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Recognising service users' diversity: social identity narratives of British Pakistanis in a mental health context

Abstract

Purpose

This study aims to investigate how British Pakistani people talk about their social identity, in the context of mental health, and how this shapes their experiences and perceptions of care delivered by the National Health Service (NHS), UK.

Methodology

Eight narrative interviews were conducted amongst members of the Pakistani community living in a city in the UK. The data were analysed using a narrative analysis approach using 'social identity' as a theoretical lens.

Findings

Considering Pakistani service users as a single social entity, and responding with generic approaches in meeting their mental health needs, may not be helpful in achieving equitable treatment. Study participants reject a simple conceptualisation of race and how a response based upon stereotypes is woefully inadequate. The study revealed that people from one ethnic or national background cannot be assumed to have a fixed social identity.

Originality

This study broadens understanding of how people from a single ethnic background may construct and view their social identities markedly different to others from the same ethnic group. This has implications for service providers in understanding how their clients' social identity is treated and understood in practice.

Key Words:

Social identity, ethnic minority service users, mental health services, NHS, Pakistani

Introduction

The prevalence of mental illness among people who associate with minority ethnic identity in the UK is relatively higher than the white majority population (Cudjoe et al. 2019; Moore et al. 2019). The way various ethnic communities conceptualise and express mental health difficulties 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 distress (Fenton and Sadiq-Sangster 1996). People of Pakistani ethnic identity in the UK, tend to associate mental illness with religion and seek traditional and religious methods of coping, often to treat *Jinn* (evil spirits) (Cinnirella & Loewenthal, 1999; Bhui et al. 2008). The literature indicates intergenerational differences in help-seeking behaviour with the younger generation adhering to a more Western approach (Tabassum et al. (2000). The strong stigma attached to mental illness (Gunasinghe et al 2019) and hospitalisation are important factors which limit the help-seeking behaviour of Pakistani people (Bradby et al., 2007).

This study sets out to investigate how British Pakistanis perceive their social identity, in the context of mental health, and how they perceive their social identity is treated and understood by service providers. In doing so, this study contributes to the healthcare management literature in important ways. By using social identity theory in a mental healthcare context, this study explores the role of social identification and perceptions about the Pakistani ethnic group in relation to understanding, conceptualisation and response to mental health issues in the UK. It also attempts to uncover how social identification within the Pakistani ethnic group, shape experiences of care received by people of this group by the National Health Service (NHS), UK and what policy implications this would entail for service providers, who aim to cater for the needs of diverse and marginalised service users in an equitable fashion.

Background and theory

Mental health service users and their carers from black and minority ethnic groups (BAME) have reported unsatisfactory experiences when using statutory mental health services (Bowl, 2007; Watson et al., 2019). The experiences of service users highlight a number of organisational, structural and staff-related barriers (Watson et al.2019). Among the important barriers are: language; ethnic specific stereotyping; lack of cultural awareness and shared understanding; lower prescription of non-drug

treatment interventions; less community and user involvement; an incompetent and barring role in primary care, and stigma (Watson et al. 2019). Interestingly, the studies which review the perspectives of mental health professionals manifest some similarities among the issues identified by service users and the professionals. For example, professionals highlight the need for in-depth cultural competency training and reducing the strong mental illness stigma in BAME communities. Research on the professionals also confirm that ethnic specific stereotyping exists in mental health services (Burr, 2002).

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). Social identity theory attempts to explain how social behaviour is influenced by the group membership of the individual (Alexander 2014). Understanding the 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, 2014), as well as perceptions about the quality of the services (Dreachslin et al., 2012). Social identification, as a person with a mental illness, is positively correlated with the process of help-seeking and is potentially more important for those who experience mental illness stigma to get help (Klik et al 2019). 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 such as ethnicity, and belongingness to a minority group such as Pakistanis in the UK.

Methodology

This research used a narrative method (Greenhalgh et al., 2005; Reissman, 2008) to explore the views of people of 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 distress in a UK context. This perspective lends support to a narrative inquiry whereby individuals can constantly

construct and reconstruct their sense of identity through relating their experiences and perceptions.

