Improving the Mental Health of South Asian Populations in the United Kingdom

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on behalf of CAREIF and Ethnic Inclusion Foundation

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Preface from Albert Chaitram Persaud, Founder CAREIF

Our culture is a fundamental part of our health footprint and shapes our ideas about health, illness and death. This cultural and spiritual bond has always remained sacred and this can be seen by the strength of the many rituals and ceremonies that are practiced today in every continent. The history of Indian migration across the globe goes back many centuries, one of the earliest large migrations from India (British India) took place after 1833 when nearly 1.3 million Indians moved to various parts of the globe, as Indentured Indians to places including, Mauritius, Trinidad, Guyana, Surinam, Fiji, Australia, Kenya, Tanzania, South Africa and Uganda. Today, communities from these countries and those in this report of South Asians, can be found in all corners of the UK.

The health challenges for all these communities are similar, whether it be Coronary Heart Diseases, Strokes, Diabetes or Mental Ill health; a striking example is suicide rates in Guyana are similar to that in India which is one of the highest in the world. Whilst many governments are grappling with the current Covid-19 pandemic and other challenges such as economics, climate change, security and democracy, issues of mental health can be over looked.

This is a poignant report as it sets out the clear evidence of the mental health status and challenges of South Asians in the UK, and at the same time has some clear actions to be taken to improve the experience and outcomes for people and their families and communities. It also sets a template that other countries can develop to meet the needs of their own communities.

This report also provides clear evidence of how the voluntary sector (Non-Governmental Organisations) can and must be at the forefront of shaping mental health policies and services.

In 2007 when I co-founded CAREIF, this was the sort of vision I had to be at the forefront of shaping the future, "share knowledge, change lives". I congratulate all those involved in crafting this report, in particular paying tribute to Dr Koravangattu Valsraj Menon and Dr. Sam Nishanth Gnanapragasam for their excellent appraisal and stewardship. Change is possible but it requires action -as in the words of Rabindranath Tagore, painter, poet, composer, playwright, philosopher and social reformer   **"You can't cross the sea merely by standing and staring at the water."**

Albert Chaitram Persaud
Descendant of Indentured

Foreword by Professor Dinesh Bhugra, Patron CAREIF

There is considerable research evidence that South Asian communities in the UK have disproportionately higher rates of many psychiatric disorders and yet they are less likely to seek help. Often these observations are complicated by other health and social inequalities South Asian communities face such as poor housing, overcrowding, unemployment and relative poverty.

The reasons for delay in seeking help from statutory services are many. These are particularly influenced by different and non-medical explanatory models of distress, poor past experience of health services, institutionalised racism and healthcare differentials and discrepancies among other factors. It is also well recognised that the longer an illness remains untreated, the more likely it is to become chronic as well as difficult to treat.

It is therefore timely that CAREIF and Ethnic Inclusion Foundation have jointly produced this report. The two charities deserve our sincere congratulations and thanks for pulling together information on the mental health of South Asian communities in the UK in an up-to-date manner. The findings clearly illustrate the extent of the difficulties. The report indicates that more needs to be done in engaging not only these communities but also commissioners of mental health services, policymakers and other stakeholders. Primary care and secondary care services must work with public mental health to ensure that mental health needs of the communities are met in a culturally appropriate and culturally sensitive manner.

I very much hope that this report will initiate not only further debate about what is needed to improve mental health in South Asian communities but more importantly action at all levels from national, local, community and individual levels which can bring about long-term sustainable change.

Dinesh Bhugra, CBE

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Joint Statement by CAREIF & Ethnic Inclusion Foundation Chairs

We are delighted to be working together on this important piece of work and believe that combining the expertise, skills and work of both organisations can produce synergies which can benefit the communities we aim to serve. Ethnic Inclusion Foundation brings a wealth of knowledge about the South Asian community through its work in Britain, India and Nepal, whilst the Centre for Research and Evaluation International Federation (Careif) brings knowledge about mental health, wellbeing and training in the UK and internationally. The opportunity to combine our strengths and knowledge through the production of this report is most timely. Trustees at both charities had been concerned about disparities in accessibility and the provision of appropriate mental health and wellbeing provision which properly serve all members of our communities for some time. Cultural and religious diversities have frequently been marginalised or side-lined within mental health policy and practice rather than being foregrounded, understood and properly considered. Structural inequalities, intersectionality and the social determinants of health are frequently ignored and a wider focus by policy makers and commissioners appears vital.

We also wish to recognise and pay tribute to the enormous amount of work being undertaken by South Asian grassroots organisations (often with little funding), in organising a range of mental health activities within their communities, which is often not utilised or celebrated as it should be. We support the idea of establishing a hub where information about this important work can be collated so that NHS commissioners, policy makers, clinicians and other community organisations can learn important lessons from this. The voice of the service user and community groups is often sadly lacking in academic and NHS reports and planning. The existence of diverse explanatory models of mental health and ways of expressing distress are well known but often fail to be recognised within mental health services. We know that co-production and real partnerships not partnerships which are tokenistic can make a difference. The establishment of an Office of Minority Ethnic Health appears to be an important step in collecting information systematically and bringing about change which recognises the lived experience of people from South Asian Communities and provides them with appropriate mental health provision.

