refer them to the GP. They probably would be more and more inclined to seek help from their own community through a spiritualist.'

Suggestions for improving mental health services
According to Rasheed, services need to recruit more people from a Pakistani background, as it helps to understand the issues pertaining to the community:

'I think because we have an insight. We have first-hand insight into the issues about our own community, so we can quite easily talk to our peers on a one–to-one basis. And they

would not have to explain all the baggage … I would not have to ask that. I already have understanding of why. I think that can be helpful and this is where we perhaps need more counsellors from our own background.'

However, Rasheed also identifies the issues of confidentiality and lack of trust in the close-knit community:

'Family will be reluctant to talk to a counsellor who is from their own background If they knew they live door next to them, because they will think "oh I am revealing all my personal things. They might gossip. They might talk about".

Social identity claims

From the narrative of Rasheed, it seems that he is more aligned to religious methods of treating mental illnesses. He positions himself as somebody who does not stigmatise mentally ill people.

Participant -8

Summary

Khursheed is in her early 40s. She is a second generation immigrant, and originates from the Punjab region of Pakistan. She has a college level education, and has been working with the local Pakistani community on different social services related projects. She also worked as a Community Development Worker (CDW) in the Delivering Race Equality (DRE) action plan which aimed to improve mental health services for BME people in England. I met her for the first time during the early days of doing my PhD in a small gathering at

a BME forum on mental health issues. I contacted her and asked if she would be willing to participate in the research. She happily agreed. Both Khursheed and Shamim know each other from their work in the local Pakistani community. She agreed to be interviewed at Shamim's house.

Due to her relevant experience, especially of working with delivering the race equality (DRE) project in the local TRUST, her narrative spread over various issues which included perceptions of mental illnesses in the Pakistani community and responses of the Pakistani people to mental illnesses, particularly her own experience of working around mental health issues. She was open about sharing her experiences of going through mental health issues. She had a negative image of the mental health services which are being provided in the local community. She identified a number of challenges in the implementation of the DRE programme.

Analysis

Perceptions of mental illnesses in the Pakistani community:

Stigma

Khursheed observed that in the Pakistani community, mental illnesses are considered to be taboo, and a generalised and derogatory language is used when defining it:

'The only world for it is mad, which translate it as "paagal".

According to Khursheed, the stigmatised attitude of the community is deplorable and results in hurdles for people

seeking help, as well as for those providing mental health assistance. The stigmatic attitude of the community towards mentally ill people positions them in a more marginalised place:

'People stay away from them as far as they can. They basically are the talk of the community. People will refer to them and talk about them. Talk about them rather than talk to them, and you do not want to be associated with them in any shape or form, you know, and it is quite sad. Because if it is not spoken about quite openly, you will not receive any help and nothing can be done about it.'

Khursheed concludes that in relation to the White British community, the Pakistani community does not talk about mental illnesses openly, and its tendency to seek help is also different from the White majority. The reason stated is the cultural background of the communities:

'Comparing to the White community, they talk about it openly. They access services. They got help coming in. But with the Pakistani community, there is not that, and then often it is associated to other things. It is not that, it is a mental health problem. They will say it is jinn. It is something else. They do not take it that way basically. They do not take it to medical roots, or they would rather prefer not to … they take it back to their roots and their culture.'

Issues in mental health services

Khursheed views the Pakistani community giving high regard to the advice of the professionals. This results in accepting limited treatment options. The position of professionals is more powerful in the Pakistani community:

'In the Pakistani community, whatever the doctor said, that is marked on stone. You do not challenge the doctor. So if the doctor said you got to have, for example, Dopamine injection, you have to have that. You do not say, "Can I have an alternative?" So there is no challenging, and there is no questioning. You know the doctor's word is the final word.'

She made a comparison between the Pakistani group and the host community in terms of access to services. Her conclusion identified a vast inequality in access to services between the two communities:

'When you look at the sort of access the Pakistani community has, it is 30, 40 years behind, compared to the host community. They are really, really behind. There are lots of things they do not know about.'

Khursheed observed that the professionals in mental health services lack appreciation and understanding of the perspectives of Pakistani service users. For Khursheed, this lack of concern for the needs of service users has put the Pakistani service users in a difficult position. The involvement of the service users in the treatment process is not there:

'I have a chance of going to X hospital with one lady, who had paranoid schizophrenia, and when she said that "she would just like to speak to somebody spiritual", you know, in the Muslim community. I remember when I translated that back to the consultant, he just banged his fist on the table and said, and "we need to up the medicine". You know the medicines are not right. And I was trying to tell him that, you know, you need to listen to what she is saying as well, but I think for the consultant, it is one of those things that if they said something, it has got to be listened to with the power and everything. So this individual was not listened to at all. And she was begging and crying, "Can you recommend somebody that I can go and see spiritually in the Muslim community". There was no knowledge of it. He could not recommend it, and only wanted to just double the dose. So it is really hard. It is really hard.'

She observed that as professionals working in mental health services do not have an understanding of Pakistani culture, they find it hard to give good services to the service users from a Pakistani background, which according to Khursheed is discriminatory:

'As a professional, if you are not from that community, you do not understand the underlying issues of what that person is having. So I think it is really discriminatory in that sense. Because when you are out there to receive a service, you think that you are going to receive a service, and it is going to cure everything but it is not always.'

She further added that because of the lack of cultural understanding of the service users, the professionals working in mental health services find it hard to relate to the service users from a Pakistani background, hence they cannot provide satisfactory services:

'As a professional, if you do not understand holistically where that person is coming from ... it is all right having cultural awareness training, but you see, if you have not spent time with these people, if you have not heard them, if you have not felt them, seen them, it is hard. You do not understand where they come from ... it comes back to that thing that one size cannot fit all … so it will be amazing to see if 20% of the Pakistani community will be satisfied with the service. I think that will still be a generous number.'

According to Khursheed, the role of interpreters in providing a good quality service is not adequate:

'People use an interpreter, which is OK, but does the interpreter actually translate all those emotions and everything in it? Because through interpreting you lose a lot of the essence of what is being said, and you just have the conversation. So it is really hard.'

In the views of Khursheed, the performance of mental health services in meeting the needs of the Pakistani community is very poor:

'I think comparing to the service that the Pakistani community should be receiving, I do not think fair and square that they even receive 20% of that, which is why the satisfaction levels, will be really low.'

Khursheed considers role of Community Development Workers (CDW) as critical in meeting the needs of the communities:

'When we [CDW] were there, I know, we took a lot of people. When I spoke to the people in the group, I refer them to the X BME organisation, to Y BME organisation, to Z BME organisation, because we were that link, and they felt that security, because they built that rapport with us.'

Evaluating the performance of the implementation of Delivering Race Equality programme in the TRUST, Khursheed said that the programme was implemented in haste, and with a target-oriented approach. Due to this, the programme could not achieve the actual change in the quality of the services for BME groups on the ground:

'I think when we were told to work with them, the community groups, it was like work with the groups for three months, and then move on. Now in three months if that group is meeting once a month, or once a fortnight. What sort of change can you create? You really cannot. I think the Manager at the time, I think for her, it was number printing. You know trying to get the numbers high. That is all it was about … one of the bad things for us was that we had been in the job and then the service manager came afterwards.'

According to Khursheed, due to an approach based on quantity of targets met rather than quality of outcomes achieved, the DRE failed to achieve its objectives. One of the objectives of the DRE programme was to empower local BME groups to create awareness about mental illnesses and the services in the local community:

'The Community Development Worker worked with 150 groups or 160 groups, but have those groups really been empowered to take all this work on themselves, even feel confident to talk about this to their members? I do not think that they have, any of them.'

Khursheed's pessimism about bringing about meaningful changes in services is not only limited to the current conditions, but she also thinks that the way the DRE programme was implemented, and the way service providers view the Pakistani community, has ruined the relationship of trust between the service user and the service provider:

'I do not know anything can be done now. You know what I mean? Once the services have been dismantled, once the people have lost the trust, it is very, very hard for our people to get that trust again. Because what our community feels is that they always have been used as a tick box exercise for a very, very long time. And people will come and consult, and you will never see them again … So I think it will be a tough job if they [the TRUST] ever tried to do that again. Very, very tough job. I just do not know how they would do it.'

Although Khursheed is critical of the way the DRE plan was implemented, she identifies herself as someone who is very sympathetic to the needs of her community, and affirmed that she performed her CDW role to the best of her ability in bringing about change in the services for the BME community in the local area:

'When you come from that [Pakistani] community, and you know the sort of discrimination that they face in the sense that they do not know about the service, you tend to push yourself harder. You know tomorrow it could be me in that position. I've got to make a change whether it is small. I've got to do it. Because tomorrow if I am in that position, where I can make a choice for myself, at least if this service is there, and the more people that know about it, they will be able to make a proper choice for me.'

Khursheed said that it was hard for her to work for the local TRUST as a community development worker, because of her social identity, coming from a minority ethnic group. She has to work hard to fit into the organisation. She blamed the local TRUST for being institutionally racist:

'I think when you are from a minority community, it is more challenging. It is harder trying to fit into a big organisation, where there is institutional racism that exists … it was like big brother thing. You were watched upon and monitored.'

Social identity claim

Khursheed openly shares her own mental health issues of the past, and thus positions her positive identity in relation to mental illnesses. She also sees herself as somebody who is quite enthusiastic about working with mental health issues in the Pakistani community. She thinks that because of her minority social status, she experienced discrimination while she was working as a community development worker for the local TRUST.'

Summary of the findings from the community data

Drawing on a narrative approach, I have explored how service users of the Pakistani ethnic group perceive mental illnesses, how they respond to these illnesses, and their views on the mental health services. Additionally, I synthesised the social identity claims being made by the interview participants.

Taking the narratives of the eight participants as a whole, there are many similarities in the views of these participants about how mental illnesses are perceived, explained and responded to. Overall, mental illnesses are highly stigmatised and attributed to supernatural beings, so the Pakistani community routinely turns to traditional and non-medical treatments when mental health problems occur.

Yet despite the commonalities in the views of the eight participants with regard to how mental illnesses are perceived, explained and responded to within the Pakistani ethnic group, there was diversity in the views and social identity claims of these participants in the context of mental illnesses and mental health services in the UK.

I have seen from the data that although mental illness is highly stigmatised in the Pakistani ethnic group, and people like to hide their stories, participants from this research have openly shared their personal stories about experiencing mental illnesses in the past.

Although mental illnesses are generally perceived to be caused by supernatural beings, this research indicates that non-traditional or medical explanations of mental illnesses co-exist in the community. People in the Pakistani community struggle to identify the actual illness and how it is caused.

Similarly, this research has found that treating mental illnesses through non-traditional or medical methods co-exists with predominant traditional ways of responding to these illnesses. The participants in this research have openly challenged the authenticity of traditional healers, and these healers are said to be involved in 'money-making scams'. Interestingly, most of the participants suggested treating mental illnesses through a mixture of traditional and medical routes, but in practice whether this is possible within statutory mental healthcare context is debateable.

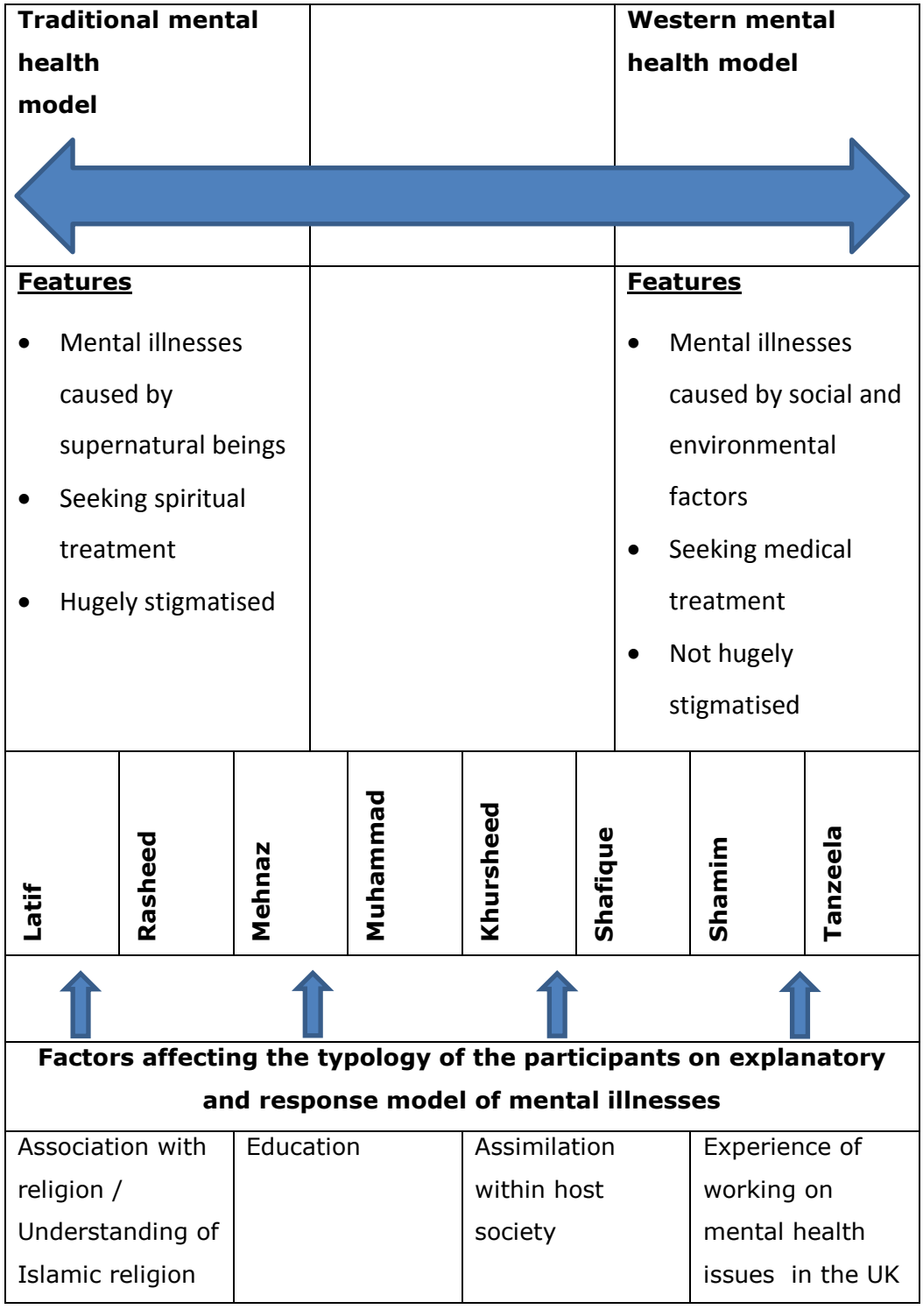
On the one hand, this research has found that mental health services are blamed for being discriminatory and incompetent in meeting the needs of Pakistani service users; on the other hand, participants have much praise for the compassion and competence of the staff and the services being provided by NHS mental healthcare organisations.

