Part I

Contextual Information

Introduction

The tragic murder of George Floyd in the United States in 2020 served as a pivotal moment, igniting a widespread societal reckoning with institutional racism and its impact on disparities in healthcare, education and criminal justice. One significant response was in the push for educational reforms, particularly in North America and parts of Europe. Within academia this involved a call to revise systems of belief and sets of ingrained assumptions that have dominated generations of thinking in the West, thereby exposing the inherent power structures that have reinforced the status quo. It also initiated the inclusion of voices, approaches and practices that had been omitted or overlooked. History cannot be undone but new narratives can be written that account for lacunae in scholarship. The uptake of this process, known as decolonising, is ongoing but its implementation within the academy has not been consistent either in effort or approach.

This book continues the decolonising work done in the pioneering field of cultural psychiatry and focuses on the UK context. Whilst research in this field seeks to problematise the monocultural Western and white perspective, advocating the need to look cross-culturally and interculturally, thereby preventing cultural dominance, this study actualises that perspective. It looks at the lived experiences of South Asian[1] psychiatrists in the UK who, as a matter of course, have had to shift between at least two distinct perspectives in their lives. For first-generation migrants who came to the UK from countries such as Bangladesh, India, Pakistan or Sri Lanka, this shift was most pronounced in the very different cultural settings of their home country and the UK, which informed their life journey. They experienced their formative years in their home country, where they also attained their medical qualifications. Migrating to the UK was motivated in many cases by a desire to improve their work prospects, but it also involved having to adapt to a completely new environment, undertake further training and begin working life. The process of settling in a new country was often undertaken with little support and involved juggling two very different cultures. For second and subsequent generations, there were numerous shifts in perspective between the culture of their family of origin, which can be described as their home culture, and the cultures present at school, work and other realms, which largely reflected those of the majority group.

These collective experiences have in common the understanding of cultural difference not at a distance, or theoretically, but embodied in complex and fluid negotiations between professional and personal identities. For these psychiatrists, cultural difference plays out in many experiences, including during the process of migration, during training, in

[1] Within the UK, people with South Asian heritage are also known as 'Asian' but, for the benefit of global readers, the term 'South Asian' is used instead.

interactions with patients and colleagues, and within other areas of their working life in the hospital, clinic, academy or other organisation that forms their place of work.

Cultural psychiatry recognises the need to diversify the discipline of psychiatry in order to cater to the needs of culturally heterogeneous and global societies. One of the long-standing problems with Western psychiatry before the introduction of cultural psychiatry was its Western-centrism and failure to recognise its biases. This led to the pathologising of cultural difference, especially in relation to people of colour. This monocultural approach needed to be revised to become critically reflective and cognisant of ethnographic perspectives on culture, which stress the importance of examining culture in the terms of the group being studied. This requires the evaluation of its methods and processes to ensure that it is fit for purpose in a global context. One of the objectives of this process has been the inculcation of cultural competency or capability within clinical practice, which has been implemented in various ways.

One of the ways in which knowledge and understanding of 'ethnic minorities (excluding white minorities)'[2] – to use a phrase recommended at governmental level that replaced the erstwhile term BAME (Black, Asian and minority ethnic) – can be deepened within the field of cultural psychiatry is by giving the platform to members of these groups. In postcolonial theory, foregrounding the perspectives of ethnic minorities is vital as this empowers groups and individuals within these groups to speak for themselves rather than to be spoken for.[3] From a practical perspective, this will improve understanding about mental health services because the latter will be informed by those within the same or similar cultural groups, who have more of a tacit understanding of their needs. And, given the ongoing challenges that South Asian people have with services, knowledge of this kind remains valuable.

Within the discourse of cultural psychiatry, it is often assumed in research when discussing therapeutic relationships that (1) the patient is from an ethnic minority background, often from a BAME group, and (2) by implication, the psychiatrist is white and from the majority group. The first assumption can be explained by looking at the evolution of cultural psychiatry, which developed to meet the needs of increasingly diverse societies, where diversity concerns people from non-white ethnicities. The second assumption is hugely problematic. It points to the very issue that cultural psychiatry has been trying to correct, that of the problem of normative white bias. The default assumption within research on cultural psychiatry of the identity of the psychiatrist as white leads to a grave oversight, namely the quite different implications that may arise if the psychiatrist is from a non-white ethnic minority background. These include issues that the psychiatrist might face when, for instance, treating patients from a background similar to their own in terms of expectations and boundaries. Or issues that may arise for this same psychiatrist in treating patients from a white background. It also fails to recognise what is distinctive about the contribution of the ethnic minority psychiatrist. The view that 'within a cultural framework the practitioner is not to be seen as neutral or scientifically objective, but an active player in the cultural exchanges, bringing to bear his or her own cultural knowledge' is an important reminder of the inherent dynamism of the therapeutic relationship (Bhui and Gavrilovic, 2012, 105). The psychiatrist can contribute *both* to the identification of needs *and* ways in