Professor Rachel Tribe, Chair CAREIF
Anil Bhanot OBE, Chair Ethnic Inclusion Foundation

CAREIF

The Centre for Applied Research: International Federation (Careif) is an international mental health charity that works towards protecting and promoting mental health and resilience, to eliminate inequalities and strengthen social justice. Its funding is sourced through project bids, fundraising and donations and its primary resource are volunteers who undertake various tasks. Careif has no staff or employment costs. Our trustees are mental health professionals.

We work to preserve and protect good mental health, in particular but not exclusively by:
- Increasing awareness of mental health in its local, national and global contexts amongst professionals, service providers and the public
- Conducting study and research for the public benefit by publishing and disseminating the results

OUR VISION
To enhance the wellbeing of individuals and communities through sharing knowledge and understanding of their cultures and traditions.

OUR MISSION
To advance and share knowledge of good mental health practice respecting and engaging with local and international cultures and traditions.

We work to a core set of values. These are to:
- respect the traditions and values of individual societies and cultures around the world
- encourage people's natural creativity and to share with and inspire others
- bring together individuals, communities, non-government organisations and government bodies to achieve change
- develop evidence of what works through formal research, evaluation and practice-based knowledge
- promote positive changes to services (or how services are provided) and good quality care

We deliver our work through:
- high quality learning and teaching locally, nationally and internationally
- research, evaluation and practice development into culture, health and wellbeing
- providing international volunteering, exchange and twinning schemes
- promoting and developing positive practice on sports, the wellbeing of individuals and communities

CAREIF
Contact email: enquiries@careif.org

The Ethnic Inclusion Foundation

The Ethnic Inclusion Foundation is a social enterprise charity that heads a group of organisations in the UK, London and Leicester, and the Indian subcontinent, Delhi, including an initial start in Kathmandu. Ethnic Inclusion's work is centred around socially empowering communities with a fair ethnic representation among decision makers in UK at policy level, through inclusion. Its subsidiary group charities aim to deliver these objectives through practical projects with communities: empowering them via the arts, fitness & wellbeing, children's nursery welfare, social technology and vocational education access, and general poverty reduction.

As a social enterprise charity, Ethnic Inclusion generates income from its own business activities and property rentals. Surplus income is then used to fund the charitable projects carried out by both Ethnic Inclusion and its subsidiaries. In addition, Ethnic Inclusion seeks external grant funding for its charitable projects.

Ethnic Inclusion works in several different fields to empower communities:
- Advocacy work that highlights the injustices that take place in our society — aiming to inform and influence policy makers to enact substantive change in society.
- Policy and research into topics that impact the lives of ethnic communities in the UK. Our current focus centres around mental health issues; whilst former topics have included Brexit, House of Lords reform, and the role of British civil rights activists.
- Capacity building of ethnic communities and their organisations, supporting leadership skills and creating networks.
- Supporting individuals, including differently abled persons, through the provision of fitness classes.
- Funding its subsidiary charity, the Peepul Centre Leicester, as its major social empowerment project in the UK.
- Funding Peepul Delhi charity on poverty reduction by making food available to those in food insecurity and providing education and training to upskill individuals so as to increase their employability, in particular by using social technology solutions.

Ethnic Inclusion seeks out partnerships with organisations who offer a significant contribution in their field, such as Careif. By such partnership working, Ethnic Inclusion is able to expand beyond its direct expertise and thus have a broader impact. Indeed, the idea of partnership is intrinsic to the concept of inclusion for us we seek in society as a whole.

A strategic objective which the organisation is currently focusing on centres around a holistic approach to wellbeing. It is within this broader context that we embark upon this partnership with Careif. This report, not only highlights areas that are under-researched but also makes tangible recommendations for clinical and therapeutic interventions into a more robust structured policy.

Anil Bhanot OBE
Chair of Ethnic Inclusion Foundation

Ethnic Inclusion Foundation Project Sponsor

"We at Ethnic Inclusion are pleased to partner with Careif on this important work which highlights the improvement needs of South Asian mental wellbeing. We look forward to collaborating with Careif and other parties on addressing the recommendations from this report.

I wish to convey our thanks to the authors and support teams from both organisations."

Santosh Bhanot PhD
Ethnic Inclusion Foundation

1. Executive Summary

The purpose of this report is to sensitise key opinion formers and clinicians when formulating policy and interventions in dealing with mental wellbeing issues affecting South Asian Minority Ethnic Communities in the UK.

South Asian individuals and families living in the United Kingdom face a unique set of mental health challenges related to biological, psychological, social, cultural, environmental risks over their life course. It is important to recognise that all these determinants are interlinked one affecting the other. Furthermore, it has been shown clearly that this population suffers from different rates of psychiatric disorders when compared to other ethnic groups, including those often grouped together within the Black Asian, and minority ethnic (BAME) classification.