Findings concerning social identity claims made by the participants also indicate that members of the Pakistani ethnic group associate with diverse social groups, and construct fluid and multiple social identities. The diversity in social identities is manifested when individuals align themselves with different explanatory models and responses to mental illnesses, and they also have different views on the mental health services being provided by the NHS.

It is found that there is range of mental health perspectives, and there is a co-existence of various views. Features of western ways of interpreting mental health problems include seeing mental illnesses in medical terms, seeking medical help and being more open. In the figure (5.2) below I have typified the eight participants according to their alignment with the mental health model derived from the interview data.

The typology of each participant may be influenced by their experiences of working with NHS mental health services in the UK, their level of assimilation within the host society, their level of education, and their understanding and association with the Islamic religion. It is interesting to note that these factors are also part of health belief model constructs (Becker, 1974).

Fig: 5.2 Typology of community participants of their explanatory and response model of mental illnesses



The eight case studies illustrate a marked variation in each individual's interpretation of mental illnesses and response.

While the interpretation is different, each participant rejects (in a different way) a simple formulation, conceptualisation or fixed construction of social identity response. There is a huge range of beliefs, views and expectations which co-exist: some arise from traditional cultural beliefs; some in response to experiences of discrimination and lack of understanding from NHS professionals; and some result from a lack of education or experience. As a whole, findings from the community data suggest that considering Pakistani service users as a single social entity, and responding with generic approaches in meeting their diverse mental health needs, may not be helpful in achieving the vision of the CEO to deliver mental health services which should be equal and meet the needs of diverse service users.

CHAPTER SIX: DISCUSSION

6.0 Introduction

In my findings chapter, I have described the perspectives of staff working at various levels within the organisation (TRUST), and the views and experiences of people from the local Pakistani community. In this discussion chapter, I explore the relationship between these two perspectives with reference to existing literature and research.

6.1 Summary of the research aim, method and key findings

Aim: This research was conducted in the context of policy expectations for NHS mental healthcare organisations to bring 'cultural changes' to address racial inequalities (Department of Health, 2005c) in service delivery. The research aimed to explore the response of one NHS mental healthcare organisation to the mental health needs of BME groups, in particular, the Pakistani ethnic group in the UK. Theoretically, the study is informed by social identity theory and organisational development literature.

Method: I conducted this research by creating an organisational case study of a large NHS mental health TRUST delivering a range of secondary services in an ethnically diverse region in England. The response of the organisation was studied with reference to one BME group, i.e. the Pakistani community. Semi-structured interviews were used to collect data from 20 participants working at different levels of

the organisation. Eight members of the Pakistani community living in the local catchment area were also interviewed.

Study limitations: The findings reflect the experiences of staff from a single NHS TRUST, and a single community, so caution is needed in generalising the findings across all Trusts and communities. However, the TRUST is one of the largest in the UK, serving a very mixed population, and is likely to be broadly representative. The qualitative interviews were conducted amongst members of the Pakistani ethnic group who are the second largest ethnic community after the local Indian community, and one of the most established in the UK. The small sample of participants from the organisation and the Pakistani community prevent a generalisation of the findings from these two data sources. Nevertheless, the key themes identified from both data sets were highly consistent across the participants.

Study strengths: I collected data from three levels of the organisation as well as from members of the Pakistani community living in the service area of the studied NHS TRUST. In previous research, the focus has predominantly been upon service users, with minimal research into service providers. The data were collected across the three levels of the organisation, and from a range of practitioners.

For NHS staff, purposive sampling was employed with the intention of interviewing people with a particular role and working at different levels of the hierarchy of the organisation. For community members, participants were recruited from first and second generation, professionals, and males and

females from the general public, of different age groups, different regional places of origin, and varying linguistic capability. Among the participants themselves, some have experienced mental health problems in the past or have worked as carers for their family members; some have worked in the NHS and some have worked in the voluntary sector. A number of the participants have close relatives or friends who have experienced mental health issues or have experience of working in the mental health services and the community. One of the participants is in a position of religious authority within the local Pakistani community.

The use of semi-structured interviews helped me to address the research questions and also to collect rich data. The community members were interviewed at length using an approach that facilitated openness, reflection and elaboration of important views and perceptions. The interviews were supported by, but not restricted to, the topic guide. For organisational data, I started with an open question 'H*ow does the issue of race influence your role on a day to day basis?'*. Similarly, for the service users '*I am researching mental illnesses among the Pakistani community. I wonder if you could share your thoughts about it*.' Where needed, appropriate prompts were used.

The reliability was enhanced using case study protocol at the data collection stage. It included an in-depth focus on one organisation, delivering a range of services in an ethnically diverse region of England. The staff data is collected from one part of the service (the adult mental health services), as these are the services which are likely to be accessed most by the

Pakistani community in this city. Ethical concerns were addressed keeping in view that race and mental illnesses were sensitive topics to be studied in the NHS mental health as well as in the context of the Pakistani community. Concerns about poor practice related to racial equality raised by the participants, as well as allegations of institutional racism, were discussed with the organisational gatekeeper as agreed when negotiating access for this research.

Key findings: As stated by the CEO, in the past the studied organisation suffered from a lack of trust in the services being provided to BME service users in the local area. Service users from the BME community were not sure about the 'fairness' of the process of service provision.

To change this image, the organisation is pursuing an aspirational vision of a 'culture of equality and diversity' in the service delivery. Being equal and diverse is stated in the core organisational values. The vision implies that the organisation has a 'whole-organisational' change approach. The 'whole-organisational' change requires change in the work processes and practices of the workforce at every level.

With regard to organisational change interventions, strategically, the organisation is pursuing a 'mainstreaming' approach. Other interventions include: the provision of interpreting services for those who are not fluent in English language; compulsory equality and diversity training for all staff to make them aware of TRUST policy on racial equality in the service provision; ethnic/religious specific training sessions; recruitment of staff to ethnically-match the service

provider and service user; promotion of ethnic minority staff through a BME mentoring scheme; and engagement with the service users of a BME background.

The participants across the organisation seemed aware of the expectations of the racial equality policy and they considered the aspirations to be helpful in setting expectations. However, there was a clear distinction between strategic, middle management and frontline staff in their experience of race issues on a day-to-day basis. The strategic leaders were explicitly aspirational in their vision and were positive about the effectiveness of the current organisational strategy in achieving goals on racial equality in the service provision for local BME groups. However, experience and perspectives from middle managers and frontline practitioners revealed that the current organisational strategy and the associated interventions are having limited effects at the grass roots level when it comes to delivering culturally sensitive mental health services to the target population groups.

Participants from middle management and frontline services identified a variety of practical challenges to providing equally accessible and culturally appropriate services to the service users who identify themselves with a Pakistani ethnic group. The middle managers have limited control over the services received and they identified financial and managerial challenges to ensuring that service users from BME are treated in the best way. Most participants providing practical care and support found it challenging and frustrating to provide accessible, effective, supportive care for culturally diverse clients. This echoes the findings of Taylor and Alfred (2010).

Major challenges for the practitioners working at the frontline include meeting the language needs of the BME service users, and having an understanding of BME specific ways of conceptualising and responding to mental health issues. The research found that frontline staff have limited organisational support to meet the needs of BME service users. The middle and frontline staff did not have the training or support to provide culturally sensitive care. This resonates with Ellis's (2014) findings that staff seem caught in the middle, where on the one hand they are expected by the TRUST to provide good quality services, and on the other hand they are not offered the organisational support needed to perform their role. The participants from these two levels of the organisation also acknowledged the gaps in the service quality for people of Pakistani ethnicity. This gap is more evident when viewed from the perspective of Pakistani community members.

Findings from the community data suggest that people of a Pakistani ethnic group have a range of social identities. The data suggest that there is diversity in the way people from this community conceptualise, express, and respond to mental illnesses and their experiences with the mental health services. There is diversity among the community in terms of their linguistic capabilities. Some participants viewed mental illness like other physical illnesses, whereas for others mental illnesses are highly stigmatised.

The challenge of addressing cultural issues in the provision of mental health services is not only specific to the UK context. Healthcare systems in other developed countries such as USA, Canada, Australia, and New Zealand are also experiencing

similar issues. One of the common threads in addressing cultural issues in psychiatry among these countries is the focus on provision of some kinds of cultural competence training for health professionals. However, based on my findings on utility of such training for mental health professionals in the era of super diversity, in this discussion chapter, I have argued that cultural competence training may not be helpful for providing person–centred, individualised mental healthcare in the UK context.

Kirmayer's work in transcultural psychiatry and cultural brokering is cited in the literature as tackling cultural issues related to mental health provision in ethnically and culturally diverse countries (Kirmayer et al., 2011). Like other researchers in transcultural psychiatry, he has also emphasised the important role of culture in conceptualisation, explaining and responding to mental health issues. Understanding concepts such as selfhood and personhood is important in mental healthcare. Kirmayer argued that the concept of self, and personhood are culturally determined, and this should be an important consideration for the practice of psychotherapy (Kirmayer, 2007). In addressing culture in mental health, according to Kirmayer, cultural psychiatry is capable of playing a positive role in a rapidly changing environment through its focus on the lived experience of individuals during mental health crisis and healing (Kirmayer, 2006). This contribution of cultural psychiatry can extend to challenging the assumptions of Euro–American psychiatry traditions, having its roots in limited datasets that ignore cultural contexts, including the values and concepts of self and person (Kirmayer et al., 2008a). He eloquently states that the expectations from clinical psychiatry to respond to the

diversity of mental illnesses experiences cannot be achieved if we do not listen to the perspective of diversity that challenge conventional approach.

In terms of addressing 'cultural' issues, Kirmayer has suggested the concept of 'cultural formulation' in diagnosis and charting out treatment plans for service users who come from a of minority ethnic background (Kirmayer et al., 2008b) . In 'cultural formulation', mental health professionals are urged to show real concern for the person, and avoid making generalised assumptions about his/her cultural needs (Mezzich et al., 2009). According to Kirmayer (2011), considering cultural difference as a legitimate political concern, can help us in the design of health care systems, policies, and practices that are truly inclusive as they actively seek to understand and respond to the 'cultural' particularities of each individual's experiences of suffering and healing.

In his recent article, Kirmayer (2012a) has criticised cultural competence training stating that 'this approach tends to reify and essentialize cultures as consisting of more or less fixed sets of characteristics that can be described independently of any individual's life history or social context' (p.155). Highlighting epistemological and methodological issues, Kirmayer (2012b) has also noted incompatibility in evidence – based psychiatric practice, and cultural competence literature.

He further suggests that the cultural identity of an individual must be understood in terms of ongoing interactions within multiple networks or communities; similarly, the culture of an ethnic community can only be understood in terms of its

interaction with the larger society. He encourages the self-reflexivity of practitioners in enhancing cultural understanding of the patients. Later on, in this chapter, I have also highlighted that an individual in a society would have multiple social identities, as he/she would have membership of different social groups. I have also argued that social identity is context specific; suggesting that ethnicity related social identity of an individual must be understood within its larger context. I have also suggested in my discussion that instead of offering 'group-culture' specific training to professionals, they should be trained and supported to practice a person–centred care, and have a curious and reflective approach when trying to understand the cultural needs of different groups.

Overall, my research has indicated that the current organisational strategy on race is not working to bring 'cultural changes' to the studied TRUST as expected in racial equality policy (Department of Health, 2005c). Consequently, there is an impasse between what the current organisational structure is offering and what the community members are expecting in terms of their mental health care. Why the current strategy is not working, and why there is an impasse in the expectations of the service users and the provision of TRUST, is the focus for the next section.

6.2 Explanation of the findings

In this section, I consider the possible explanations as to why the current organisational strategy is not succeeding in changing organisational culture and meeting the goals of being 'equal and diverse' in the service provision.

6.2.1 The managerial approach to meeting diverse needs

It seems that the organisational vision on 'difference' and the strategy to engage with diversity are policy driven. The Equality Act 2010 expects NHS organisations to promote a culture of inclusiveness. These expectations are also attested by the constitution on which the NHS is founded, and also by the leaders of the NHS at a national level.

The interventions that the organisation is taking under the racial equality strategy are also policy driven. For example, provision of equality and diversity training to all staff is expected by government, and it was recommended in the Inquiry conducted into the death of Rocky Bennet in 2005 (Department of Health, 2005c). Similarly, the steps which the organisation has taken to represent BME groups in organisational governance (e.g. at board level) and in the workforce through the BME mentoring scheme is also expected in the race-related legislation and policies attested by the NHS at a national level. This policy-driven organisational strategy to engage with the 'difference' can be termed as a traditional approach to 'Managing Diversity' (Davidson, 2011).

A 'Managing Diversity' approach focuses on a set of difference-related activities in the organisation. The 'set' of 'difference' related activities being taken in the TRUST include: equality and diversity training; enhancing the racial diversity in the organisation through a BME mentoring scheme; celebrating black history month, and producing a multi-faith calendar. The 'Managing Diversity' strategy of the organisation focuses on the short-term. This reacts or responds to situations rather

than planning ahead to prevent difficulties arising. The focus is on quick fixes, rather than looking for long-term and more sustainable solutions. In the short-term strategy, the symptoms are treated rather than the actual cause. The efforts are focused on managing the water coming out of the tap, rather than turning the tap off.

It seems that the interventions resulting from a 'Managing Diversity' strategy are not helping the TRUST to achieve its vision on race. These interventions might meet the short-term objectives, but do not seem potent in achieving a 'culture of equality and diversity' in the service provision as envisaged in the vision on race by the CEO. Why these interventions are failing to achieve the stated vision is the focus of the next section of discussion.

6.2.2 The problems with taking a 'generic approach' to organisational change: One size does not fit all

The TRUST has followed national equality policy in grouping all protected characteristics, including race, into the single equality and diversity agenda. This suggests that the organisational approach to conceptualise or address the needs of people of different social identities, including race, is generic. A generic approach to address the needs of people with multiple social identities is evident in various interventions which the TRUST has taken to address issues of health inequalities; for example, in the way the organisation provides equality and diversity training to its staff. The effectiveness of this training in helping staff to meet the needs of service users is questionable, and it is dealt with in detail in a later section.