[2] See www.ethnicity-facts-figures.service.gov.uk/style-guide/writing-about-ethnicity.
[3] This idea is articulated in Gayatri Chakravorty Spivak's essay 'Can the Subaltern Speak?' (Spivak, 1988, 271–313).

which to meet those needs. They may be better equipped to be able to identify idioms of distress, deploy appropriate explanatory models and understand attitudes about mental health within the group(s) of which they are a member of – factors invaluable to culturally sensitive care. A recent article by Ana Antić (2021) recognises the contributions of psychiatrists from African, Asian and other ethnic minority backgrounds (of which she includes Eastern Europe), which she argues is needed to diversify the field of cultural psychiatry in what she calls 'the Age of Decolonisation'.

This discussion alone has highlighted a gap in the research that needs to be addressed with some urgency. Cultural psychiatry advocates for a culturally sensitive and reflective approach, with the dynamic being set up and inculcated by the psychiatrist-as-professional, but which doesn't account for the ever present white privilege that has serious implications for a non-white professional, for example, in the culturally white spaces of a hospital, clinic or the academy.

This book foregrounds the need to learn about the perspectives of ethnic minority psychiatrists, taking as its focus South Asian psychiatrists within the UK context. There are compelling reasons for choosing this particular regional group, not least their contribution to British healthcare, chiefly the National Health Service. Of all doctors currently registered in the UK, 29 per cent are of South Asian ethnicity.[4] A recent report states how South Asian populations have disproportionately higher rates of many psychiatric disorders and yet are less likely to seek help (Gnanapragasam and Valsraj Menon, 2021). This observation is not new. In their systematic review of experiences of South Asian service users in the UK, Riddhi Prajapati and Helen Liebling (2022) make the important point that in spite of policies and action plans designed to close the gap of mental health inequality, significant problems persist. Learning more about the reasons regarding the lack of engagement of South Asian populations in mental health services, as well as ways of addressing what needs to be done by individuals culturally aligned to these groups, is vital and will provide a more culturally nuanced understanding.

Thirteen psychiatrists were invited, via interview, to reflect on their experience of living with different cultural identities and the bearing this had on their working life.[5] The narratives of these psychiatrists, that present cultural psychiatry as self-reflexive praxis, form the metaphorical spine of the book. The psychiatrists are *not* talking about cultural psychiatry; they are actually *doing* it. Decolonising the curriculum is an ongoing process. It is only when the voices and experiences of those on the margins are made central and embedded within discourse that long-lasting change can be seen in history, politics and culture. Much work has been done to combat these exclusionary practices, which in philosophy is described as 'epistemic injustice',[6] but the endeavour needs to be ongoing. This book is part of that endeavour.

[4] This figure is the percentage of doctors with declared ethnicity who identified as Asian/Asian British, that is, excluding those who did not declare their ethnicity (4 per cent of total). www.gmc-uk.org/about/what-we-do-and-why/data-and-research/gmc-data-explorer.

[5] The terminology of 'living with' is deliberate and to be contrasted with 'identifying with'. Ethnic minority (excluding white minority) individuals may be assigned an identity by others because of their racialised difference and this may distort their own views about group identity. The idea of 'living with' accounts for this, makes fewer assumptions about their affiliation and will be developed in Chapters 4 and 5.

[6] See Kidd, Medina and Pohlhaus (2017).

Throughout this book, an interdisciplinary approach is endorsed that looks at critical concepts and themes within the humanities and social sciences and especially within the domain of critical and cultural studies, which pertain to cultural psychiatry and are relevant to South Asian populations. For the benefit of readers from different disciplines, key terms, ideas and concepts are defined and explained when first introduced and are contextualised within the overarching approach of decolonisation.