The help-seeking and patterns of presentation are strongly influenced by cultural factors such as explanatory models of illness, use of alternative and complementary therapies etc. For example, South Asian older women who are first generation immigrants often present with somatic symptoms such as pain, tiredness and weakness during periods of stress, anxiety and depression and would rather seek help from religious leaders or peers. It is necessary to recognise significant heterogeneity within South Asian populations themselves. This is on account of a range of religions, languages and cultures among South Asians who hail from different countries (for example Nepal and Sri Lanka), and even within countries themselves (e.g. South India and North India).

To support the mental health and wellbeing of South Asians and to tackle challenges, a public health and epidemiological approach is necessary.

This report is based on observations from published reports and input by professionals in the field of mental health and wellbeing.

We offer the following recommendations for consideration by opinion formers and practitioners:
1. *Concerted efforts to identify unmet health needs for South Asians, with appreciation of differences from other BAME groups and the differences between South Asian groups.*
2. *Co-development of mental health services through co-design and co-production with the establishment of Government Office of Minority Health.*
3. *Stigma focussed work, with cultural awareness and care taken not to pathologise distress.*
4. *Effectiveness evaluation of interventions for this population.*
5. *Adequate provision of cultural training for service providers so that care provided appreciates cultural (religious/spiritual/faith), historical and gendered influences of this population.*

Given the rates of mental illness in this population, unique challenges faced and wider health inequities exposed by COVID-19, there is a pressing need for urgent action. As recommended above the **Office of Minority Health** is envisaged to be a central coordinator for mental health initiatives for ethnic minority groups, including South Asian populations, to provide cross-governmental oversight and act as a repository for related data and help develop and drive evidence based health policies.

2. Introduction

Mental Health relates to our emotional, psychological and social well-being. It influences how we think, feel and act. Mental health disorders are estimated to be the second-largest burden of disease as per Public Health England data (Public Health England, 2019). At any given time, one in six working-age adults are thought to have symptoms associated with mental ill health (McManus et al., 2016). The cost of being ill has a profound impact on the individual with considerable distress and suffering, and this is further compounded by stigma and discrimination.

The issues are even more complex and challenging for ethnic minority individuals. This report provides an overview of the mental health of South Asians living within the United Kingdom (UK). Through exploring and analysing the issues faced by this population, the report makes a series of policy recommendations and highlights areas where further evidence is necessary. The key purpose of this report is to generate discussion of the findings amongst members of the South Asian diaspora, community leaders, policy makers, service users, clinicians, carers and other stakeholders for sensible, meaningful and sensitive approaches to improve the mental health of people from South Asian background.

This report is divided into four main sections; defining the population, exploring historical factors and patterns, rates of mental illnesses and resulting challenges, and concluding with policy recommendations. Our observations and recommendations are based on current available evidence and where available referenced accordingly. No primary data was collected for this report.

This is not to be seen as a one-off report but rather as start of a dialogue and conversation to improve the mental health of South Asian diaspora.

3. Background and Definitions

South Asian

In this report, we define South Asians as individuals who share both geographic and ethno-cultural heritage and roots with the South Asian region. This includes individuals who are themselves migrants from, or are descendants of individuals from countries in the South Asian geographical region. The countries in question are Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan, Sri Lanka (in alphabetical order). See Image 1.
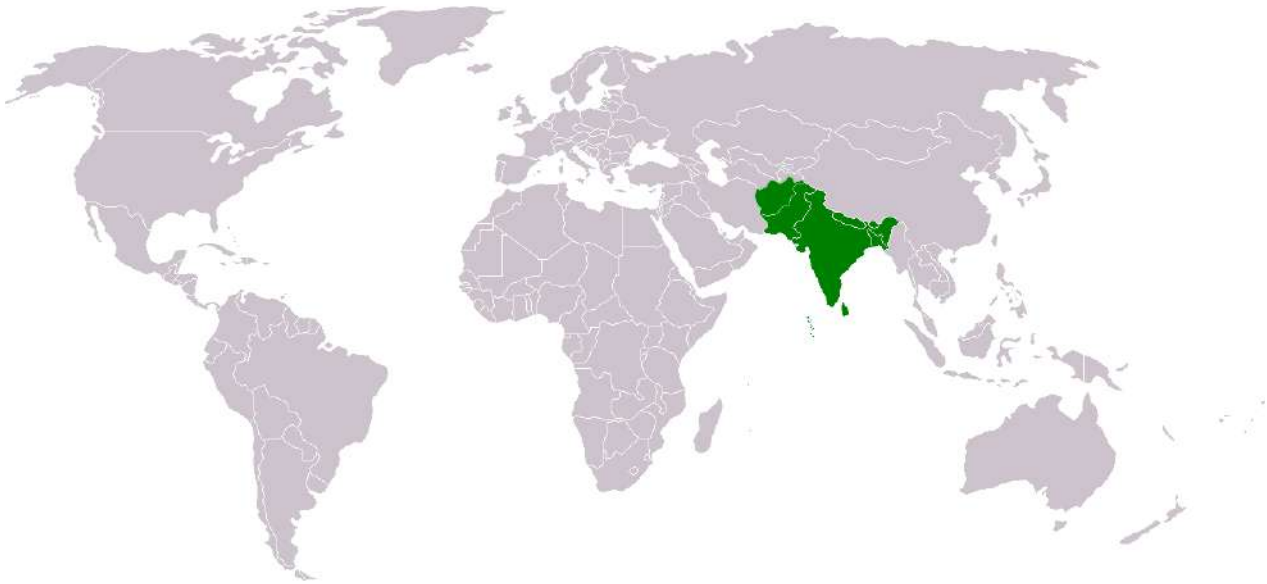