The CEO and other strategic leaders proudly mentioned how they have ethnically diversified the organisational governance structure by giving representation to a woman from a black African background on the board of the TRUST. There seems to be an implicit assumption that a person from one ethnic minority group can represent all BME groups. However, there are huge inter- and intra-ethnic group variations in the UK, and these groups do not consider themselves as belonging to the same social category. For example, a member of a Pakistani ethnic group may not like to be categorised together with a member from an African-Caribbean background. However, at the national policy and the organisation level, all people of immigrant background are categorised under the single BME label.

The ’one-size fit all’ approach is also evident from the fact that broader ethnic categories such as Pakistani, British-Pakistani, or umbrella terms like Asian are offered to people to categorise them in the collection of ethnic data in the NHS TRUST. If we explore the empirical foundations of these umbrella terms, both theoretical and methodological problems become apparent, as exemplified by the generic use of the term ‘black’ to delineate a common experience of discrimination based on the physical appearance of people (Aspinall, 2002). The ethnicity labels are considered generalised concepts that mask the impact of other factors such as migration, education, health beliefs and socio-economic status of individuals, hence they are problematic (Spickard, 2013).

Grouping all the characteristics together also means that now all kinds of 'differences' or 'disadvantages' are treated equally. However, the nature and dynamics of all the nine (such as gender, race, age) protected characteristics are different. Therefore, the disadvantages associated with each social characteristic or social identity should not be generalised or regarded as shared.

For example, being a member of a minority ethnic group would generate different needs and experiences from that of being disabled; indeed two people from the same religious background may have very different experiences and preferences. A person might have a disability at the time of his or her birth, but ethnicity and religion is more ascribed by society or he/she can choose later in life. A person may change his/her ascribed racial identity, but it is less easy to change disability. Similarly, a person may have more than one 'difference' at a time. He/she can be female, aged 60 years, from an ethnic minority group, and a Muslim. So, engaging with a person with multiple 'differences' through a 'one-size fits all approach' does not seems helpful.

According to social identity theory, an individual can have single or multiple social identities, and the social identity or identities he/she will have would influence how he/she experiences the social world (Jenkins, 2008). Therefore, migrants and minority groups are noted to have complex identities at one time, and those identities shift and change over the course of time and changing circumstances (Spickard, 2013). Overall, data suggests that people of Pakistani ethnicity have diverse social identities, hence

different needs relating to mental health. People of Pakistani origin have different migration histories, and originate from different regional parts of Pakistan. Therefore, 'Pakistanis' living in the UK are not a homogenous group (Fountain and Hicks, 2010)

There are many intra-group variations within the Pakistani population, including language, religious beliefs and observance, cultural practices including food and personal care practices, social support and coping mechanisms (Ahmad *et al*., 2002). For example, research has found a number of regional, generational and socio-economic status-wise differences among the Pakistani population in terms of food and exercise behaviour in the UK (Shaw and Hussain, 2013).

Social power and influence matters when it comes to determining which voices and which differences will be attended to (Davidson, 2011). Therefore, one of the potential disadvantages of grouping all the protected characteristics together is that one protected characteristic may get more attention than another at any one time because of political expediency. For example, currently there is much emphasis on the integration model rather than multiculturalism within the UK. It means that specific needs of different ethnic groups might not get such a priority as gender or disability-related differences. Immigrant groups have raised their concerns about the rise in the popularity of anti-immigration political parties in the UK. This rise in popularity may negatively influence the future political priorities on racial equality issues.

Ethnicity is sometimes defined in terms of the cultural characteristics of a group. Culture is not static, and in the case of immigrant groups, cultural practices are prone to change as aspects of the 'host culture' are adopted (Botsford *et al*., 2011). This process of acculturation or cultural exchange, according to Kottak (2013), occurs at different rates for different groups, or different families or individual within these groups. This means that there will be a variation in the degree of expression of these cultural values to be found even within specific ethnic groups (Botsford *et al*., 2011). This is evident from the community data collected in the present study, when all eight members of the local Pakistani community differed in how they identified themselves.

Furthermore, subdivisions and subcultures exist within all ethnic groupings. Alongside membership of a cultural group based on shared ethnicity, an individual is simultaneously a member of any number of additional subcultural groups (Barth, 1998), each exerting its own overlapping, and in some cases conflicting, normative influences on beliefs and behaviours. Whilst individuals may have shared cultural reference points through their ethnicity, their presentations will vary as a consequence of the interplay between these multiple factors. According to Kleineman (1978), the ways in which individuals adjust to changes in their own health status will be influenced by the cultural values they are exposed to. This is evident from the community data, where some people from the Pakistani community are still holding their traditional explanatory model of mental illnesses and their treatment. However, some of them of have a tendency to view mental illness in a western medical framework. This means that social

identities of the people of a Pakistani ethnic group are not fixed and a single entity. Rather, these identities are changing and multiple.

Identity is not as transparent or unproblematic as we may think. Perhaps instead of thinking of identity as an already accomplished fact, which the new cultural practices then represent, we should think instead, of identity as a 'production' which is never complete, always in process, and always constituted within, not outside, representation. This view problematizes the very authority and authenticity to which the term 'cultural identity' lays claim (Hall, 1990). The people of Pakistani communities differ in terms of their perceptions, explanatory models, and responses to mental illnesses. Some people view mental illnesses as being caused by supernatural beings, whereas for other these illnesses are like any other physical illnesses. For some, mental illnesses are highly stigmatised, whereas other people are open and comfortable in talking about and sharing their own mental illnesses.

People also differed in their help-seeking behaviour and expectations from the services. Although the majority of the people still prefer traditional or spiritual help, there are people in the community who think that getting medical treatment is more helpful. Some people even suggested mixing both medical and spiritual help to recover more quickly.

The community also differs in terms of their English language fluency, and cultural and religious orientations. Some people are well assimilated into British culture, whereas others still

strongly hold their original cultural and religious traditions. Interestingly, the diversity of the views on mental health is evident even among siblings of a same family who are born and brought up in the UK.

On the one hand, there is diversity amongst service users with regard to an understanding of mental illnesses. However, on the other hand, the TRUST approach is to respond generically, and its actions appear to be oriented to meet the minimum legal and policy compliance, rather than ensuring that the organisation actually meets the needs of the Pakistani service users. The CEO also stated that the TRUST has been successful in employing black service users as champions or brand ambassadors to reduce the stigma of mental illness. All of these steps might have helped service users from black communities, but members of the Pakistani community may not identify themselves with the black ethnic group.

The generic approach of the organisation is also evident in the way it provides compulsory 'equality and diversity' training to its staff. The strategic leaders view equality and diversity training as an important intervention to address race issues. However, the generic training does not provide staff with the competencies required to respond to the diverse needs of the people of the Pakistani community (or any other BME specific ethnic group).

The challenges of adopting a generic or a 'one-size fits all' approach is also evidenced by the use of generic assessment tools being used by practitioners working for the TRUST. There are many concerns raised about the validation of western tools

for non-western population groups. These standardised tools are not applicable to people who have individual histories and come from different cultures, and are diverse, such as Pakistanis. So, the use of these generic tools may lead to over- or under-diagnosis of illnesses (Mungas, 2013). An example of this is the reported finding that developing culturally sensitive instruments that do not over-diagnose dementia remains a challenge (Copeland *et al*., 2002).

On the whole, it seems that the generic approach of the TRUST is unable to address the individual needs of service users, who are diverse in many ways. Having a 'one-size fits all' approach results in 'category fallacy' (Iliffe and Manthorpe, 2004), where for example the universality of the validity of specific ways of description of symptoms or responding to illnesses of a social category like ethnicity is taken for granted (Corin, 1994). Therefore, the task for health and social care providers is to recognise the diversity of users and to increase access to appropriate quality mainstream person-centred services, rather than develop segregated or specialised services (Iliffe and Manthorpe, 2004). This being the case, I will go on to argue that the focus should be shifted from category fallacy to person-centred and individualised care (Iliffe and Manthorpe, 2004).

6.2.3 Inability of the TRUST to provide quality interpreting services - creates a basic barrier in the delivery of quality services

Mental health professionals need to be able to work effectively with interpreters to promote good clinical practice and ensure equality of access and service delivery as well as meeting the

requirements of European law (Tribe and Lane, 2009). Therefore, language is an important element in the provision of mental health services and its needs are recognised at various points. These include information about the services available, understanding of the admission process, history taking, charting out a care plan, and monitoring care.

It is noted that migrants who do not speak the language of the host country may be disadvantaged in professional encounters and access to the service system (Iliffe and Manthorpe, 2004). Limited language skills also pose challenges for professionals who take the history of patients in a mental health context (Yeo and Gallager-Thompson, 2013). Non-English speaking patients are at a double disadvantage in encounters with English-speaking physicians, firstly in their understanding of the English language, and secondly in the way what they say is interpreted. These patients make fewer comments, and the ones they do make are more likely to be ignored (Rivadeneyra *et al*., 2000).

There is also the issue of the difficulty of language or conceptual equivalence (Iliffe and Manthorpe, 2004). These observations are paralleled in the UK, where some individuals from South Asian cultures classify dementia as madness or their language has no name for dementia (Bowes and Wilkinson, 2002). There is a complex relationship between language, culture and world view (Tribe and Lane, 2009). This leads not only to difficulty in diagnosis but also to challenges for the service providers. Less frequently raised challenges include differences in the use of non-verbal methods of communication. Language barriers faced by older service

users or potential service users are consistently reported in health and welfare encounters, for example, with a poorer uptake of services by Gujarati-speaking elders in Britain (Lindesay *et al.*, 1997). Thus, the language barrier is also resulting in a poor uptake of services by Pakistani people.

The claim that staff from similar backgrounds may be helpful in overcoming language barriers needs to be treated with caution. For example, Shah (1999) reported on the difficulty of a Gujarati speaking psychiatrist in communication with older people of Gujarati background resident in the UK; a difficulty connected with age gaps, the limits of Gujarati vocabulary in speaking of western models of mental health, the cultural unfamiliarity of medical assessment and hospitals, and the difficulty when family members consider an older person's difficulties as unproblematic.

The use of interpreters is described as leading to inaccuracies, embarrassment, and miscommunication (Cylwik, 2002). Current practices in the TRUST to meet the language needs of the people are: providing an interpreting service through hiring formal interpreters; informal help from colleagues; and using family members as interpreters. Frontline staff and the service users reported negative experiences regarding the quality of the interpreting services.

Amongst the reasons are included delays in arranging interpreters, and finding the right interpreters with the same indigenous background. A difference in social identity related factors, such as age and gender of the interpreter and the service user, may also negatively influence the openness of

the service users to share things or the ability of interpreters to understand experiences. For example, a woman may not feel comfortable about sharing a story of miscarriage or sexual violence to a male interpreter. Consequently, service users may not trust the interpreting service which is being provided by the TRUST (Correa-Velez and Ryan, 2012). Similarly, a young female interpreter may not have sufficient knowledge of pregnancy issues. It seems that this response is not adequate due to several factors. These include:

Delays in arranging formal interpreting services

A delay in the service negatively influences the perception of its quality. As the current practice in the TRUST is to hire face-to-face interpreters, this takes time. Sometimes, they have to come from other towns or cities. The delay also happens during the approval process to spend money on interpreting services, so this negatively affects the perception about the services (Correa-Velez and Ryan, 2012).

One of the suggestions to reduce the delay is to use online interpreting services, which is being used by some Trusts in England. This can be more beneficial than the telephone as body language can be observed through Skype interpreting services.

Limited offer of formal interpreting services due to financial and operational constraints

Communication is very important in mental health care; it helps in building therapeutic relationships between service users and practitioners. Limited availability of interpreting

services due to financial and operational constraints also seems to be contributing to poor service experiences.

Quality of care is compromised when Limited English Proficiency (LEP) patients need, but do not get, interpreters. The quality of care received by LEP patients is inferior, and more interpreter errors occur with untrained ad hoc interpreters. Inadequate interpretation services can have serious consequences for patients with mental disorders (Flores, 2005). It means service users with limited English proficiency on a mental health service ward would not have the opportunity to speak to anybody because of the language barriers. This would lead to more distressing conditions and negative experiences of the service.

One of the important service quality issues related to BME is the offer of only pharmacological interventions, rather than psychological therapies. The reasons stated are the language barriers. Connecting these service users to somebody online, who can speak their language, could be helpful. It would also reduce the financial constraints on the TRUST as well as the administration cost.

<u>Errors in the care journey due to misinterpretation and misunderstanding of symptoms and cultural practices</u>

Medical errors influence negatively on the service experience of the users. It is especially relevant in a mental health setting, where it can lead to misdiagnosis due to misinterpretation of the description of symptoms (e.g. staff data. P. 182-183), or misunderstanding of cultural practices as symptoms of mental illnesses (e.g. community data p. 289).

To address the above issue, practitioners should avoid jumping quickly to conclusions about interpretations of the description of symptoms of the service users. They should also avoid generalising their own cultural practices as symptoms for mental illnesses for all service users. Rather, professionals should be curious, open and reflexive in making sense of different descriptions of symptoms and cultural practices.

Practitioners and service users not trusting competencies of the interpreter

Trust is a fundamental aspect of human relations and becomes relevant in conditions of vulnerability and uncertainty (Möllering, 2006). In healthcare services, the trust in the competencies of the professionals is very important. If the users had trust that the professional who is providing his/her service has the relevant competencies, then he/she would be more confident about using the services. A lack of trust in the competencies of the service provider influences negatively on the perception of service quality.

Service users not trusting interpreters for fear of breaching their confidentiality

Patient confidence in the confidentiality of the consultation may be higher when the interpreter is not present, especially if interpreters who are physically present would otherwise be recruited from the patient's local community (Jones and Gill, 1998). Consideration of stigma is very important in delivering mental health services, even more so in communities such as Pakistanis, where stigma attached to mental illness is still very high.

If the service user fears that his/her confidentiality would be breached, then it is less likely that he or she would use that service. He or she may use the service, but may not be more open to share the conditions related to illnesses. There are examples cited about this in the community data.

Practitioners and service users may not trust family members as interpreters

The issue of trust deficit in the current interpreting practices are not limited to the professional interpreters, but also to family members. The use of family members as interpreters is often dismissed on ethical grounds. For example, a person might have mental health problems because of poor relationships with family members. The family members may subsequently not share the information accurately. There is an example cited in the findings chapter (part-i) of this thesis. This phenomenon is also recognised in the literature (Raval and Tribe, 2014).

Organising interpreting through colleagues is challenging, as it is not formalised

There are many issues related to organising interpreting services through colleagues. The team or service where interpretation help is needed may not have a colleague of the required linguistic background. The colleague may not be happy to work on an informal basis. The bilingual colleagues may not be trained in interpreting (Bischoff *et al*., 2003), which can result in errors during cross-language medical encounters (Elderkin-Thompson *et al*., 2001). This can result in a misunderstanding of complaints by the physicians from non-English-speaking patients. Most importantly, if the

colleague and the service user are known to each other, the service users may not feel comfortable.