Chapter 1

Culture and Psychiatry

Cultural Psychiatry: Surveying the Field

Cultural psychiatry is concerned with the cultural aspects of psychopathology and the role of culture in the development, expression and outcome of mental health. More fully, '[c]ulture influences the experience, expression, course and outcome of mental health problems, help-seeking and the response to health promotion, prevention or treatment interventions' (Kirmayer, 2012, 149). It is inherently interdisciplinary and draws from anthropology, sociology and psychology amongst other disciplines. Laurence J. Kirmayer discusses how, 'unlike the social sciences of medicine', cultural psychiatry is driven 'primarily not by theoretical problems but by clinical imperatives' (2007, 3). This needs to be emphasised because it explains many features of the field, including the extent to which research has been generated in the clinical encounter.

The term 'transcultural' is used by some interchangeably with 'cultural' in 'cultural psychiatry' but by others in place of it. Eric Wittkower adopted the term 'transcultural' to 'imply moving through and beyond cultural barriers' (Wittkower and Rin, 1965, cited in Kirmayer, 2007, 13). His endeavours, from the mid-1950s onwards, led to the setting up of various committees and societies and the founding of journals of transcultural psychiatry. Kirmayer cites Raymond Prince, from Prince's 1997 article 'What's in a name?', as an example of someone who uses the term 'cultural psychiatry' to indicate 'that all human experience is culturally constituted and that we can examine cultural meanings in a single society as well as comparatively' (Kirmayer, 2007, 13). Cultural psychiatry was believed to have a broader remit, to be inclusive of the transcultural and to be fundamentally committed to examining culture in a more encompassing way (see also Dein and Bhui, 2013, 770).[1]

One of the main objectives of cultural psychiatry is the inculcation of a stance of self-reflexivity with respect to culture and cultural difference, which has as its aim the production of culturally competent – some prefer, culturally capable – practitioners. Cultural psychiatry advocates reflexivity about the cross-cultural aspects of mental health and illness, is concerned with understanding how psychopathology is defined and treated in various cultural contexts, and seeks to develop culturally sensitive diagnostic and therapeutic approaches. Relativism about culture is the view that the mind and mental illness are understood and conceptualised in different ways depending on the cultural tradition in question. This raises questions of a philosophical, epistemological, technical and practical nature, which are addressed in the reformist thinking central to the discipline. What constitutes good clinical practice in one setting may not apply in another, given the

[1] Fernando (2017, 116) talks about how transcultural psychiatry in the UK gradually became known as cultural psychiatry.

importance of context-specific understanding. That being said, practical reasons necessitate the implementation of classificatory systems. Within psychiatry the International Classification of Diseases (ICD) and Diagnostic and Statistical Manual of Mental Disorders (DSM), the former currently on its eleventh edition and the latter its fifth (DSM-5), are recognised internationally as authoritative but should not be regarded as value-free (in the sense of being free of bias) (see Mezzich et al., 1999). In keeping with the emphasis on the centrality of culture is the view that regardless of the cultural makeup of the geographical region of clinical practice, healthcare practitioners should be able to administer care that is culturally sensitive.

A more elementary question, and one that is useful here, is the very definition of culture itself. 'Culture' is a broad term that has been defined and deployed in many ways by scholars from different academic disciplines. Patti T. Lenard's (2020) entry in the *Stanford Encyclopedia of Philosophy* is comprehensive. She describes how culture refers to the norms, practices and values that characterise groups. That being said, the boundaries between cultures are porous and people belong to multiple cultures. Lenard highlights the human element to her discussion, arguing how cultures matter to people: they help shape experiences and values, and create meaning. The definition of culture in the DSM-5 is also broad and inclusive, and recognises that:

> Cultures are open, dynamic systems that undergo continuous change over time; in the contemporary world, most individuals and groups are exposed to multiple cultures, which they use to fashion their identities and make sense of experience. (American Psychiatric Association, 2013, 749–59)

From its inception, cultural psychiatry has focused mainly on the cultures of ethnic minorities, particularly non-white minorities. The way in which culture is framed varies. In the United States, it is framed predominantly in terms of race, whilst in the UK it is ethnicity[2] (see Bhui and Singh, 2004, 125; Kirmayer, 2012, 154). The relative merits or demerits of looking at race rather than ethnicity or vice versa are not as critical as the point that culture is much more than race or ethnicity. National census categories may allow for multiple choices but are essentially limited in that they 'do not capture the diversity of the society and the rapidly growing numbers of people who define themselves in hybrid ways that cut across these categories or escape them entirely' (Kirmayer, 2012, 154).[3] Culture should be viewed instead as open, fluid and in a state of change (Kirmayer, 2012, 154).[4] The authors build on this line of thinking and believe what needs to be advanced is an understanding of the identity of a person of a non-white ethnic minority as composite and multifaceted, and inclusive of different components, such as the plural understanding of culture that comprises variables that may comprise ethnicity, race and so on, including social determinants (Antić, 2021, 364, 369).[5] The recognition of the complex nature of

[2] See '2. Ethnic minorities and ethnic groups', www.ethnicity-facts-figures.service.gov.uk/style-guide/writing-about-ethnicity.