Given that understanding the social self of the person is important, it was decided to collect data from members of the Pakistani ethnic group to understand how they construct their social self in the context of mental health difficulties and mental health services in the UK. Participants were asked to share their thoughts on this subject and encouraged to story-tell their experiences. Further questions were asked on topics such as their perceptions of mental illnesses, mental health help-seeking behaviour, overall perceptions about NHS mental health services and suggestions for improving these services. All the interviews were conducted in English and were subject to a narrative analysis using a theoretical lens of social identity. The interviews lasted about one hour on average. The participants talked freely and told stories to illustrate their experiences and perceptions. The findings are presented as vignettes of the eight participants.

A non-random sampling along with a purposive and convenience sampling strategy was adopted for inviting members of the Pakistani ethnic group (Riessman, 2008). In total, eight members from the Pakistani ethnic group, living in the local catchment area were interviewed. Actual identities of the participants were concealed and pseudonyms were used. Every participant was given the option to freely withdraw from the interview and the study at any time. This study gained ethical approval from the University of Nottingham Medical School ethics committee

FINDINGS

This data were analysed through a narrative analysis approach and is presented in terms of a 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. These are presented as vignettes and the final section of each participant summary relates to their social identity in relation to mental illnesses.

Tanzeela

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 BAME support

organisation. She herself experienced post-natal depression. 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.

'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.'

She identified that there are generational differences among Pakistani community members regarding perceptions of mental illnesses. 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 programmes, 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. She 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 believed that western medicine can play an important role in improving poor mental health conditions. In a way, she was suggesting the adoption of an integrated approach based on both traditional and western models of addressing mental health issues: She thinks that people are different. They have different circumstances, and diverse ways of coping with these issues.

Tanzeela affirmed that she was treated for her post-natal depression through a medical route. In the quote below, Tanzeela clearly identified 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.'

As she does not believe in religious explanations, she is aligned to the medical model when she said, *'I will just stick with the doctors'*. 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 in the interview, however, she also identified differences in the mental health perspectives of second-generation attitudes as well. 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'

She discouraged 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 viewed ethnic-matching among service providers and service users as 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 was helpful, it could not address the barriers of time.

'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.'

It seems that Tanzeela was associating herself with a more western model of perceiving, explaining and responding to mental illness. She also positions herself as an open person who can share her own story of mental illness without feeling stigmatised by the community.

Mehnaz

Mehnaz is in her 50s, and originates from Punjab area of Pakistan. 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.

Mehnaz made comparisons between the Asian communities and the host society regarding the stigma associated with mental illness. 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 fear:

'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 marriage) for instance'.

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. Narrating issues in the services, she observes that language is a major 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.'

Mahnaz 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 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.

Muhammad

Muhammad is male and 35 years old. He is a first-generation immigrant, and came to the UK 10 years previously. He is a law graduate from a Pakistani university. He works as a teacher, but occasionally acts as a leader for conducting Friday prayers in one of the local NHS Trusts. Muhammad 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.'

In terms of explanations for mental illnesses, Muhammad thinks that

'...in Pakistani community especially, there is this belief of jinn'. ...'...we as Muslims do believe that there are jinns'. However, 'if the belief is poor, then you would associate everything with jinns'.

This indicates that the causes of mental illnesses are not physically visible; people in the Pakistani community associated mental illness as being caused by supernatural things. Muhammad observes variations among the generations in responding to mental distress. He particularly sees the influence of the host culture and integration to the host society playing its role in changing the perception of mental distress among people of the Pakistani community.

Muhammad suggests that even if the people were aware that there was a mental health hospital service, 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. Muhammad clarifies 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 suggests that the local NHS 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.'

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.

Shafique

Shafique is in his mid-40s and is a second-generation immigrant. He has a postgraduate qualification in mental health nursing and has worked within the local NHS mental health trust. Shafique thinks that budget cuts in ethnic-specific services

have resulted in poor services and 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 integrated with the culture of the host society. Shafique considers this as 'a complete fallacy':

'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 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.'

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). The Act protects individuals from discriminatory treatment and promotes a fair and more equal society:

'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 a 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 organization:

'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.'

Evaluating the cultural training provided by the local Trust to its organisational members, Shafique thought 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. 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 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.'

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 illness. 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.

Shamim

Shamim is a 41-year-old female second generation Pakistani immigrant, and has GCSE level education from the UK. 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. 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 thinks that most Pakistani community members experiencing mental distress do not use NHS mental health services. The reasons for this are primarily cultural and relate to widely-shared traditional mental health beliefs. 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.'

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 asserts that the service provider has a generic approach towards Pakistani service users. 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.

Latif

Latif is a 33-year-old second generation man who has a degree in religious studies from Pakistan, and works as an Imam in a local Mosque. 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.'