Views from the middle management group indicated the financial burden the TRUST has to bear in hiring an interpreter. This may be the reason that it is not providing interpreting services to all the service users who need them, at all times. Rather, this service is provided only at important phases of the treatment journey. A view from the community data is that the interpreting service is made available when the practitioner needs it, not when a service user needs it. So, it seems that the decision to provide an interpreting service is practitioner-led, rather than the service user. The practitioner-led decisions are likely to be influenced by the organisational constraints such as funding.

It seems that the ongoing internal discussion in the TRUST to use colleagues or family members as interpreters is driven by the financial considerations for the organisation. The suggestion to use family members or colleagues as interpreters is being opposed by the practitioners on an ethical and operational basis. Family members are suspected to be reporting incorrect information, mixing their own interpretations, or hiding information in the interpreting process. This may result in the collection of invalid information about the service users, which can result in clinical errors and have negative implications on the treatment and recovery process of the patients.

Similarly, using colleagues as interpreters also has ethical and operational implications. The ethical implications are both for

the service user and the colleague, who is a member of the organisation. As reported in the findings, the colleagues are not paid by the TRUST to do interpreting work. This is not included in their job description and is perceived as extra work. Operationally, the colleague may not be available when needed. The colleague and the service user may both be categorised as belonging to same 'broad' ethnic category, but may not be fluent in the language of the service user. This case is particular true for people of Pakistani origin where people speak a number of regional languages.

Using colleagues of apparently the same ethnicity may also inculcate doubts on the professional confidentiality of the colleague to keep the information official, and not shared with anybody in the community, or even himself/herself be influenced, or perceive the service user and his/her family in a stigmatised way. The clinical staff opposed using family members as interpreters on an ethical basis. They pointed out that the service users may not like it because of confidentiality issues and family members mixing their own personal views. The practitioners were not found to be confident about performing their role with the interpreter. Resultantly, there have been clinical errors on the practitioner's side during the treatment journey.

The operational challenges relating to interpreting services include arranging an interpreter at the time of need. So, there might be a case that a patient of Pakistani ethnicity, who is not fluent in English, is brought to a psychiatrist whose linguistic capabilities are limited to English only. The psychiatrist will request his/her manager for an interpreter.

The request will be processed, and may be scrutinised as well. The manager might take several days to arrange the interpreter. Resultantly, things will be delayed and the person may continue to experience distress.

A lack of fluency in the language negatively influences the development of meaningful therapeutic relationships between the practitioners and the service users. A lack of fluency in the language influences the offer of a range of choices, including non-pharmacological treatment options such as talking therapies. The issue of language is not limited only to verbal communication, but also to non-verbal and body language. The data from staff and the community bear witness to errors resulting from misunderstandings in non-verbal communication.

Most of the communication material produced by the TRUST is in English Literature; other languages are offered on request. In practice, how many Pakistanis would request the communication material in Urdu is questionable. Some segments of the Pakistani population, especially from the first generation, are illiterate; they are even unable to read and write their own full name and address. This creates access barriers for the people.

6.2.4 Unhelpful ways of training practitioners to understand the social identity of the service user -not helpful for organisational change

Understanding the socio-cultural dimensions underlying peoples' health values, beliefs and behaviours is critical to a successful clinical encounter (Betancourt, 2003). Knowing

cultural norms for the patient is an aspect of knowing the individual and is key to knowing the patient (Doutrich *et al.*, 2012). In other words, it is an attempt to understand the individual and social identities of the patient. One of the ways health organisations are trying to train their practitioners to know the individual and social identities of the patient in this context is through the provision of 'cultural competence' training. The stated goal of cultural competence training as an educational and professional development practice for the staff is to improve the cultural understanding and needs of the patients

Literature on healthcare has noted the advantages of 'cultural competence' training for healthcare professionals (Brach and Fraserirector, 2000; Qureshi *et al.*, 2008). However, there is strong evidence which highlights that studies reporting a positive influence of cultural competence on patient health outcomes lack methodological rigour and are based on self-reporting (Truong *et al*., 2014). A recent review also found methodological problems in studies reporting the positive influences of cultural competence training on health outcomes for patients (Clifford *et al*., 2015). These methodological problems include weak study designs and the use of confounding and non-validated measurement instruments for cultural competence. The literature has also identified ambiguity and a lack of consistence in defining terms such as 'culture' and 'cultural competency' (Spickard, 2013). The effectiveness of such training programmes is found to be weak even when they are incorporated in person-centred care models (Renzaho *et al.*, 2013). It means there is limited research showing a positive relationship between cultural

competency training and improved patient outcomes (Bhui *et al*., 2007; Lie *et al*., 2011).

Organisational approaches to cultural training for frontline staff appears to be based on the 'cultural awareness' model (Downing *et al*., 2011). The training based on the 'cultural awareness' model might help the staff to become 'aware' of certain things, but it does not seem effective in providing staff with the necessary 'skills/competencies' so that they feel confident to perform their role and to deliver a quality service to individual patients from different ethnic groups such as Pakistanis (Downing *et al.*, 2011). For example, the training does not educate staff about traditional explanatory models of mental illness and the practices to respond to these illnesses among the various sub-groups of the Pakistani community. It must also be added that not all people from Pakistan will share Pakistani beliefs – every single person will differ in some way.

Culture is an overarching and very dynamic concept. As noted from the data, it seems very difficult for the staff to understand all the nuances of each culture of the various BME groups. Health systems have little evidence about which cultural competency techniques are effective and less evidence on when and how to implement them properly (Brach and Fraserirector, 2000). For example, in a comprehensive literature review on cultural competence, Williamson and Harrison (2010) found that there are two main approaches to culture; the first focuses on the cognitive aspects of culture, the 'values, beliefs and traditions' of a particular group, identified by language or location such as, 'Chinese women' or 'Arabic speaking women'. This approach views culture as static

and unchanging, and fails to account for diversity within groups. The second approach incorporates culture within a wider, structural framework, focusing on social position to explain health status rather than on individual behaviours and beliefs. It includes perspectives on the impact of the colonial process on the ongoing relationships of indigenous and non-indigenous people and how this affects health and health care. The authors concluded that most of the literature focuses on the cognitive aspects of culture and recommends learning about the culture of specific groups which is presumed to apply to everyone. This generic approach can lead to stereotyping and a failure to identify the needs of the individual receiving care. The concept of cultural safety derived from the second approach to culture and practice has potential, but evidence to show how it is being incorporated into practice is lacking and health professionals appear to be unclear about its meaning.

Another method to improve the cultural competence of the healthcare workforce is to incorporate cross-cultural curricula in medical education. The goal of these curricula is to prepare students to care for patients from diverse social and cultural backgrounds, and to recognise and appropriately address racial, cultural, and gender biases in health care delivery. However, there are still challenges in developing strategies to evaluate the impact of cross-cultural curricula on the student's attitude, knowledge, skills and impact on health outcomes (Betancourt, 2003). These kinds of education or training may develop essentialist views of culture, rather than seeing it as socially and historically constructed, which results in making students 'aware' of different cultures (Vandenberg and

Kalischuk, 2014). Therefore, current approaches to cultural education, embedded in traditional anthropology, are obsolete and fail to acknowledge the global environment that impacts even the most remote and isolated cultures (Duffy, 2001).

The principles of transformative education are offered as an alternative to the current approaches to cultural education. In transformative education, students are encouraged to be vulnerable to personal change when interacting with people from other cultures because transformative education is as much about personal growth as it is about the enhanced care of others. This contemporary approach to cultural education transcends the standard adaptation of care from the dominant culture of the health care delivery system to the culture of the client/patient (Duffy, 2001).

From the above argument about cultural education, it is reasonable to argue that offering generic equality and diversity training, delivered by the TRUST, might be helpful in making the workforce aware of the existence of difference, and 'what is needed', but it may not develop enough competencies among the practitioners about 'how to meet these needs' or how to be equal and diverse in the service provision.

Similar arguments can be made about the delivery of 'ethnic/cultural/religious specific' training sessions. Firstly, these sessions are limited in number. Secondly, and more importantly, they provide superficial information about various ethnicities, cultures and religions. A superficial level of knowledge might help the staff in some instances, but it may

also result in stereotyping and making broad generalisations about the social identities of the target group.

The issue of training is not only confined to the content, and the way 'equality and diversity' training is conducted, but more importantly, the limited ability of individual staff of one culture to learn about other cultures to the extent that it helps him or her to comfortably work with service users of diverse backgrounds. The possibility for NHS staff to learn about diverse cultures to the extent that one becomes 'native' with every possible culture seems near to impossible. Therefore, the expectations from the staff to become culturally competent in diverse cultures through a generic 'equality and diversity' or through 'cultural/ethnic/religion specific' training seem obscure.

The demographic and ethnic diversity of the developed world is changing rapidly. Social identity literature suggests that people have multiple social identities, and putting them in only one box may not be helpful in mental healthcare practice, which needs a much more individualised approach. Each individual has a different personal history and applying a broad, generalised knowledge of a social category to all individuals may not be helpful in understanding the personal history of an individual.

The community data suggests that people in the Pakistani community attribute mental illnesses to super-natural beings, and seek spiritual healing. The cultural competence training is not helping practitioners to appreciate non-western explanatory models of mental illnesses and respond to them

accordingly. This is resulting in a trust-deficit between the community and the service provider. If the practitioners dismiss the explanatory model of the service users, then the service users might not comply with the treatment, and hence may not recover quickly.

The fourth way the TRUST is attempting to bring cultural competence to the workforce is getting support from BME third sector organisations through formal collaboration with them. Both the community and the TRUST interview data identified a number of advantages for having 'ethnic specific' services. However, this seems simplistic as it ignores diversity within a single ethnic group, and also the issue of the strong stigma attached to mental illnesses in the community.

Recently, there have been significant cuts in funding to small community-based organisations, which has resulted in the existence of only large organisations in the locality which are able to win collaboration through a competitive tendering process. This enhances the risk that services - just one large organisation - will have a generic approach, for example, delivering services for 'Asians', and will ignore the heterogeneity within this broad term.

6.2.5 Ethnic-matching in the provider and the users – a failed intervention for organisational change in the mental health context

One of the ways the TRUST is attempting to respond to the needs of the people of Pakistani ethnicity is through recruiting and promoting people of BME background, with the aim to match the ethnicity of service users and practitioners. It is

assumed that ethnic matching helps a practitioner and a service user to understand each other's perspective and needs. It is also assumed that this helps in meeting the language needs of service users. In other words, it is assumed that ethnic-matching brings dual competencies, i.e. clinical as well as cultural (Huria *et al*., 2014). However, staff simply sharing a similar language or ethnic background does not automatically warrant trust or cultural similarities. Trust is developed through a sense of respect that staff demonstrate within a cultural context (Chow and Wyatt, 2003).

There are also challenges associated with operationalising ethnic-matching across all the frontline teams of the TRUST in the era of supra-diversity of service users. There are two barriers. One is from the supply side, where the organisation may not find qualified people from a particular ethnic group, and also the people from that ethnic group may not want to join the organisation. The organisational side barriers include structural, cultural and semantic issues (Rangarajan and Black, 2007). Structural barriers are caused by formalised structures, rules and procedures such as qualification levels and professional experience. Cultural barriers refer to dissonance in shared beliefs and value systems of members and subgroups, including experience of racism for the BME workforce. Semantic barriers arise from unclear definitions and ambiguities in the organisational change initiative. But the question is, does the diversity in staff reflect the local population? For example, we might end up having more African staff when the preponderance of patients from BME backgrounds is West Indian patients.

One participant of a BME background who has previously worked within the TRUST referred to workplace discrimination and racism. This is consistent with the research findings that despite significant advancements in the overall socioeconomic status of minorities and working women, race and gender remain important impediments to their attainment of authority (Smith, 2002). Similarly, the minorities face lower odds than white men of achieving higher levels of workplace power (Elliott and Smith, 2004). Today, discrimination is less overt, more subtle and readily identifiable, posing problems for social scientific conceptualisation and measurement (Pager and Shepherd, 2008), and hence difficult to tackle by managers.

The TRUST is championing and aspiring to have an ethnic diversity in its workforce, but currently there are no targeted recruitment practices around ethnicity. The ethnic diversity in the workforce seems to be by chance or by compulsion. As reported by one of the practitioners, there is some ethnic diversity among the psychiatrists, but less among the nurses. According to this practitioner, psychiatry is not a popular profession among White medical graduates, which compels the TRUST to recruit psychiatrists from abroad. Even the recruitment from abroad is concentrated into a few geographical or national locations such as India, Pakistan and Africa.

The TRUST is promoting its existing minority ethnic staff to higher positions through a 'BME' mentoring scheme. However, the 'BME' term itself includes a number of ethnic groups. For example, promotion of a staff member from a black ethnic group may not be helpful for the Pakistani service users.

The TRUST may not find the qualified people to recruit into the workforce, or the people from a particular ethnic group may not be interested in certain careers. Pakistanis are said to be not interested in becoming a mental health nurse. During the data collection, it was reported by two participants that there is not a single mental health nurse of Pakistani background working in the local adult mental health service.

Industry context can strengthen or weaken the effects of organisational diversity (such as race) on performance (Ali *et al.*, 2011). Therefore, workforce diversity might be helpful in manufacturing, or in certain services contexts, but it does not seem helpful in the mental health setting. Then there is the issue of the strong stigma attached to mental illnesses in the Pakistani community. Being a small community, who may easily know each other, service users of Pakistani background may not want a practitioner of Pakistani background to know about their illnesses. So ethnic matching, instead of helping the service users as assumed, may actually deter the service users from accessing the services or sharing the information related to their illnesses openly. Therefore, not all racial-ethnic minority individuals make their choice of a worker solely on the basis of race, ethnicity or culture (Shin *et al*., 2005).These are traditional methods of 'managing diversity' and do not help organisations to achieve their goals on diversity issues (Davidson, 2011). It means that diversity management alone is insufficient for improving workplace performance, as it may not take into account the views of the employees and enhance their self-esteem (Sabharwal, 2014).

Davidson (2011) has noted that there are many challenges associated with the efforts to diversify the workforce based on social identities such as race. Hiring to enhance diversity is difficult because often organisations have not discovered where to find the talented people they want. The staff data points towards this, where the organisation has a view that they are unable to find people from a Pakistani background to work as mental health nurses. It is also observed that certain professions are not regarded in high esteem by certain groups. So how can an organisation which has limited resources educate people to join certain professions? All these questions limit the organisation's capacity to create a diverse workforce.