[3] Kirmayer here is referring to the US census but the idea applies widely to other censuses.

[4] Another important point is the recognition that culture, race and ethnicity are related to economic inequities, racism and discrimination that result in health disparities, claims stated in the DSM-5 (American Psychiatric Association, 2013, 749–59).

[5] One of the problems of the traditions of cultural psychiatry in their history has been the limited interpretation of culture, where culture is read as ethnicity or race, to the detriment of a fuller understanding of that incorporates the social determinants of identity (Antić, 2021, 364, 369).

individual identity is required for understanding cultural heterogeneity, namely the idea of diversity within group identities. And adding to that is the idea that people belong to multiple cultures (Lenard, 2020).

Before moving on, a reminder of the rationale for thinking about culture in relation to minority groups is useful. The imperative of cultural psychiatry was to develop a more culturally reflective understanding of global mental health in the light of the dominance of the Western perspective on the discipline of psychiatry. Developed historically from colonialist practices, psychiatry espoused Western traditions and values. Those outside of these traditions were subject to structural racism and pathologisation. In contemporary society, these groups continue to experience political, social and economic disadvantage and often have more precarious relationships with mental health services. The shift towards looking at cultures in their own terms in cultural psychiatry provides a corrective to outmoded practices. In a position statement about psychiatry in the era of decolonisation, Ana Antić (2021) celebrates the contribution of psychiatrists from ethnic minority backgrounds, whom she believes have become adept at examining cultural identity in a more holistic way than more established traditions.

An overview of the historical development of cultural psychiatry is worth considering before looking more specifically at the UK picture. The progression of cultural psychiatry can be mapped in stages (Kirmayer 2007, 4–8; Kirmayer and Minas, 2000, 438–9). The first stage involved the encounter between European and non-Western cultures during colonialist missions and expeditions. The discipline of cultural psychiatry emerged out of the legacy that colonialism had on the mental health of the cultural 'other', a narrative that Kirmayer (2007), amongst others, underscored as imperative to its evolution. Notwithstanding this, Sloan Mahone and Megan Vaughan (2007) warn against exaggerated accounts of grand colonialist schemes, arguing that reports of psychiatric practices in colonial contexts should not be conflated with the intellectual history of imperialist psychiatry (2). That is not to deny the brutality of colonialist psychiatry but rather to demystify narratives that concocted elaborate schemes of institutionalisation. What actually went on was the exercise of the imperialist mindset that colonised in the name of 'civilisation'. The rationale was that it was in the interests of the colonialised to be 'civilised', 'for their own good', and this responsibility fell to the white colonialists, a duty subsequently described as 'the white man's burden'.[6] The violence of colonisation was not only seen in physical actions such as the taking of land but also in the psychological damage, which is no less harmful (see Price, 2018; see also Mahone and Vaughan, 2007).

In broad terms, colonialism involves forcible change in the colonised of their culture, habits integral to identity and wellbeing. The philosopher and psychiatrist Frantz Fanon (1986, 191–5) studied the psychopathological effects of colonialism, what he termed 'cultural imposition', on the colonised who were unable to transcend their fate. He conveyed in vivid terms how the colonised suffered under regimes of control that had devastating impacts on identity. This is conveyed trenchantly: 'Madness is one of the means man has of losing his freedom. And I can say, on the basis of what I have been able to observe from this point of vantage, that the degree of alienation of the inhabitants of this country appears to me frightening' (Fanon 1964, 53). Fanon is a figure of great significance in cultural

[6] The justification, 'the white man's burden' is taken from Rudyard Kipling's eponymous poem, written in 1899.

psychiatry and his method of reflecting on the lived experience of himself as the 'other', an African-Caribbean person under French colonialism, and the insight this gave him into his patients' lives make his work essential.

The second stage of cultural psychiatry involved adjusting to a postcolonial world. Mass migration and postwar development across the globe after the fall of empire in the twentieth century transformed societies, especially in parts of the West/Global North. The movement of migrants, refugees and exiles continues today, creating increasingly culturally diverse populations. The mental health needs that arose were attributed to the stressors of displacement, whether through migration, forced exile or other processes, including the continuing effects of colonialism. The term 'postcolonial' may be used to signal the official end of imperialist regimes but it also acknowledges the aftermath of these histories.