Image 1: South Asian Region. CC: https://en.wikipedia.org/wiki/File:SAARC.PNG

There are a number of important aspects to consider when using the term South Asians in discourse.

The term South Asian is often used instead of Black or White by brown-skinned people living in the UK. Despite this, it is important to recognise the frequent use of the term BAME in governmental, academic and clinical analysis of mental health services although in view of the recent Sewell report (2021) this may well change. As such, it is necessary to also engage with broader BAME literature when seeking to better understand the mental health of South Asians in the UK.

1. Limitations with BAME: The term stands for Black, Asian and ethnic minority. As can be seen, although the 'A' in BAME represents Asian, it does not delineate between different regions in Asia – South Asian, East Asian or South East Asian. The terms lump the non-white 'other' as BAME, without adequate and appropriate recognition of cultural, linguistic and religious differences. As raised by some, these categories are often "imprecise, time and context specific and do not cross borders

well", and "make data interpretation and policy-making less effective for certain populations" (Selvarajah et al., 2020). Furthermore, it includes groups being compared on skin colour with geographical heritage and origins and minority status.

2. Heterogeneity: Despite the term South Asians being more precise than BAME, the term still includes groups that are vastly different. For example, it would be wrong to conflate the circumstances, cultural heritage and idioms of distress of people from different regions of South Asia. Similarly, even if individuals hail from the same country, such as India, there are likely to be significant differences between a Punjabi individual (North India) and a Tamilian (South India). At an even more granular level, even within similar ethnic communities, there will be significant differences. For example within Tamil populations, the experiences of those from South India are likely to be significantly different from those who hail from Sri Lanka. Recognition and understanding of this is crucial in interpreting evidence, developing clinical interventions and improving clinical outcomes

3. Impact of Colonisation and Early Migration: There is also a heterogeneity caused by the early migration to work in British colonies as part of indentured migration and the later generations consider themselves with a South Asian heritage but they also have a sub cultures of the new environment or the countries they resided prior to migrating to UK creating a bi-cultural identity.

History and Patterns of Migration

The long arch of the British Empire has had complex and significant historical consequences on migratory patterns of South Asians. With the exception of Nepal and Bhutan, other present day South Asian countries were colonies of the British Empire for periods of time. For purposes of brevity in this report, the migratory pattern described are incomplete and in simplistic terms.

During the eighteenth and nineteenth centuries, migratory patterns from South Asia were of affluent individuals and their children arriving for education, and then often but not always returning to their countries of origin (Visram, 2015). The period following the second world war including the 1960s saw a shift in migratory patterns, with resettlement from the colonies including South Asia (such as Pakistan, present-day Bangladesh, India and Sri Lanka) and the Caribbean (including Indo-Caribbean individuals) to assist with rebuilding infrastructure. Further South Asian migration followed from East Africa following the expulsion from Uganda under the Idi Amin's regime.

Since then, there have been further South Asian migration including of manual labourers, semi-skilled labour, healthcare professionals and more recently IT professionals. These complex migratory push and pull factors are varied by different South Asian countries, and time periods. For example, Sri Lankan migrants in the early 1960s and 1970s were often

while-collar professionals including healthcare professionals. The next phase of Sri Lankan migration in the 1980s was related to the civil war and resulted in those with a variety of backgrounds seeking asylum to escape state persecution.

This varied migratory pattern is important to consider given the impact that these have on the social determinants of mental health for this population as well as integration in the community and across communities which also feed into health behaviours. In particular, there is a need to recognise the significant socio-economic, educational and occupational inequality within the South Asian community (as defined above).

Mental Health

For the purposes of this report, we take the definitions, diagnoses and syndromes as defined by a classification system for diseases called the International Classification Diseases (ICD-10) and the mental health model outlined by the World Health Organisation. It is however important to note that although a widely-used concept, mental health has competing models of illness and wellness. These range in their scope across South Asian countries and at times, they confront the Euro-centric mental health model. A key difference between the European model and the South Asian model is that former focuses on mind-body dichotomy and latter has a more integrated approach.