These recruiting system flaws are exacerbated by the biases that hiring managers invariably hold. A great deal of research outlines the deficiencies of managers in recruiting and hiring people who are different. For example, managers may have stereotyped perceptions about race, age, disabilities and other differences. Some of these biases are the unconscious and implicit psychological biases that influence decisions about whether to hire an applicant for a position. These dynamics can make it difficult for managers and leaders to hire enough diverse people.

It is not only hiring for diversity which is challenging; retaining a diverse workforce is also a big challenge for the organisations as they attempt to build a more diverse workforce. The causes for low retention are varied. Staff participants from a BME background in the TRUST seem to be experiencing or have experienced racism on institutional,

interpersonal and internalised levels, leading to marginalisation and being overworked yet undervalued regarding their cultural skills (Huria *et al.*, 2014). Additional challenges for maintaining a diverse workforce in organisations are found in studies on relational demography. For example, it is noted that increasing racial or female diversity in workgroups can lower the organisational attachment of the White and male team members (Tsui *et al.*, 1992), and consequently they may leave the organisation. These dynamics can make it difficult to retain a diverse workforce in the organisations.

We live in an era of super-diversity (Vertovec, 2007). This super-diversity has changed the demographic and social landscape of the UK (Ram *et al.*, 2012).This super-diversity has challenged the traditional multicultural model of service provision, which is based on the understanding of migrants as large and geographically contained clusters of predominately post-colonial migrants (Phillimore, 2011). There are nine protected characteristics: expecting an organisation to be ethnically diverse, generationally diverse, sexually diverse, and religiously diverse. It seems impossible to have all these in every healthcare team. Moreover, every individual will at some time carry some sort of protected characteristic through age, gender, disability and so on, and many will carry more than one of these protected factors at any time. So it is not possible to provide a generic approach that meets every possible need. Furthermore, demographic profiles of areas change, with changing social identities. Therefore, this approach is not going to be sustainable in the long run. A cultural understanding can be provided by people who come

from different backgrounds, but require curious approaches to learn these new understandings. This seems to be a more sustainable solution than ethnic matching (Maramba and Nagayama Hall, 2002; Karlsson, 2005).

6.2.6 Organisational culture not supportive to individualised care

It was found that the organisational culture of the TRUST is becoming more corporate in style. In a corporate style of culture, greater emphasis is given to close supervision, control and micromanagement, work standardisation, efficiency and meeting targets (Raelin, 1986). This is in contrast to professional culture which values autonomy, professional expertise, commitment to professional ethics, doing meaningful work and dedication to delivering a quality service (Raelin, 1986).

The strategic leaders reflected a corporate approach in their unanimously positive construction of the TRUST, its ambitions and achievements. Participants from middle management and frontline category were less positive:

'On paper and on literature those things, the TRUST pronounces all around the messages. I think around the BME agenda but also around LGBT agenda. We got Stonewall and so on. But I think the TRUST is good sometimes in making things on paper, but it does not always translate to the practice on the ground. And I think the culture of the TRUST is becoming very much corporate like, and it is losing touch with public service values somehow in doing that. There is a lot more attention paid to the business plan and bids and tenders

and policies on the window dressing, rather than caring for the people on the ground if you like on everyday level.' (FS-5)

There is a risk associated with placing such emphasis on meeting targets, 'being seen to be doing well': looking good. Organisations with these types of cultural characteristics, tend to be 'focused on doing the system's business– not that of patients' (Francis, 2013:4)

Views from the middle management and the frontline staff was that the top leadership promotes a good image of the organisation on equality and diversity through different communication tools in an effort to sell a positive image and reduce reputational risk, but in practice things are worse. The organisation does not support an 'open discussion culture'. Evidence of this is in the staff data. This suggests that strategic leaders are not prepared to hear bad news, and this encourages staff to bury the bad news, rather than discussing it openly without risk of negative implications for their jobs. A lack of an open culture discourages people in organisations to learn from their mistakes. The whistle blowers are ostracised in these kinds of organisations. Race, being politically and socially a sensitive subject, also discourages staff to speak even if they might be right. This has the potential to lead to neglect and short cuts amongst other things on behalf of the staff. The findings of the Francis Inquiry identified that such kinds of organisational culture attaches 'more weight to positive information about the service than to information capable of implying cause for concern' (Francis, 2013:4), and thus hinders the potential to improve the service. To address these organisational culture issues, the organisations should

'foster a common culture shared by all in the service of putting the patient first … [and] ensure openness, transparency and candour throughout the system about matters of concern' (Francis, 2013:4)

Data from the current and past employees of the organisation from minority ethnic groups suggest that there is a perceived presence of racism within the organisation, where colleagues of White ethnicity discriminate against colleagues from minority ethnicities. In an organisation where its BME colleagues do not feel treated equally, the service users who are in a more vulnerable position are even less likely to be fairly treated.

Interviews with frontline staff revealed that they feel powerless and micro-managed. A powerless and micro-managed workforce is less likely to be innovative in their practices. Middle managers seemed to be criticising the strategic leaders as well as the practice staff, and the practice staff seem unhappy with the middle managers and strategic leaders. There seems to be a lack of common perspective and 'tribalism' among strategic leaders, middle managers and the frontline staff. A 'tribal' culture is not helpful in developing a shared vision and understanding among the organisational members. A teamwork culture, rather than a tribal culture, is found to be associated with patient satisfaction (Meterko *et al*., 2004).

6.2.7 Higher expectations of the service users

Studying the management of user expectations in a professional services context, Ojasalo (2001) argued that

managing expectations is important since service quality and satisfaction results from how well the actual service performance, in other words the service process and outcome, matches the expectations. The author suggested that making fuzzy expectations precise, implicit expectations explicit, and unrealistic expectations realistic, facilitates long-term quality and user satisfaction.

The nature of the expectations that the service users bring to the organisation influences his or her levels of satisfaction. In some instances it seems that service users had expectations from the services that could not be satisfied. For example, one of the participants from the frontline category mentioned that there was a request from a patient on the ward that he/she should be treated by a Muslim doctor. It might be the case that a non-Muslim doctor may not understand the needs of the service user, but for a service user to be treated according to his or her wishes may not be genuinely practical for the organisation. This view also reinforced that there may be an 'over–dependency' attitude among the community; where there is an expectation that the services have all the answers and can do everything for them.

6.2.8 Poor engagement with the service user groups and marketing of the services

Increasing engagement with service user groups from BME communities can have many benefits, including reducing the fear of the services, active engagement of the communities in the planning of the services, making people aware of the services and educating staff on cultural issues (Fountain and Hicks, 2010). The data suggests that people from the

Pakistani community are unaware of the services being offered by the local TRUST. People do not know how to access the services and what the process of treatment is. This indicates that the organisation has not been successful in marketing its services to the local Pakistani community.

The participants from the organisation stated a variety of reasons associated with the Pakistani community which hinders community engagement. These include intra-community politics and the stigma attached to mental illnesses. However, community data suggests that Pakistani people perceive that they are not consulted, and even if they are consulted, it is just a tick box exercise. This indicates a blame-game between the two parties.

Community members are unaware of the services available and need more information about the services and how to access them. The TRUST produces a range of reports, booklets and other communication material, but it is in the English language. A considerable number of Pakistani service users do not understand written English. The offer is also made that if someone wants the report in other languages, it would be made available. This takes time and is not always possible. If the reports were made available in various languages in the first instance, it would reduce the extra barrier for the service users as they have to make requests for these. The media used for communication are written reports and leaflets. Reading habits among the community are reported to be limited; hence this is an inappropriate communication media.

The TRUST has done some work in reducing the stigma through anti-stigma campaigns, but it does not seem to be working in the Pakistani community. There might be multiple reasons for this, including inappropriate use of language, imagery and media (Knifton, 2012). The TRUST has used anti-stigma ambassadors from another ethnic group (i.e. black), which the Pakistani community members might not associate with. Hence, the people of Pakistani ethnicity are not socially influenced by other ethnic group members. The TRUST is using a local radio programme to reduce stigma, but the members of the Pakistani ethnic group may not be listening to this radio station. Anti-stigma material is also published in the English language, which the majority people of Pakistani background may not understand.

6.2.9 Conclusion

Sustainable organisational change is linked to winning both hearts and minds of the people involved so that they support the issues. It is not a set of interventions that are 'done to' them to meet the policy expectations. This discussion has demonstrated that a 'Managing Diversity' approach is not appropriate. When diversity-focused changes are not clearly connected to the organisation's core strategic goals and approach, deep change becomes unlikely to be achieved.

Davidson (2011) argues that a 'Leveraging Diversity' approach is helpful in bringing the desired changes in an organisation. Leveraging difference provides that connection between strategy and diversity. In a 'Leveraging Diversity' approach, the way the organisation looks and acts towards 'difference' can change. A 'Leveraging Diversity' approach positions an

organisation to take advantage of the current 'differences' as well as the future because of changing demographic profiles of the area. Operating under a Leveraging Difference frame helps organisations develop a capability for engaging and using difference to achieve its goals. That capability becomes woven into the fabric of the organisation. It can become the standard operating procedure. It becomes the blood for the organisation as it passes through each and every level. It becomes systematic.

One way in which this more transformational approach can achieve a more culturally sensitive workforce is through 'person-centred and individualised care'. A leveraging difference approach encourages curiosity, learning, creative thinking, and innovation. All of these qualities are also associated with providing person-centred services which base care and support on the individual needs, background, preferences and experiences of the individual.

Organisational capability is a collection of knowledge and skills that are embedded in, and supported by, the organisation's people, practices and systems (Davidson, 2011). A few examples of organisational capabilities are being able to make important changes rapidly, collaboration across organisational boundaries and silos, and managing costs efficiently. A capability becomes valuable when it is directly useful in helping the organisation achieve its fundamental mission, strategy and goals. Organisational capabilities equip the organisation to do what it needs to do in order to achieve results.

Developing a capability for valuing difference is critical for organisations in the 21st century. The purpose of an organisation, including an NHS Trust, is to achieve goals such as delivering a service as expected by the service users and the government. Organisations create value for their stakeholders. The problem is that in the UK service users are more diverse than ever before. It is no longer a viable strategy to marginalise or ignore the diversity of the service users they embody. Ignoring such diversity would just increase inequalities in health. How the studied NHS organisation can develop its capability to leverage from the 'difference' is the focus for the next section.

CHAPTER SEVEN: CONCLUSIONS

7.0 Introduction

In this section I will focus on suggesting how the TRUST can develop itself which helps it to change its culture and meet the expectations of service users of diverse backgrounds, including Pakistanis'.

Organisations can develop capabilities through an organisational development framework. Organisational development is a planned process of change in an organisation's culture through the utilisation of behavioural science technology, research and theory (Burke, 1982). It has a system-wide focus with the aim to plan, develop, improve and reinforce the organisational strategies, structures and processes that lead to organisation effectiveness (Cummings and Worley, 2014). It requires the development of new cognitive schemes among organisational members for understanding organisational context and its relationship with purpose and mission of the organisation (Bess *et al*., 2010). Evans *et al*. (2010) argued that organisational change is not only about change in the organisational system, but it is change in the organisation's approach to providing human services. These definitions suggest that organisational development focuses on changing organisational culture to improve its performance, and thus achieve the stated vision.

Referring to the specific purpose of this study, I now focus on how NHS Trusts facing similar issues can have a culture of equality and diversity in their service delivery function.

Keeping the findings of this research in perspective, where the frontline staff have expressed an inability to learn nuances of every culture, and where it seems impossible for the organisation to provide ethnic matching of workforce and its service users because of increasing diversity in the population, it is suggested that the organisation needs to change its strategy and interventions, aiming to address race issues.

There is a need for the organisation to have an individually-centred culture to become able to respond to the needs. The 'why' of this need is the focus of the next section:

1) Recruiting staff for their values;
2) Equipping staff with a person-centred approach;
3) Providing organisational support to provide elucidated needs through person-centred approach;
4) Meaningful engagement with the community.

7.1 Recruiting staff for their values

The findings from the community data suggest that service users of Pakistani origin perceive that they are treated discriminatorily by the TRUST both in the workforce and in the service provision. These findings are consistent with the previous research on ethnicity and mental healthcare delivery in the UK context (Wheeler, 1998; Bowl, 2007; Penny *et al*., 2009). Community members stated that people of Pakistani origin receive discriminatory treatment from mental healthcare providers because of their social identity associated with a minority ethnicity in the UK, i.e. Pakistanis.

According to social identity theory, the social identity of a person influences how he/she experiences the social world (Jenkins, 2008). The basic assumption of social identity theory holds that an individual's self-concept and self-esteem is influenced by his/her membership of social groups (Forsyth, 2013). Accordingly, individuals' attitudes towards societal 'out-groups' and the beliefs underpinning these attitudes help 'in-group' members to distinguish themselves from out-groups (Eagly and Chaiken, 1998). Furthermore, an out-group will receive discrimination, stigma, feelings of unimportance and marginalisation. This suggests that people of the Pakistani community belong to an out-group for the NHS staff; hence they have experiences of perceived discrimination, unimportance and marginalisation.

Findings from the TRUST data suggest that every staff member is expected to uphold values of equality and diversity in their daily practice. Upholding these values for the staff in the service provision means that they would provide a quality service to every service user, irrespective of which social group he or she identifies with. Findings from this research suggests that there is a gap in the expected core values of the NHS and the actual values exhibited by the staff in providing services to the people who associate themselves with Pakistani ethnicity. This suggests that the current recruitment practices of the TRUST are not oriented towards recruiting people for their equality and diversity values along with the required competencies to perform the role.

One way the TRUST can address this issue is through adopting the Value Based Recruitment (VBR) practices. Recruiting staff

for their equality values is a very important step towards providing equal and good quality services to all, including minority ethnic groups. This is endorsed by a number of recent reports produced by the Department of Health and independent experts suggesting that NHS organisations should recruit people for their values (Berwick, 2013; Department of Health, 2014). The purpose of value-based recruitment is to ensure that the future and current NHS workforce is selected according to the values of the NHS constitution, which include provision of equal and best quality care for all.

Values based recruitment aims to ensure that the NHS has the right workforce, with the right skills, in the right numbers and with the right values, to support effective team working and deliver excellent patient care and experience (NHS Employer, 2014). It is argued that if staff come into the organisation with certain values which include commitment to meet the needs of every individual, and work with every individual irrespective of their social identity, that will be helpful at the individual staff level, both for the organisation as well as for the service users.