The third stage, which continues to the present day, is the anthropology of psychiatry; that is, 'the ethnographic study of psychiatry itself as the product of a specific cultural history' (Kirmayer and Minas, 2000, 438). This involves looking at cultures from the inside, ethnographically, where culture is interpreted in its own terms, by the standards and conventions of the culture in question rather than by any other. This method mitigated against ethnocentrism and exposes the cultural production of knowledge and, concomitantly, power. Its trajectory is paralleled by the transformation undergone in anthropology.

Classical Western anthropology arose from imperialism and 'emerged as an attempt to scientifically classify groups of human beings as different and therefore separate' (Pels, 2008, 280). During fieldwork visits to remote places, knowledge was construed in terms of a binary between the anthropologist-as-investigator and the object of enquiry. The crisis of representation in the 1980s and 1990s within the human sciences was part of a larger critical turn arising from postcolonial thought that necessitated a shift in thinking about legitimate modes of enquiry which problematised previous practices. The process of representing other cultures was not to be seen as an exercise of excavating truth, where the bearer of knowledge, in this context, the anthropologist, 'discovered' a culture in absolute terms. Instead the culture should be described *from* the perspective of the anthropologist. Advocating a 'self-critical' reflexivity (Clifford and Marcus, 1986, 24) to prevent cultural domination, the process of representing other cultures was to be understood as 'inescapably contingent, historical and contestable' (1986, book summary).[7]

The above developments in the stages of cultural psychiatry have led to ratified changes mandated by professional bodies, as seen in the progression of ideas from the DSM-4 (1994) to DSM-5 (2022). The transition evidenced here involved the reconceptualisation of culture where it was not seen as the preserve of minority groups (as reflected in the hugely problematic notion of 'culture-bound', in DSM-4) to an understanding, in DSM-5, that everyone has and belongs to different cultures and these cultures shape value systems. This transition included unpicking the culture of the institution of psychiatry, which was equivalent to white, Western culture. Making the culture *of* psychiatry visible was an indispensable move in the development of cultural psychiatry.

Cultural psychiatry has made great strides in its development. Early scholarship focused on delineating the academic and clinical concerns of the discipline, which included articulating the history, theory, methodology and practice of the discipline. The scope of interests

[7] A highly influential text that encapsulates many of the central ideas in this revolution of thought and which is also relevant when thinking about cultural psychiatry is James Clifford and George E. Marcus's *Writing Culture: The Poetics and Politics of Ethnography* (1986).

and methods is wide: of overriding importance for professionals is the adoption of a sensibility, that is, a stance of cultural reflexivity and sensitivity. The migration histories of different populations are reflected in the variation of trajectories and priorities that cultural psychiatry has taken. Nonetheless, there are various threads that are common across contexts, which include the impact on mental health of migration and structural racism in society and its forms of disadvantage to ethnic minority groups (Littlewood and Lipsedge, 2014; Fernando, 1988).

Research in Cultural Psychiatry: The UK Context

The history of British imperialism has been integral to understanding the priorities of cultural psychiatry in the UK. This encompasses the aftermath of the fall of empire, which included the postwar influx of migrants from Commonwealth countries that led to the growing diversity of what is now a multi-ethnic landscape. Cultural psychiatry in the UK has been oriented toward examining the impact of migration across generations, which includes thinking about processes of acculturation. The approach taken is twofold, with some overlap between the two components: the recognition of the effects of racism and discrimination on mental health, and, relatedly, efforts to achieve services that meet the needs of ethnic minority groups. Research thus far has concentrated mainly on particular minority groups (Littlewood and Lipsedge, 2014, 258) including South Asians.

The contribution of key figures within the development of cultural psychiatry is a useful starting point for exploring the terrain. One of the earliest studies, *Race, Culture and Mental Disorder* by Philip Rack (1982), came out of his work in Bradford with the Mirpuri[8] community on the basis of which he established a specialist centre to cater for its cultural needs. Roland Littlewood and Maurice Lipsedge's (2014) *Aliens and Alienists: Ethnic Minorities and Psychiatry*, originally published in 1982, is regarded as a classic text that examines the relationship between racism, mental health and the treatment of ethnic minorities, and consists of case studies of diverse groups including African-Caribbeans, Turkish Cypriots and Hasidic Jews. Another early important study was John L. Cox's (2020) edited book on *Transcultural Psychiatry* (originally published in 1986), which looked at different aspects relating to the needs and backgrounds of ethnic groups.