4. Migration and Acculturative Stress

The migratory process can be stressful, and the stressors may relate to the pre, peri and post migratory experiences. Stressors include financial difficulties, separation from family and social isolation. Migrants also face acculturation stressors as they seek to integrate to the new culture while seeking to maintain their culture of origin (Bhugra and Jones, 2001). The acculturation process is also impacted by the wider societal atmosphere towards migrants as well as governmental policies related to immigration. Further, the challenges related to acculturative stress will notably change across the migratory generations.

Individuals and groups may acculturate in different ways as suggested by Berry: integration, assimilation, separation or marginalisation (Berry, 1990). See Table 1. Biculturalism where an individual feels comfortable in two cultures has been shown to be common in some South Asian populations. However, other factors such as economic status and educational factors may play a role in this adjustment. Settling down in a new culture is always stressful but marginalisation and separation may lead to acculturative stress and more susceptibility to mental ill heath such as depression.

	Maintain the home culture	Do not maintain the home culture
Participate in the new culture	Integration	Assimilation
Do not participate in the new culture	Separation	Marginalisation

Table1. Berry's Acculturation Model (Berry, 1990)

5. Review of Evidence: Rates of Mental Illnesses in South Asians living in the UK

Depression and Anxiety

Depression is the most common of all mental health diagnoses among South Asian people in the UK (Anand and Cochrane, 2005). South Asian women have elevated rates of depression (particularly Pakistani and Indian women) and mixed anxiety and depression (particularly Pakistani women) compared to white populations (Rees et al., 2016). The same study found that rates of Generalised Anxiety Disorder was of similar prevalence across different ethnic groups. Another study in England found that even after adjusting for socio-economic status, older Indian and Pakistani women, as well as middle-aged Pakistani men had higher rates of depression and anxiety (Weich et al., 2004).

Contributing factors for South Asians developing depressive symptoms are thought to be related to levels of literacy, financial difficulties, gender roles, social isolation, older age and poor physical health (Karasz et al., 2019). The impact of physical health must be considered given elevated rates of conditions such as diabetes and high blood pressure within the community.

The symptomology amongst South Asians is also different compared to White counterparts. For example, South Asian cancer patients presented with depressive symptoms of hopeless and helpless at greater rates than white patients (Gray et al., 2013). The study also found that the symptoms of depression continued for a longer period of time. Bhugra and colleagues also noted the somatic expression of depression included internal sensation of heat, feeling a weight in the body, heaviness in the heart and heart sinking and pressure in the brain (Bhugra et al., 1997).

Deliberate Self-Harm and Suicide

There is varied evidence related to rates of self-harm and suicide in the South Asian community. Historical evidence has suggested that South Asian women, particularly older women, have higher rates of suicide compared to White women (McKenzie et al., 2008). A more recent population based study on the other hand has found South Asian women have lower rates of suicidal ideation compared to White women (Rees et al., 2016).With regards to suicide attempts, the same study found no difference with other ethnic groups. For South Asian men, the study found prevalence of suicidal ideation and attempts to be lower comparatively to White men. Qualitative research has helped identify contributing factors related to suicidality in this population. This included post migratory social isolation, familial difficulties, relationship challenges (including feeling trapped by marital family) and financial problems (Al-Sharifi et al., 2015). For reasons discussed, a polled analysis of evidence such as a systematic review or meta-analysis (highest level of research evidence pyramid) would

be of benefit on this topic. Other approaches including questions to the Office for National Statistics have not resolved the uncertainty(Office for National Statistics, 2016).

Psychosis (affective and non-affective)

Affective psychosis relates to the presence of psychotic symptoms (such as delusions, hallucinations and thought disorder) in the context of mood related changes such as a major depressive or bipolar manic episode. Non-affective psychosis describes disorders not explicitly related to mood changes such as schizophrenia, schizophreniform disorder and others. A study that sought to identify the incidence of severe mental illness by pooling results from several studies in a systematic manner found elevated risk of non-affective psychoses compared to the reference population in England (risk ratio of 2.27, 95% confidence interval of between 1.63 – 3.16) (Halvorsrud et al., 2019). The study also found that rates were elevated for affective psychoses (risk ratio of 1.17, 95% confidence interval between 1.07 and 2.72). This is consistent with previous findings of modestly elevated risk in South Asian people when compared to a reference population (Kirkbride et al., 2012).

It is important to note however that a different study did not find a difference between South Asian and White populations (Rees et al., 2016), suggestive some uncertainty with available evidence. It is to be noted that all studies recognise that Black and Caribbean individuals have greater rates of psychosis when compared to both Asian and White populations.

6. Utilisation of Services

A number of factors are thought to impact under utilisation of services. This ranges from language barriers, distrust of mental health professionals, cultural ideas of mental illness and low literacy levels.