It is reported that organisations who have implemented values based recruitment have discovered a number of benefits (Miller and Bird, 2014). These include: less agency recruitment; less staff turnover; a higher staff morale; more positive work environments; staff report feeling more valued; a lower sickness and absence rate; greater job satisfaction among staff and better care as reported by the patients. The author concluded that values tested against are integral to the

development of a workforce that can provide the care required by the NHS and improve the culture of healthcare.

Research into organisational behaviour and human resources disciplines has identified factors related to Person-Organisation fit and its positive outcomes, both for the organisations and for individuals working in those organisations. According to the Person-Organisation fit theory, staff with similar values to those of the organisation will perform better in delivering organisational goals. Person-Organisation fit is also found to be an important factor influencing the work attitudes of public sector employees (Sangmook, 2012). Employees' values which fit with their organisation increase their job satisfaction and organisational commitment (Maden and Kabasakal, 2014), and it positively correlates with the adjustment in the organisation (Chatman, 1991) and decreases the staff turnover (Jung and Yoon, 2013).

Importantly, the research has shown that Person-Organisation fit is related to the development of prosocial behaviour (such as helping, benefiting and empathising with others) towards colleagues, organisations and patients (Cha *et al.*, 2014). It is found that the congruence between personal values and current organisational values positively affects employee's creativity (Saraç *et al*., 2014). It is apparent that all these advantages are also related to the NHS organisational context.

The question then arises is of 'how' the NHS organisation can achieve a better Person-Organisation fit. It is found that Higher Performance Human Resource Practices (HPHRP) are helpful in achieving Person-Organisation fit (Mostafa and

Gould-Williams, 2014). HPHRP refer to a set of interconnected human resource practices designed to enhance the skills and efforts of employees in organisations. These include recruitment, selection and training.

There are different ways through which the TRUST can practice value based recruitment. The NHS Employers (2014) has listed the following three main ways for Value Based Recruitment:

Pre-screening assessments

There are many kinds of assessment, such as Psychometric Assessments, which if used wisely are found to be helpful in measuring candidates' values, and can be helpful as these can inform the organisations which candidates are likely to perform and stay in the job (Hutchison, 2012).

Values based interviewing techniques

In values based interviewing, the values of a person are assessed during recruitment interviews using different techniques such as role play, written responses and scenarios etc.

Assessment centre approaches

Assessment centres are events used to evaluate the skills or personal capabilities of participants. All participants take part in a number of assessment exercises such as business simulations, interviews, psychometric tests and questionnaires. Several assessors take part in the assessment centre, observing and evaluating the candidates' performance.

At the end of the session, the assessors meet to compare their evaluations and make recommendations about the suitability of the participants for appointments.

Winter (1995) concluded that assessment centres can play a major role in helping organisational change by identifying those of high potential and focusing their development towards the future needs of the company. The author also gave suggestions for making assessment centres more effective. These include making sure that exercises relating to assessment centres need to be realistic and credible to the participants; the exercises need to be well communicated; and the approach should have the support of management as well as align with the strategy, structure and style of the organisation. There is evidence that Values Based Recruitment is being practised in some NHS Trusts (e.g. Sussex Partnership Foundation Trust, Northern Lincolnshire and Goole Hospitals NHS Foundation Trust). Evidence from these cases have documented positive results of VBR (NHS Employer, 2014).

It is argued that recruiting people at every level, based on their values for providing best quality services to the people of all social backgrounds, is one of the important interventions which the studied NHS TRUST may adopt to achieve its vision of having a culture of equality and diversity in its service provision. As 60% of staff are nurses, VBR also needs to be embedded in university processes.

7.2 Developing a person -centred approach among staff

After recruiting staff with beliefs and values consistent with providing the best quality care to service users irrespective of their social identities, the second intervention which could help the TRUST to improve responses to the mental health needs of people of Pakistani ethnicity is to encourage frontline staff to have a person-centred approach in their daily practice. There is evidence that person-centred care has a positive outcome in terms of patient satisfaction and self-management of illness (Rathert *et al*., 2012). A recent systematic review conducted by McMillan *et al*. (2013) has also shown benefits associated with the person-centred model of care, including patient satisfaction and perceived quality of care.

In a person-centred approach, each person is taken as an individual person. The professionals and service providers are encouraged to use a personal and curious approach. Consistent with a person-centred approach, professionals are interested in the individual, and are discouraged from making any generalised assumptions based on the perceived social identity of the person. For example, a person-centred approach would discourage a professional from making assumptions that people who appear to be from a Pakistani background would perceive and treat mental illnesses in a particular way. It is apparent from the community data that the eight members I interviewed expressed *difference* in many ways about their perceptions and responses to mental illnesses.

Identity literature suggests that people have multiple social identities (Brewer, 2001), and defining people with only one social identity, such as ethnicity, does not seem helpful in mental health practice. In a person-centred approach, when professionals meet with a service user, they are interested to know the whole person. Professionals are interested to have knowledge of the social and religious beliefs of the individual service user. The professionals are interested in understanding how the person himself/herself understands his/her illness; how the person wants to be treated and so on.

The person-centred approach is about *relational ethics* (Bearskin, 2011), where healthcare professionals are expected to pay close attention to their relationship with the service user. The relationship between professionals and service users in person-centred care is collaborative, participative, educative and empowering to the service user. Before imposing any treatment, the professionals ask the service user questions such as: 'How would you like us to help you?' 'Is there anything in terms of meeting your religious needs we can be of any help with?' How can we help with this?' 'Are there any special requirements you have in relation to diet?' etc. Through a collaborative and participatory approach, the professionals have a better chance of understanding the individual's needs. On the other hand, the service users feel empowered and his/her perception about the service quality also changes.

The next section focuses on how the studied NHS organisation can make its staff *believe* and *actually* practice a person-centred care. In other words, how the TRUST can make a

person-centred care a ‘culture’ rather than a tick box practice in the provision of mental health services.

7.3 Making organisational culture supportive to person-centred practice

Making person-centred care part of everyday practice is concerned with the professionals working for the organisation and the management of the organisation aspiring to implement this approach. Its concerns are with the professional practices of the practitioners, and its organisational concerns relate to the organisational structure surrounding these professionals.

Professional practice means how professionals in any field are performing the duties entrusted to them. There are many ways through which people learn their professional practices. These include formal education and training in the academic institutions before commencing their professional role. After commencing their profession, the goal of learning professional practices is achieved through an organisational socialisation process.

The organisational socialisation process consists of two types, namely formal and informal (Van Maanen, 1978). In formal socialisation, the organisations educate and train their members through organised and structured processes. These processes include specifying training objectives, choosing appropriate methods of delivery and evaluation of learning outcomes. The findings from this research indicate that the formal socialisation process specific to race within the studied

organisation comprises online equality and diversity training and limited sessions specifically on ethnic groups. The aim of both types of training is to make the frontline staff aware of the equality and diversity requirements and to enhance cultural competency amongst staff. However, as indicated by the findings, these types of training are unable to socialise staff to become competent at providing good quality services to diverse service users.

Competencies are seen as a core organisational cultural aspect that is hard to change (van Buuren and Edelenbos, 2013). Developing a person-centred approach among staff would mean that instead of training staff in different cultures as it is currently being done, the training around the culture needs to allow and encourage staff to embrace *difference* and to become curious about different ideologies people hold about their lives and their mental distress and how these ideologies affect their behaviours and their practices. Staff need to be trained in what is likely to be different,, what questions to ask, and how to respond to the needs identified.

Research has noted the important role that an existing organisational culture plays in implementing a new health care model such as person-centred care (Alharbi *et al*., 2012). For example, the impact of organisational culture on patient uncertainty during the implementation of person-centred care in Sweden indicated that a culture of stability, control, planning and goal-setting contributed to a reduction in patient uncertainty more than a culture characterised by flexibility, cohesion and trust (Alharbi *et al.*, 2012).

Similarly, Kirkley *et al.* (2011) explored the role of organisational culture to person-centred dementia care. Aspects of organisational culture that are perceived to influence person-centred care include: understanding of person-centred care; attitudes to service development; service priorities; and valuing staff and solution-focused approaches. The research found resource constraints and the knowledge, attitudes and personal qualities of staff to be a barrier to implementing person-centred care. Leadership style, the way that managers support and value staff and the management of risk were also considered important influences in practising person-centred care. Research has suggested that different instruments may be used to understand existing organisational culture, and plan for change (Alharbi *et al.*, 2012).

Training staff in person-centred care alone, however, is not enough to change practice. Institutions wishing to implement such an approach must also act upon the beliefs of individuals, as well as upon work situations (Viau-Guay *et al*., 2013). The next important thing after identifying the needs of service users through a person-centred approach is to make sure that organisational structures enable the professionals to meet those needs. For an organisation to provide an enabling structure for person-centred care, there is a need for financial resources (Anders and Cassidy, 2014), which is dealt with in the following section.

7.4 Gaining support for person-centred care through the *invest to save* model

In order to persuade government and get the commitment of NHS organisations for allocation of resources, I would propose an economic case, i.e. *invest to save* here. In the invest-to-save model, short-term funding is provided to enable transformational change to happen in public services that will lead to long-term benefits.

For example, it is found from the community data that in the Pakistani community, mental health is related to spirituality. There is evidence from wider literature that spirituality and mental health is related (Khalifa *et al.*, 2011; Walpole *et al*., 2013; Islam *et al.*, 2015; Loynes *et al*., 2015). However, if the TRUST does not provide support for meeting the spiritual needs of service users, it will mean that service users may not recover earlier and the issue may become more serious, resulting in the use of much more expensive services later on. For example, if the professionals treat somebody with a very strong belief that mental illnesses are caused by God, and the professionals are treating them with medication or do not have support from the organisation to meet spiritual needs, it is likely that the service user will not recover. Therefore, if professionals try to find a way to meet the spiritual needs of the service users, they will recover more quickly and hence save money in the long-term. The same is the case with the provision of quality support for addressing language issues. Encouraging Pakistani people to receive language support can help in reducing medical errors, and preventing relapse into poor mental health conditions (Chaudhry *et al*., 2012).

One example of promoting a person-centred approach is through Recovery Colleges. I have observed this when I interviewed the Manager and an instructor from the local college. I also attended one of the educational sessions. I observed how the service users were brought together to educate them as to how to manage their mental health. The service users were able to listen to the experiences of other service users and benefit from peer support.

In recovery colleges, people are allowed to share what they want and the college accepts it and tries to meet their needs. Recovery is about co-creation of services. In a recovery approach everything is done in collaboration with the service user. It means that if the services are developed in collaboration with the Pakistani community and professionals, this may help deliver a relevant and effective service.

A recovery orientated practitioner believes that everybody knows what is best for them, and professionals need to help the service users to achieve their recovery plans. There is a big emphasis on self-help and education in the recovery model. In this model people are empowered to manage their own conditions, and the way it is done is very much led by the individual. So the individual decides what they want, and the organisation makes efforts to ensure that it is available. Empowering service users also helps to effectively change healthcare organisations to achieve the goal of person-centred care (Anders and Cassidy, 2014). So with the example of the Recovery College, my recommendation is that similar types of colleges may be opened by other mental health care providers.

7.5 Using a social marketing approach to market the services

In this section, I will discuss why the engagement of the NHS TRUST with local Pakistani communities is important, and how it can be achieved.

In this study, it is evident that the NHS TRUST does not have fruitful engagement with the Pakistani community. Engagement with the community can help service users as well as the service providers. Through this engagement, the members of the Pakistani community can become aware of the available services, and on the other hand, the staff can have an understanding of the community needs. The service provider can also receive feedback from the service users which can be used to continuously improve the services. The service provider may also use community engagement to manage the 'unreasonable' expectations of the service users. The ways the NHS organisation can achieve meaningful engagement with the local Pakistani community include: employing community development workers from this community, and involving the community through an involvement centre.

I conclude this chapter suggesting that the studied NHS organisation can better respond to the mental health needs of the people of Pakistani ethnic group if it develops in four interrelated aspects and changes its practices. These include: Values Based Recruitment; equipping staff with a person-centred approach; providing organisational support to staff to implement a person-centred approach; and developing

meaningful engagement with the Pakistani ethnic group. This means instead of putting money and other resources into cultural competence training, focus should be given to the four areas identified above.

7.6 Future research

Future research may need to focus on other Trusts and the BME groups. These findings require confirmation and expansion. Response to diversity needs to be studied in various contexts, and data sources should be triangulated by observation and documentation.

Longer term research objectives should include developing a reliable scale to assess the diversity capability of the organisation. Research also needs to be conducted to explore how a person-centred approach which espouses recovery-focused principles is helpful in addressing the equality agenda.

The current study used semi-structured and narrative interviews in the collection of data. While this approach gave rich insights on how service providers are addressing the issue of race, and how service users view mental illnesses and mental health services, other methods could elicit different types of information to provide a more comprehensive picture. For example, future studies may collect data using observational methods that provide insights during real-life interactions of service providers and users.

7.7 Reflections on the study

By focusing on a single mental health service provider organisation and referring to one ethnic group, this study demonstrates the enormity of the challenge of any service to understanding the expectations, beliefs and practices of an increasingly diverse society.

There is also the population churning phenomenon in local areas where people from one minority ethnic group are moving to other more up-market areas, while relatively new ethnic minority groups are getting housing in these areas. This makes the ethnic matching of staff and service users operationally very difficult for the organisation.

This study suggests that the current approaches to addressing equality and diversity expectations in the service provision may not be helpful. Increasingly, diverse societies need fundamental changes in approaching diversity issues for those using the mental health services. To effectively meet these challenges, I have suggested a new strategy for bringing cultural changes into NHS mental healthcare provision. This strategy is based on an organisational development approach consisting of recruiting staff for their equality and diversity values, training staff in person-centred care, and using social marketing tools for engaging service users of BME background. Of most importance is the adoption of person-centred care as the over-riding cultural change required to meet the needs of every individual. This curious, supportive, flexible and individualised approach allows the inevitable diversity of needs, cultures and expectations of all those using the service to be rigorously assessed and met in ways that

take into account their unique situation, characteristics and preferences.

I kept a journal over the period of this study. This has not only provided me a space to write my feelings, but also acted as a record for important decisions I made during this study. Thus the journal also contributed in enhancing rigour of the study. I have divided my reflections in three parts. In the first part, my reflections are about the origins and conceptualisation of the study. In the second part, I have reflected on my design and data collection. In the third part, my reflections are about the findings of the study.

Reflections on conceptualisation of the study

Being a qualitative researcher, it is important to give an account of myself and reflect on my ontology, as this will have influenced the whole research process. Who I am? What is my educational and professional background? What is my motivation to undertake this study? Why I conducted the study the way I did? How have the participants perceived me? How have I perceived my participants? How have I interpreted data? Ultimately, with all these questions answered and reflected upon, I consider the relevance to the findings and contribution to knowledge.