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.'

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.'

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.

Rasheed

Rasheed is in his mid-30s. He is a second-generation immigrant and has a postgraduate qualification in a scientific discipline. He has developed a western appearance and is clean shaven. He is, however a practising Muslim. According to Rasheed, the issue of stigma is so strong in the Pakistani community that people do not even openly discuss the course of treatment. 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.'

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.'

From Rasheed's narrative, it seems that he is more aligned to religious methods of treating mental illnesses. He positions himself as somebody who does not stigmatise people with mental health issues.

Khursheed

Khursheed is in her early 40s. She is a second-generation immigrant. 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 BAME people in the UK.

According to Khursheed, 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'.

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'.

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.'

Khursheed openly shares her own mental health issues of the past, and thus positions her positive identity in relation to mental illnesses. 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.

Discussion

Applying social identity theory on the narratives of the eight participants of a minority ethnicity in the UK, there appeared many similarities in the views of these participants about how mental illnesses are perceived and responded to. The findings support a key role of social identity in responding to mental illness (Klik et al. 2019). Overall, mental illnesses are highly stigmatised, especially for women (Gunasinghe et al 2019) 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 the participants in the context of mental illnesses and mental health services in the UK. However, despite the fact that mental illness is highly stigmatised in the Pakistani ethnic group, and people prefer to hide their stories, some participants in this research have openly shared their personal stories about experiencing mental illnesses in the past and the care they have received. Although mental illnesses are generally perceived to be caused by supernatural beings, the findings suggest that non-traditional or medical explanations of mental illnesses co-exist in the community.

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 contexts is debatable. 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 individual staff.

Findings concerning social identity claims made by the participants also indicate that members of the Pakistani ethnic group construct fluid and multiple social identities (Vertovec, 2019). The diversity in social identities is manifested when individuals align themselves with different explanatory models and responses to mental illness, and they also have different views on the mental health services being provided by the local NHS Trust. There is range of perspectives, and there is a co-existence of various views (Anwar et al 2012).

Public Policy & Managerial Implications

This study highlights significant public policy concerns. Findings suggest that the illnesses of a social category such as ethnicity should not be taken for granted. 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. Although this study focuses on one minority ethnic group, other minority BAME groups in the UK and perhaps in other Western countries with significant ethnic minority populations may experience similar issues. In the era of super-diversity (Vertovec, 2019), service providers need to have an approach which is not just focused on a single social characteristic or an aspect of social identity such as ethnicity. Rather, there should be a more inclusive approach which signifies the need to take cultural, and social characteristics into account (Seeleman et al., 2015).

Therefore, superficial interventions, undertaken by organisations in a 'policy compliance' mode, are not going to be beneficial in meeting the needs of each and every service user (Basharat et al 2020). This research suggests the need for shifting the focus away from a fixed, generic 'ethnicity' based approaches to considering population diversity '*as a collective feature that influences social life and public service provision of the whole population, not just racialised or otherwise visible minorities or new immigrants*' (Bradby et al., 2017:6).

Limitations and Future Research Directions

Given the use of eight participants constitutes a small sample size, and the fact that these participants were selected from a single geographical area, the findings of this

study cannot be generalised to the wider Pakistani community in the UK. Future researchers may attempt to carry out a large-scale investigation by selecting a more representative sample of Pakistani community, drawn from different regions of the UK, characterised by higher concentrations of the Pakistani ethnic group.

Conclusion

This study set out to investigate how service users, in the context of mental health, perceive their social identity is treated and understood by the service provider. Eight participants of Pakistani origin, drawn from a diverse social and occupational backgrounds, provide rich accounts of their beliefs with regard to the use of mental health services by Pakistani community in the UK. By using social identity theory, in the mental healthcare context, this study reveals that social identity is invariably a fluid and dynamic concept and people from one ethnic or national background cannot be assumed to have a fixed social identity. Although mental illnesses are generally perceived to be caused by supernatural beings, the findings suggest that non-traditional or medical explanations of mental illnesses co-exist in the community.

Findings suggests that lumping together members of a particular ethnic group (UK based Pakistanis in this case) in a single category of 'Pakistani' grossly overlooks their individual social identities. This over-simplistic approach is particularly problematic as social identity is a fluid and dynamic concept, not a fixed identity. This study has broadened understanding of how people from a single ethnic background may construct and view their social identities markedly different to others from the same ethnic group.

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