A study that reviewed available evidence explored fifteen studies around help seeking facilitations and barriers from the perspective of South Asian service users in the UK (Prajapati and Liebling, 2021). They found that "institutional racism and cultural dissonance marginalise South Asian service users from access to quality and effective mental healthcare" (pg 1). Cultural dissonance is defined as a sense of discord, disharmony, confusion, or conflict experienced by people in the midst of change in their cultural environment. The changes are often unexpected, unexplained or not understandable due to various types of cultural dynamics.

There may also be geographical variations within the UK. For example, with regards to onward referrals to specialist mental health services when patients are reviewed in general practice, the rates in West London were reported to be similar between South Asians and White patients whereas South Asians had lower rates in Birmingham(Bhui et al., 2003). Given it has been over 18 years since that study, further evidence is needed to determine if such disparities still exist.

There is also significant variation within different South Asian communities. With regards to inpatient metal health admissions for example, rates of admissions are lower than average for Indian groups, and in line with the national average for Pakistani and Bangladeshi groups (NCCMH et al., 2011).

Case Study: Review of Seven Studies of Pakistani Women between 1960 and 2014 (Kapadia et al., 2017)

- Less likely than white women to use specialist services
- Similar rates of general practitioner consultations for mental health problems
- Less likely to be referred to IAPT, and also treated by those services.
- Rates of outpatient service use were lower – this included for community crisis services.
- Pakistani women had high levels of social support with family and friends
- Had less interaction with outside community networks compared to white women
- Felt isolated in dealing with mental illness due to stigma, and stigma was a barrier to seeking support
- Wished to be treated by healthcare workers from similar background, but had some reservations related to risk of disclosure in community

7. Stigma and Explanatory Models

Stigma is when someone is viewed differently because of some perceivable social characteristics that distinguish them from other members of a society, in this case mental illness. Discrimination is often related to this, and it occurs when someone is treated differently and in a negative way because of this distinguishing characteristic. Stigma and discrimination in mental health pose significant — both for those who experience symptoms but feel unable to access help, and for those who are receiving support and face stigma and/or discrimination from others on account of their diagnosis and symptomology. For South Asian populations, this can lead to double jeopardy as they may feel stigmatised against for their ethnicity/heritage as well as mental illness.

A study in Scotland with children and young people found that stigma and "fear of gossip about children's 'madness' constituted a major barrier to service use" among South Asian families(Bradby et al., 2007). In this study, some parents described their children's illnesses with a range of terms such as "immaturity" and had negative associations with psychiatry ("psychiatry is a bad word it means wrong in the brain") and/or cited other challenges such as that of racism. This study highlights important variations in explanatory models, with some South Asians struggling to identify with a Euro-centric biomedical framework, opting instead to understand symptomology within the wider context of life's circumstances. Explanatory models refer to an individual's understanding of illness and the causal attributions, and these in turn impact treatment preference and outcomes. For some, religion may also play a central role in understanding illness and wellness. As such, there may be use of religious acts such as prayer or counsel from religious leaders to deal with mental health challenges.

8. Pharmacological Treatments

Biological, psychological and social interventions are needed in supporting people with mental illness. There are a range of pharmacological treatments offered and these include anti-depressant, anxiolytics and anti-psychotic medication. For some of these psychotropic medications, the doses need to be varied on the basis of ethnicity and related psychopharmacology and side effects.

Further, individual and cross-cultural views related to psychotropic medications influence their acceptability and adherence. Even where there is acceptability, there is evidence that is variation in prescription of psychotropic medication by healthcare providers related to ethnicity. For example, a study that looked at differences in psychotropic drug prescribing in the UK found Asian patients with Dementia were prescribed antipsychotic drugs for longer than White groups, and similarly they received less potentially beneficial symptomatic treatments(Jones et al., 2020).

9. Cultural Adaptation of Psychological Treatment

Cultural adaptations to treatments are necessary and have been shown to be more effective. A study of British Pakistani depressed women randomised participants to three groups: those receiving social group intervention, antidepressant and both social group intervention/antidepressant (Gater et al., 2010). The social intervention consisted of a network of women participating in social activities together. They found that those who received social group intervention, either on its own or with medication, at the three and nine month stages had significantly greater social functioning. This was thought to be due to the culturally appropriate treatment model established. This finding in South Asians is consistent with wider literature, including pooled analysis (meta-analysis of 78 studies) across all ethnic groups and countries that found that culturally adapted psychological interventions were more effective than unadopted versions of the same interventions(Hall et al., 2016). This has been also found for specific mental health conditions such as depression: a pooled study (meta-analysis of 16 studies) that considered depression found that treatment changes related to language, context and therapist delivering the session had significant patient benefits (Chowdhary et al., 2014).