I spent my childhood in Mirpur, the region of Azad Jammu and Kashmir, where I was born. As noted in the introduction chapter, most of Pakistanis residing in Britain today originate from this region. This gave me familiarity with the language and culture of the community I focused upon in my research. In my childhood, I have experienced migration. At the age of

seven, I migrated with my family to another geographical region of Pakistan, known as South Punjab in Pakistan. Like Pakistanis in the UK, my family also migrated because of economic reasons. However, settling in a new area within my own country was a challenging experience.

I noted that there were some similarities in terms of some cultural traits. But on the whole, my mother tongue was different from the indigenous people. I experienced many challenges in my social life because of my immigrant status in the new region. The core challenge was language, which is the main source of human communication. I experienced difficulties in understanding the language the majority of indigenous people were speaking. They in turn experienced difficulty in understanding me. Public and private services were organised and staffed by the majority indigenous population, and I had to learn the local language to survive and fit in.

The challenges of settling in a new region were further complicated by the fact that there were many differences in the way the majority indigenous population may organised their lives. Their daily routines, gender relations, food, dressing and other things included in a culture were different than the culture followed by my family.

I observed that indigenous people living in that area were quite different from us in terms of their health behaviours. The language and terminologies they used to describe their illnesses were also different to us. One example is how they described pain. People in Mirpur region used ‘dard’ to describe pain. However, the local people were using word ‘Peerr’ (a

different word, but the same meaning). My family believed in a combination of traditional and western medicine. However, most of the people living in that area were from villages, and they used to treat their illnesses through self-remedies using food, drink, rest, visiting a holy person, suggesting a predominantly non- western health model.

So when I came in the UK in 2005 for my MA in Research Methods, I wrote my dissertation on food consumption behaviour of Pakistani women in pregnancy. During this time I became aware of the cultural competence model being used in the western world in providing healthcare to migrants. I also became aware during my stay that people from the Pakistani community in the UK have higher rates of certain illnesses including mental illnesses. So, I became interested in this subject, also because of the paucity of literature in this area. So, I wanted to understand how healthcare organisations in the UK context were providing mental healthcare to people of a Pakistani background, and how they tackle cultural and linguistic issues in their provision.

My main aim in this research is to highlight the perspective of an NHS TRUST in meeting expectations of race equality policy in the provision of mental health services to the people of BME ethnicity. Learning from my previous professional experience is that national and organisational policies may not achieve their stated objectives unless we understand the perspective of those actually implementing the policies. Being a social organiser in a rural development programme in Pakistan, I remember very well the cognitive, emotional and practical struggle I used to experience on a daily basis. I was handed over policies from my head office, and some of these policies

were handed over to my regional office from the main head office. I am not saying that all of these policies were not well intended, or I was not prepared to work hard and achieve desired objectives. But I was not prepared and supported well from my organisation to *actually* meet the expectations of these policies. During my dealings with service users at the grass-roots level, many times, I felt constrained in achieving stated policy vision, but at the same time having to comply with operational procedures. At times, I felt that I am not convinced about the policy objectives. Other times, I was not convinced of the effectiveness of policy instruments, which were either suggested by policy makers or by my organisational heads in achieving policy goals. At times things were not humanly possible.

I used to feel frustrated and powerless. I always wished policy-makers would visit me to listen to my everyday difficulties and frustration. But my wish was never granted. Among colleagues we used to discuss that policy-makers would sit in big, posh offices at the head office level having poor understanding of grass-roots reality of policy implementation.

Later on in my professional career, I worked in a provincial level policy and planning unit in Pakistan. Here I saw how policies were developed, and handed down to frontline level. I saw how policy-makers themselves used to struggle with meeting government expectations (i.e. chief minister, and ministers). I saw fragmentation among work of different agencies. I saw well intended programmes not being executed or supported due to lack of political will, or because of the vested interest of the government in office. I saw well

intended policies interpreted and implemented quite differently at grass-roots level. I saw how people at the frontline known as street level bureaucrats in the policy literature used to use their interpretation and discretionary powers.

So, I became aware of the involvement of different subjectivities in the policy -making and implementation process. I think this process is not mechanical or robotic. This does not mean that a policy made at the national or organisational level would be implemented with its full letter and spirit. The social reality for me is not same as one plus one equals two.

Reflections on design of the study, and its implementation

Qualitative data is co-created. As a researcher, my participants and I were both involved in the creation of the data. Therefore, the data I have collected for this research will have been influenced by my ethnic minority background (Pakistani).

I feel that negotiating access to the Trust was facilitated by one of supervisors, as he/she is working within the TRUST, which may have been difficult otherwise. Also the TRUST CEO seems to have good reputation for encouraging or facilitating research in his/her organisation.

I think I was good in building rapport with my participants. In terms of building rapport, participation in the research was kept voluntary. In all cases, participants suggested the date,

time and venue of the interview. As per choice of the participants, all interviews were conducted at the workplace of the participants. It means participants were given more control in the arrangement of the interviews.

I always managed the agreed time, and venue for the interview. Before the beginning of each interview I would repeat the aim of the research, and talk about confidentiality of the data. I used to do this to encourage the participant to be open in sharing their responses. Particularly, I highlighted that the aim of research is to have perspective of people working in the TRUST on race issues.

At the beginning of each interview, I asked open questions about the role of the participant in the TRUST, and how long he/she has been doing this. Then, an open question of how the participant's role is influenced by the racial equality policy in the service provision.

When I was planning to conduct this research in an NHS TRUST, I was aware that most of my participants would be of White British ethnicity. This awareness raised questions about how the participants from the TRUST might perceive my ethnic identity, and what influence it would have on their responses. I was mainly concerned that the TRUST participants might perceive me evaluating their performance on race issues, and because of my Pakistani ethnicity, they may tailor their response to paint a good picture of themselves. This suggested the possibility that the TRUST participants may not be open in sharing their challenges and gaps on race issues.

Issues of differing ethnic identity of the participants and researcher are heightened because I was studying mental healthcare, which is considered as a sensitive topic in the UK context. I became more interested in how my participants' subjectivity would influence the data I am collecting. In a nutshell, I was concerned about participants making assumptions about my ethnic identity, and hence not sharing what they actually felt about the implementation of racial equality policy in the service provision.

However, during the data collection, I felt that this was not the case with all participants. The participants who were strategic leaders seemed to be painting a positive picture of their performance on race issues. I also observed that participants from this category would also ramble, rather than directly respond to my interview questions. There were instances where the facial expressions of the participants would suggest that the participant was not happy about the question I asked, and the participant was finding it difficult to select the right words to explain their responses. An excerpt from my journal entry indicates instance as:

> *I asked few questions from Director nursing, where he/she seems uneasy though his/her body language. He doesn't seem to giving me relevant data. His anger is evident from his interaction with me during the interview. I observed that his/her body language will change when responding to some pressing questions like priorities on race, barriers in providing good quality services to people of Pakistani ethnicity. I observed that his/her face colour will become red; he/she would avoid*

eye contact, and struggle in answering question. He/she seemed choosing words very carefully (29/1/13)

I am also presenting an excerpt from interview transcript to further explain the point. The dots in the interview transcript here represent time in seconds the participant took to respond.

Basharat: What are the things which are hindering you to embrace this diverse culture in terms of staff and service users?

Participant: *I think there are...there are clear universal issues that all organizations can face, and you know I think what we try very hard to do is to respond If you are going to engage people meaningfully. You then have to respond meaningfully. So ...I think we are very clear on that. But I think you have to keep monitoring that because it can be quite easy for people to become a little bit of disillusioned if their feelings are not being heard. So our approach is to actually listen and to really trying to understand where people have come from and respond to that, and be very upfront if we cannot respond where people perhaps think we should have at times. So I think being kind of open and direct is important. I think there is no organizational hindrance around resource how we do that. We definitely resource and the team so that they can have the impact they need.*

As I could not get response about barriers, later on during the interview, the participant mentioned how the TRUST is working hard to provide equitable experience of the services

to the people of BME background. I wanted to seize the opportunity, and asked the question about hurdles in providing equitable experiences to BME service users. But the participant seemed upset, and even when he/she responded, he/she blamed the community. The dots in the interview transcript here represent time in seconds the participant took in responding.

> **Basharat:** Things which are in your way in providing equitable experience of the services? What are the hurdles?
> **Participant**: *You asked this question before. Didn't you? emm...the....there are not .....I am not going .....I do not want to repeat what i said ten minutes ago, but you know getting ...or being assured that people feel that they can access ....are going to receive service is really important and and given the our staff population is ...needs to mirror the local community. We have on going challenges on perhaps recruiting staff from BME backgrounds, and ensuring that they ...you know...So that is where the mentoring scheme is important. So …But we have to do that within the local community. We cannot just leave it to chance.*

In contrary to above, most of the participants especially from middle management and frontline staff seemed open in sharing the challenges they experienced, and acknowledged their own gaps when providing services to people of a BME background. For example, a middle level manager spoke about his/her openness:

I have been very honest with you. You know I read it [pointing to the study information sheet] and I can speak my mind freely. You know if you want to disadvantage people, you know. If you take the link between statutory services and them out. We are going to have gap, is not it? You know it is probably not what you want to hear.

Similarly, I felt that frontline staffs were also open in sharing their views on the subject. For example a quote below from an interview transcript reflects the openness of the participant:

I have to admit, if I know I am going to work with an interpreter, my heart sinks because I know it is going to be make things more difficult…And that is just personal ...a personal thing which I need to work on…I do not know if that is useful for you to know or not. It makes me worried that I am not going to do good enough job.

It is not only the ethnic identity, but professional identity is also important to consider when conducting qualitative interviews. I started from top level of the TRUST, interviewing the CEO. I am just a PhD student, and my participant occupied an elite position in the NHS. So I was nervous when I went to interview him/her. Sitting outside his/her office's waiting room, I was thinking that 'I might say or ask questions which the CEO might not like. I might ask him/her direct questions related to performance of the TRUST on race, and this may upset him/her. Consequently, it could have influence on their decision to give me access to the TRUST'.

As I have lived most of my life in a different culture. Being an outsider to the UK culture, I also experienced cultural ignorance while collecting data in the field. I was careful of my behaviour and etiquettes during the field work. I was sensitive not to offend anybody unintentionally. For example an excerpt from my journal below indicates how I was thinking about small things such as hanging my coat on the wall, instead on chair:

> *I am sitting in the office of my participant. Then she finished her lunch and excused for 5 minutes to go out saying that she remained busy whole day in the meeting (interview took place between 1-1:20pm) and now is tired . She might have gone for cigarette or fresh air. I like this frankness and I was not having problem with that. I put my coat on chair in her absence. First I was thinking to hang at the wall .But then I thought that it might offend her. But when she came I asked her if it is ok to put coat on the chair which she agreed. I am doing all this to avoid offending her. (3/1/2013)*

It was not the participants making assumptions about me; I also made assumptions about the identities of the participants, especially about their gender. For example, when I went to interview a participant from middle management, from the name I assumed that it is a female participant. However, when his/her secretary took me to his/her office, I was bit surprised to see a male participant waiting for me. Below is an excerpt from my journal.

> *Today, I interviewed (X) who is clinical director for adult mental health services. I was not sure whether (X) is male or female. My guess from the name was that she is a female. To my surprise when X's secretary took me to a room I saw a male sitting there. I was bit surprised as it was out of my expectations (Diary 11/1/13).*

Many times I noticed that TRUST participants had assumed my Pakistani identity from my name. I remember CEO asking me if I played cricket, which in actual fact I do not like much. Few participants from the TRUST asked me for cultural help for the Pakistani population. I was concerned about my relationship with participants, and potential dependence it might generate. Therefore, I did not give any promise to the participants, and explained that my role is just to complete this PhD, and I do not consider myself to be expert on giving cultural advice to staff on providing mental healthcare to members of the Pakistani community. I was aware that the little knowledge I have on Pakistani culture, may generate ethnic stereotypes among professionals.

The TRUST participants, especially strategic leaders showed great interest in having the findings from my research, and utilising them for the improvement of mental healthcare for Pakistani people, but none of them contacted me for this afterwards. However, as per my commitment, I have shared my findings with the organisational gatekeeper. I have also offered to share more about my study but it seems that there is not much interest in my study now, a couple of years on.

Over the period of data collection, I was learning about the complexity of the subject, which I did not know before. An excerpt from my journal:

> *I interview x psychiatrist. X said 'you cannot have a mini Pakistan with different rules. Something I found quite disturbing. They wanted to bring their own laws and, sharia law. I mean you cannot have things like this, can you. It is unreasonable expectation, you cannot. I do not know, does that mean that I am racist'.*

It seems difficult for people to distinguish what is racism, and what is not. How would one determine the issue of racism at interpersonal levels? How can you monitor racist behaviour at interpersonal level? Who will do it? May be monitoring and punishment is not going to help. It is more about encouraging a positive attitude amongst staff. It is about relationships between service users and providers. You can encourage compassionate and non-racist attitude, but cannot force staff to be compassionate and non-racist.

I would say that my experience of interviewing with each participant was different, and may be different at different points of the interview. So, I will not generalise it. In summary, I can argue that my experience in terms of openness has been a range from very open to people being cautious.

While interviewing members of the Pakistani community, I felt that they considered me a member of their own cultural heritage. I felt this through the content of the interviews. As they were aware that their heritage is the same as mine, so

sometime they used terminologies and words without translating them into English. I also did not feel any need for asking further clarifications, because I understood what they meant.

Members of the Pakistani community participated with great interest in my research. I did not have any difficulty in accessing them. I would largely attribute this to my personal links in the local community. Being a PhD student, I also felt respected in this community. My feelings are that generally people from this community gave high regard to a PhD considering that the person would have much knowledge on many issues.

As I also interviewed four female participants from the Pakistani community, I did not have any feeling of our gender influencing the interview conversations. I felt that these conversations were engaging and participants appeared comfortable speaking with me. They used ranges of examples to make their points, even shared their own personal stories of experiencing mental health issues in the past.

With the exception of one participant, they did not have issues about the aim of the research. The one who seemed to have an issue with the aim of the project asked me about 'who politically owns the project'? I replied that the project is owned by the School of Health Sciences, University of Nottingham. To this he/she seemed satisfied and spoken with me openly and comfortably on the issue.

Reflections on analysis and findings of the study

There is much literature on analysing qualitative data, but I think it is up to the researcher, and the specific objectives of a research project which influence key decisions about data analysis. As a novice qualitative data analyst, I struggled with the process and I found that analysis is iterative and sometimes a painful process. Data coding processes took me a long. I found that same chunks of data can be coded in different ways. Making sense of the data and interpreting it also seemed challenging. At times I thought that there can be more than one interpretation of a quote. This can be due to differing contexts or the person analysing the data. In presenting findings, participants' quotes proved helpful to substantiate my analysis.