One of the early pioneers of cultural psychiatry within the UK was Suman Fernando (2017), whose *Institutional Racism in Psychiatry and Clinical Psychology*, amongst his numerous publications in this field, gave an overview of the problems faced by ethnic minority (excluding white minority) psychiatrists in the UK and of the changes in mental health care, particularly throughout the later part of the twentieth century. Very much an activist, he spoke of the 'race-based' glass ceiling in relation to the appointments of senior staff through the 1960s to the 1980s and set up the Transcultural Psychiatry Society (TCPS), which was critically important in campaigning against racism in mental health services both in terms of the difficulties encountered by the said professionals and ethnic minority (excluding white minority) users of mental health services (Fernando, 2017, viii, 114–16). With a membership comprising mental health professionals from a variety of cultural backgrounds, all with a shared motivation to address the importance of culture in discussions about mental health, the efforts of this group brought about change, with an

[8] The British Mirpuris originate from the Mirpur district in Azad Jammu and Kashmir, a region in the north-east of Pakistan.

increase in the appointments of ethnic minority psychiatrists in the 1990s. Another early figure of profound importance was the psychiatrist Aggrey W. Burke, also well known for his activism. He researched the role of racial discrimination in psychiatric disorders (Burke, 1984, 1986). His work in the 1980s showed how deprivation is associated with mental illness, which he uncovered especially within black communities. In 1986, together with his colleague, Joe Collier, he published a paper that showed racial and sexual discrimination in admission to London's medical schools (Collier and Burke, 1986; see also Andrews, 2022).

One of the pre-eminent figures in the field of cultural psychiatry in the UK is Dinesh Bhugra, who has numerous accolades and is a leading figure in the social justice of mental health care. Emeritus Professor of Mental Health and Cultural Diversity at the Institute of Psychiatry, Psychology and Neuroscience at King's College, London, his contribution to the field is extensive and his output prolific. His role encompasses clinical practice, research, teaching and activism. His global work involves the implementation of training and education into low- and middle-income (LAMI) countries, and demonstrates the importance of acknowledging relativity about culture. His philosophy aligns mental and physical health and endorses his core value of holistic medical care.

He has authored and edited numerous books in the field, notably the award-winning *Textbook of Cultural Psychiatry* (2007). Not to be overlooked are his more practical texts on how 'to do' cultural psychiatry that provide clinicians with case studies and examples (see Bhugra and Cochrane, 2001; see also Bhugra and Bhui, 2001). One of the most significant areas of his research is his writing on the impact of migration on mental health. Bhugra's personal journey of migration began as the son of migrant parents who fled to India from Pakistan during the Partition, and continued when he became a first-generation migrant in the UK. The special significance of migration, within the field of cultural psychiatry, underscored by Bhugra, explains one of his special interests in the mental health of refugees and asylum seekers (Bhugra et al., 2010; Bhugra, 2004a). The range of topics within his scholarship are wide-ranging. He also draws on first-hand insights of the needs of South Asian communities (see Bhugra, 2004b, for example). One of the most comprehensive studies in this area is his 2005 volume *Handbook of Psychiatry: A South Asian Perspective*, which is an extensive examination of clinical practice in South Asia.

Bhugra has spoken about the need for a broader approach to medical education, in which he considers the humanities and arts as integral (Jones, 2018, 531; Bhugra, 2003). His postgraduate qualifications in sociology and social anthropology support his approaches and methods used in the humanities and social sciences, broadening the approach to mental health by looking beyond the medical model to incorporate other perspectives (see Mohammadi, 2017, 746). This involves widening understanding about the relevance of culture in mental health, and appreciating that cultures have different means of evaluating behaviours and providing support (see Bhugra 2006; Deakin and Bhugra, 2012).

Current research in the field should be considered against the backdrop of continual change in the ethnic makeup of the UK, including the flow of migrants and other groups of people from different parts of the world in response to socio-political events. The impact of migration on mental health and on racism are ongoing themes in the literature (Dein and Bhui, 2013, 769). The research by pioneers in the field in the UK, such as Rack in Bradford, Roland Littlewood in Birmingham, and Julian Leff in London, helped identify specific ethno-cultural groups by region. Building on this, the development of the subjective views of ethnic minority groups in their experiences of healthcare provision is vital (Dein and