"Racism, discrimination and prejudice tend to play a major role in creating double and triple jeopardy where people from ethnic minorities choose not to seek help with delays contributing to chronicity of their conditions and resulting in poorer outcomes. Services in general are not culturally sensitive or competent, adding another layer to the complex nature of help-seeking" (Bhugra, 2021)

10.   Recommendations for Further Work

A.   Research on Current Practices

A number of areas in which research evidence is lacking has been identified in this report:

1. Varied experience of different migrant generations - those who themselves migrated versus second and third generations for example.
2. Patterns on how South Asians use mental health services, and their experiences of such services when used. This analysis would greatly benefit from a geographical breakdown with regions in UK to capture related nuances.
3. Review of proposed Mental Health Act reforms from the perspective of South Asian service users and diaspora, including qualitative exploration.
4. Documenting/reporting of socio-economic status, in addition to ethnicity, to allow for exploration of intersectionality of factors.
5. Evaluating the applicability and translatability of interventions from cultural broker and cultural competency training for all staff, and the shift to cultural mediation.
6. Exploring the role of digital mechanisms and platforms to engage with South Asian communities, and evaluation of treatment/therapeutic interventions that could be tailored accordingly via those platforms.

B.   Clinical and Therapeutic Interventions

In the process of gathering evidence around the mental health of South Asians in the UK, a number of key themes emerged that would enable better engagement:

1. Provision of culturally adapted psychological services: this needs to be related to language, type of therapist and treatment context.
2. Provision to users and families with 'options' as related to their mental health care: for example, this may be provision of professional interpreters, inclusion of family therapies, information about rights related to law and accommodation of cultural and religious requests.
3. Exploration and curiosity of lived experiences: clinicians and services to explore and show curiosity towards an individual's expressions of faith, values and cultural and socio-political context of individuals. This will help to avoid pathologising normal distress, and address social determinants of health.
4. Emphasis on greater community and stakeholder engagement. The model that focuses on improving literacy assumes Western cultural models of illness and idioms of distress, and that the same approaches will lead to improvements for South Asian cultural groups too. This is not necessarily the case given the varied social, cultural and interpersonal factors aforementioned. A co-development

model around services is crucial to jointly develop strategies to best communicate messages, and identify by whom, so as to avoid perpetuating cultural mistrust around use of Eurocentric conceptions of wellbeing and distress. This would allow for service engagement to move beyond recurrently promoting availability of existing services and ensure growth of appropriate services. In doing so, it will also empower local community groups within their own community to meet emotional and social needs of their groups. This must include use of voluntary sector led evaluations and community led programmes. For example, groups such as the Hopscotch Asian Women's Centre who led focussed projects on the mental health needs of young people from the Bangladeshi community (Akter, 2009). Culturally relevant social prescribing should be considered.

C.   Population Health Approaches: 'Helping Hand'

The schematic 'Helping Hand for South Asian Mental Health' identifies areas that should be tackled to improve mental health.

Figure 1. 'Helping Hand' for South Asian Mental Health

1. **Unmet needs:** Concerted efforts to identify unmet health needs for South Asians, with appreciation of differences from other ethnic minority group (often grouped together in the literature as BAME).

2. **Co-development of mental health services:** Co-development of mental health services with service users, including ethnic minority groups of South Asians. This representation must move beyond having a tokenistic 'BAME representative'.

3. **Anti-stigma campaigns:** In-reach community projects related to stigma and discrimination of mental illness. This needs to be done with cultural awareness and care taken not to pathologies 'normal' distress.

4. **Intervention evaluations:** Effectiveness evaluation of interventions for this population. This should include services aimed at all individuals, and those specifically for South Asians.

5. **Culturally competent workforce:** The mental health workforce must have appropriate cultural competency training so that care provided appreciates cultural (religious/spiritual/faith), historical and gendered influences of South Asians. Further, there must be a move beyond one-off cultural competency training towards lifelong learning and self-reflection. This is necessary to tackle conscious and subconscious attitudes, including at times, assumed superiority over the other (in this case, South Asian cultural norm).

D.   Accountability and Governance: The Case for an Office of Minority Health (OMH)

The challenges facing the mental health of South Asians must be situated as part of wider health needs for this population (greater rates of hypertension and diabetes). This must also include an analysis of the inequalities in outcomes we have seen during the Covid-19 pandemic. Death rates among BAME populations have been strikingly high, both amongst the general population and healthcare staff. As borne out in academic literature, health outcomes and inequities pre and during the Covid-19 pandemic are related to intersectionality of gender, ethnicity, religion, co-morbidity and socio-economic factors. Given this context, there is need for joined up working across a range of departments that influence the social determinants of health – education, employment, justice, transport and others.

As forcefully articulated by Professor Bhugra, the Office of Minority Health (OMH) is an important way in which this can be done(Bhugra, 2021).

There is need to create a public body through an Act of Parliament with the authority, funding and long term commitment to tackle these challenges. This creation would also recognise that yet another commission will not do, and that tackling the underlying inequities will require hard work across years to come.

There is precedent for such a move - the United States of America created a federal agency in 1986 after the landmark Heckler report and it was reauthorised more recently during the 2010 Affordable Care Act of 2010 (dubbed Obamacare). At a time when central government and civil service energy is being spent on reorganisation and restructuring of health agencies (i.e. Public Health England), there is no excuse for this not to occur. Indeed, it has the potential to be an important part of our response to protecting the health of our nation.