In terms of findings, I found interesting and new findings. For example in the literature, there is much emphasis on cultural competency of staff as a way of providing good quality health for people of differing cultures. However, after findings from the data, I can now see how challenging it is to train staff in cultural awareness of every ethnic group. Similarly, using interpreters is suggested to help meet the language needs of service users in healthcare contexts. However, I was not aware of the complexity of the challenges mental healthcare practitioners face while working with an interpreter. Now I can think of the frustration practitioners may experience if they do not speak the language of service users, and vice versa.

During the literature review, I was thinking whether the issue of poor mental health services are highlighted by BME people because of political reasons, and may be blown out of proportion, or may be saying that Pakistani people are not happy whatever you do for them, always complaining. But

data from frontline staff indicates things such as communication barriers and lack of cultural understanding which can result in poor quality of services.

Within the literature, I found that there is some discussion about racism from staff to patients. But to my knowledge, I could not find anything relating to racism from patient to staff in NHS organisation. However, after interviewing participants from middle and frontline of the TRUST, I became aware of this aspect of racism as well. It was a new and un-expected finding for me.

Given the projected reputation of the TRUST, and interviews with the strategic leaders, I was assuming that the TRUST is doing a lot for addressing the needs of BME background service users. However, my findings are not supporting my earlier assumption. Most of what is delivered by the TRUST, and claimed by the strategic leaders is a part of tick box practices. Can these practices be attributed to institutional racism? I do not have any data to support this, though I would like to investigate it further.

Findings from the community data are also a bit of surprise. I was assuming that as people of Pakistani origin had been living in the UK for a long time (some even more than five decades), their health-seeking behaviour would have been changed to a more western model of healthcare. However, I was surprised to see that most of them still follow the traditional models of healthcare.

I think I have been successful in highlighting the challenge for the NHS mental healthcare organisations when it comes to

providing good quality mental health services to the people of BME groups. I used an epistemology, which encourages multiple perspectives to emerge. My own ontology proved helpful in understanding the perspective of NHS staff, as well as the cultural needs of Pakistani service users. Focusing on one organisation as a case, along with an interpretative epistemology also proved helpful in enhancing depth of the challenge, which could not have been possible with a positivistic model of science and knowledge creation.

I do not claim that my findings from this research are the ultimate. They are not the final truth. These findings may not be same for all NHS organisations, and all BME groups. However, I do think that findings from this research can be helpful in understanding the issue of race in mental healthcare for other NHS organisations and BME groups.

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Appendices

Appendix: A -Participant Information Sheet- TRUST Participants

(Draft Version – 1.2/Final version 1.0: 21/5/2012)

Title of Study: Implementation of policy: An exploratory study of ethnicity related equality policy in the provision of mental health services to the Pakistani ethnic group in the UK

Name of Researcher(s): Dr Julie Repper, Dr. Theo Stickley, Mr.Basharat Hussain

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. One of our team will go through the information sheet with you and answer any questions you have. Talk to others about the study if you wish. Ask us if there is anything that is not clear.

What is the purpose of the study?

This study is being conducted as part of PhD for Mr.Basharat Hussain (Co-investigator). Main purpose of this study is to explore and understand how an NHS mental healthcare Trust is responding to the mental health needs of the Pakistani ethnic group in their service provision.

Why have I been invited?

You are being invited to take part because you are involved in the planning/delivery /management of mental health services to diverse groups. You have been chosen through the information provided by the management of your organisation. We are also inviting around 20 participants like you to take part.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. This would not affect your legal rights.

What will happen to me if I take part?

Mr. Basharat Hussain will interview you face- to- face for 45-60 minutes. The interview will be digitally recorded. The interview will mainly contain questions about facilitators and hindrances in the implementation of Black and Minority policy in the provision of mental health services.

Expenses and payments

Participants will not be paid to participate in the study.

What are the possible disadvantages and risks of taking part?

There is no disadvantage and risk involved in taking part in the study and every effort will be made not to inconvenience you. Your views will be quoted in any subsequent publications

and while every effort will be made to generalise them these may be recognisable by close colleague.

What are the possible benefits of taking part?

We cannot promise the study will help you but the information we get from this study may help to improve provision of quality services to the people of diverse ethnic group in general and Pakistani ethnic group in particular.

What if there is a problem?

If you have a concern about any aspect of this study, you can speak to me or/and my supervisors and we will do our best to answer your questions. Our contact details are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do this by contacting NHS Complaints. Details can be obtained from your hospital.

Will my taking part in the study be kept confidential?

We will follow ethical and legal practice and all information about you will be handled in confidence.

If you join the study, some parts of the data collected for the study will be looked at by authorised persons from the University of Nottingham who are organising the research. They may also look to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty. All information which is collected about you during the course of the research will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database. Any information about you which leaves the hospital will have your name and address removed and a

unique code will be used so that you cannot be recognised from it.

All research data will be kept securely for 7 years. After this time your data will be disposed off securely. During this time all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team will have access to your personal data. Your personal data will be kept for less than 3 months after the end of the study.

Although what you say in the interview is confidential, should you disclose anything to us which we feel puts you, service users or anyone else at any risk, we may feel it necessary to report this to the appropriate person(s) in your organisation.

What will happen if I don't want to carry on with the study?

Your participation is voluntary and you are free to withdraw at any time, without giving any reason, and without your legal rights being affected. If you withdraw then the information collected so far cannot be erased and this information may still be used in the project analysis.

What will happen to the results of the research?

The research is being carried out as part of the requirements of a PhD degree for Mr. Basharat Hussain at the University of Nottingham. The research will form part of PhD thesis .It is planned that the results of this study will be published in subject relevant peer reviewed research journals in the last phase or after completion of the research (i.e. year 2014).You can get copy of these publications from the researchers.

We assure you that you will not be identified in any report/publication.

Who is organising and funding the research?

This research is being organised by the University of Nottingham and is being funded by the School of Nursing, Midwifery and Physiotherapy, University of Nottingham.

Who has reviewed the study?

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by University of Nottingham, Medical School Research Ethics Committee

Further information and contact details:

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Appendix: B -CONSENT FORM -TRUST Participants

(dv1-2(final) / date: 23 May 2012)

Title of Study: Implementation of policy: An exploratory study of ethnicity related equality policy in the provision of mental health services to the Pakistani ethnic group in the UK

REC ref: *(C07062012SNMP)*

Name of Researcher(s): Mr. Basharat Hussain, Dr. Julie Repper, Dr. Theo Stickley

Name of Participant: ---------- **Please initial**

1. I confirm that I have read and understand the information sheet version number (Draft Version – 1.2/Final version 1.0: dated 21/5/2012 for the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my medical care or legal rights being affected. I understand that should I withdraw then the information collected so far cannot be erased and that this information may still be used in the project analysis. ☐

3. I understand that relevant sections of my medical notes and data collected in the study may be looked at by ☐

authorised individuals from the University of Nottingham, the research group and regulatory authorities where it is relevant to my taking part in this study. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential.

4. I understand that the interview will be recorded and that anonymous direct quotes from the interview may be used in the study reports. ☐

5. I agree to take part in the above study. ☐

_____ _____ _____

Name of Participant Date Signature

_____ _____ _____

Person taking consent Date Signature

Appendix: C -Interview Guide for TRUST Participants

Title of the study: Implementation of policy: An exploratory study of ethnicity-related equality policy in the provision of mental health services to the Pakistani ethnic group in the UK
These are the main interview questions; however further probing and discussion took place in response to each answer given by the participants.

- What specific role do you perform in relation to the provision of mental health services in your organisation? (*all participants*)
- How does the issue of race influence your role on a day-to-day basis? (*all participants*)

Main questions for Key Leaders and Mangers
(Chief Executive, Head of Equality & Diversity, General Manager, Manager, Modern Matron)

- What is the organisational policy on race / ethnicity / equality in the service provision?
- What is the philosophy of race / ethnic equality policy of your organisation?
- What is the vision of your organisation about race / ethnic equality in the provision of mental health services to the BME population?
- What is the strategy to implement this stated vision?
- What organisational structures are in place to implement BME policies in the provision of mental health services?
- How is organisational policy on race / ethnic equality handed down to managers, practitioners and frontline staff?

- What are the expectations?
- What is the organisational set-up for monitoring the implementation of this policy in your organisation?
- What are your main priorities for the BME population in the service provision?
- How are these priorities set?
- What are the specific initiatives for the Pakistani ethnic group?
- How these are identified?
- How these are prioritised?
- How these are implemented?
- How these are monitored?
- How these are evaluated?
- What helps you to achieve the stated vision and goals?
- What hinders this achievement?
- Do you have any suggestions as to how best you could be supported to implement the policy?

Main questions for Practitioners

(Team leaders, Staff Nurses, Healthcare Assistants)

- What do you do to implement the BME policy when delivering services to BME service users?
- What helps you to implement the policy?
- What hinders you in implementing the policy?
- How do you identify the ethnic categories of the service users?
- What do you specifically do for Pakistani service users?
- What helps you to implement the race / ethnic equality policy for Pakistani service users?
- What hinders you when implementing the race / ethnic equality policy for Pakistani service users?

- Do you have any suggestions as to how best you could be supported to implement the policy?
- Is there anything else you want to share on the subject, which I have not asked?

Thank you for your participation

Appendix: D -Participant Information Sheet - Community members

(Draft Version – 1.0/Final version 1.0: 12/3/2013)

Title of Study: Implementation of policy: An exploratory study of ethnicity related equality policy in the provision of mental health services to the Pakistani ethnic group in the UK

Name of Researcher(s): Dr Julie Repper, Dr. Theo Stickley, Mr.Basharat Hussain

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. One of our team will go through the information sheet with you and answer any questions you have. Talk to others about the study if you wish. Ask us if there is anything that is not clear.

What is the purpose of the study?

This study is being conducted as part of PhD for Mr.Basharat Hussain (Co-investigator). Main purpose of this study is to explore and understand how an NHS mental healthcare Trust is responding to the mental health needs of the Pakistani ethnic group in their service provision.

Why have I been invited?

You are being invited to take part because you are a member of Pakistani ethnic group living in the local area where study is being conducted. You have been chosen through the information provided by local community and friends living in

the local area (X). We are also inviting around 08 participants like you to take part.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. This would not affect your legal rights.

What will happen to me if I take part?

Mr. Basharat Hussain will interview you face- to- face for 45-60 minutes. The interview will be digitally recorded. The interview will mainly contain questions about your perceptions of mental illnesses, help seeking behaviour and experiences of using (or not) mental health services provided by your local NHS Trust

Expenses and payments

Participants will not be paid to participate in the study.

What are the possible disadvantages and risks of taking part?

There is no disadvantage and risk involved in taking part in the study and every effort will be made not to inconvenience you. Your views may be quoted in any subsequent publications and every effort will be made to generalise them.

What are the possible benefits of taking part?

We cannot promise the study will help you but the information we get from this study may help to improve provision of

quality services to the people of diverse ethnic group in general and Pakistani ethnic group in particular.

What if there is a problem?

If you have a concern about any aspect of this study, you can speak to me or/and my supervisors and we will do our best to answer your questions. Our contact details are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do this by contacting NHS Complaints. Details can be obtained from your hospital.

Will my taking part in the study be kept confidential?

We will follow ethical and legal practice and all information about you will be handled in confidence. If you join the study, some parts of the data collected for the study will be looked at by authorised persons from the University of Nottingham who are organising the research. They may also look to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

All information which is collected about you during the course of the research will be kept strictly confidential, stored in a secure and locked office, and on a password protected database.

All research data will be kept securely for 7 years. After this time your data will be disposed off securely. During this time all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team will have access to your personal data. Your personal data will be kept for less than 3 months after the end of the study.

Although what you say in the interview is confidential, should you disclose anything to us which we feel puts you, or anyone else at any risk, we may feel it necessary to report this to the appropriate person(s) in your family.

What will happen if I don't want to carry on with the study?

Your participation is voluntary and you are free to withdraw at any time, without giving any reason, and without your legal rights being affected. If you withdraw then the information collected so far cannot be erased and this information may still be used in the project analysis.

What will happen to the results of the research?

The research is being carried out as part of the requirements of a PhD degree for Mr. Basharat Hussain at the University of Nottingham. The research will form part of PhD thesis .It is planned that the results of this study will be published in subject relevant peer reviewed research journals in the last phase or after completion of the research (i.e. year 2014).You can get copy of these publications from the researchers. We assure you that you will not be identified in any report/publication.

Who is organising and funding the research?

This research is being organised by the University of Nottingham and is being funded by the School of Nursing, Midwifery and Physiotherapy, University of Nottingham.

Who has reviewed the study?

All research in the School is looked at by independent group of people, called a Research Ethics Committee, to protect your

interests. This study has been reviewed and given favourable opinion by University of Nottingham, Medical School Research Ethics Committee

Further information and contact details:

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Appendix: E -CONSENT FORM –Community members

Title of Study: Implementation of policy: an exploratory study of ethnicity related equality policy in the provision of mental health services to the Pakistani ethnic group in the UK

REC ref: (C07062012SNMP)

Name of Researchers: Dr. Julie Repper, Dr. Theodore Stickley, Mr. Basharat Hussain

Name of Participant: ---------- **Please initial**

1. I confirm that I have read and understand the information sheet, draft 1.0/ final version number 1.0 dated: 12/03/2013 for the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my legal rights being affected. I understand that should I withdraw then the information collected so far cannot be erased and that this information may still be used in the project analysis. ☐

3. I understand that relevant sections of my data collected in the study may be looked at by authorised individuals from the University of Nottingham, the research group and ☐

regulatory authorities where it is relevant to my taking part in this study. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential.

4. I understand that the interview will be recorded and that anonymous direct quotes from the interview may be used in the study reports. ☐

5. I agree to take part in the above study. ☐

_____ _____ _____

Name of Participant Date Signature

_____ _____ _____

Person taking consent Date Signature

Appendix: F -Interview guide -Community members

Title of Study: Implementation of policy: an exploratory study of ethnicity related equality policy in the provision of mental health services to the Pakistani ethnic group in the UK

A narrative approach is used to collect data and the interview started with opening question as:

"My study is looking at the perceptions of mental health/illness of the Pakistani community in the UK as well as their perceptions and experiences of mental health services, I wonder if you could tell me thoughts on this subject?"

And then further questions are asked on the following topics:

Topics to cover:

i) Perceptions about mental illnesses
ii) Mental health help -seeking behaviour
iii) Perceptions about NHS mental health services
iv) Suggestions for improving the services