> "Profession and individuals need to highlight the discrepancies and influence local parliamentarians and as individuals advocate for establishing the Office. Making progress against these major problems of inequalities will require dedicated work for a long time, perhaps over a generation" – (Bhugra, 2021)

Figure 2. Principles underpinning an Office of Minority Health
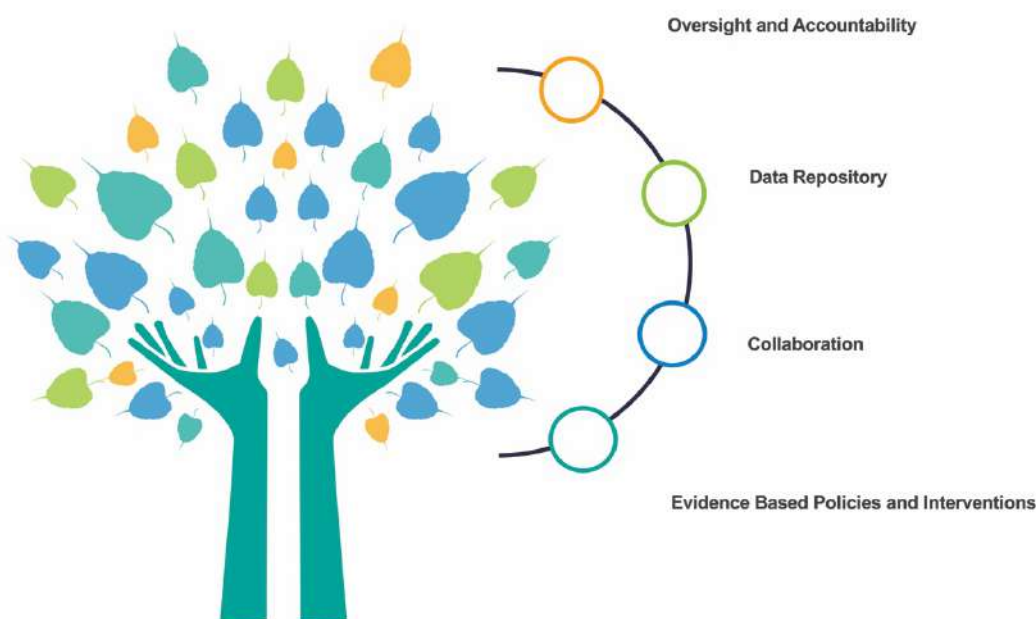
1. **Oversight and Accountability:** Provide oversight and monitoring of outcomes for ethnic minority groups, including South Asians. The body would have the remit to hold cross-governmental departments, statutory organisations, and others accountable for their impact to minority health (either directly impacting health, or via social determinants of mental health).

2. **Data Repository:** Serve as a hub of data relating to mental and physical health, and related inequalities, for ethnic minority groups. Part of data repository will also be related to examples of good practice and optimisation of mental health and wellbeing.

3. **Collaboration:** Ensure that activities related to improving ethnic minority health are under one roof, reduce bureaucratic costs and incorporate research and clinical service delivery across different settings and contexts.

4. **Evidence Based:** Develop and promote evidence-based policies and interventions to promote health equity across ethnic groups. Focus also related to stakeholder engagement in generation of evidence, and ensuring existing studies adequately represent ethnic minoritygroups.

11.   Further Strands Of Work : CAREIF and Ethnic Inclusion

Finally, this report highlights five strands of work that CAREIF and the Ethnic Inclusion Foundation, and/or other interested parties should prioritise as next steps following this report:

1. Stakeholder engagement, particularly with a) South Asian service users b) members of the South Asian community c) organisations and groups that are currently providing mental health for South Asians (e.g. Tamil Help Line and Adhar Project).

2. Consultation with an explicit and narrow remit to gather evidence of interventions that are being undertaken by grassroots organisations for the mental health of South Asians. This is necessary as relying purely on academic literature will yield limited results and miss out on these vibrant and innovative approaches. Part of this process should be the creation of an online hub and portal for submission of current practice. This will also allow for showcasing of good practice. A resultant report will be of great benefit to collate the range of approaches being undertaken.

3. Leveraging consultation period (described above) to create a long term network of mental health providers in the charitable and voluntary sector who are seeking to improve the mental health of South Asians. This network will act as a peer-support tool and allow for collaborative working.

4. Establish a national working group (with service users, members of the South Asian diaspora, service providers in the charitable sector and health policy/academic experts), in a sustainable manner, to oversee and review mental health outcomes for South Asian populations on a biennial basis. This will provide an accountability mechanism currently lacking, and the periodic report will allow for focussed advocacy/campaigning.

5. Careif and Ethnic Inclusion to consider developing bespoke training programmes from the above strands of work related to South Asian mental health. To ensure such training programmes are service user and diaspora needs led.

Acknowledgements

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