Enabling Access to Welfare Services - the Place of Social Solidarity and Dialogue

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Abstract

The welfare state in the UK presents immigrant communities with a set of institutions, which are potentially new and unknown. What is the best way to ensure that the questions of access to the welfare institutions are best managed? Trusting, understanding and feeling solidarity with the welfare state will obviously help with this problem. In order to shed light on this phenomenon, this paper presents a qualitative exploratory study dealing with elements of solidarity as perceived by members of the South Asian Community in the UK. Six indepth interviews with South Asian first generation immigrants who had never experienced mental health problems were conducted. They were asked questions about who their support networks would be in the event of them experiencing mental health problems. The thematic analysis of the interviews suggests that the respondents believed that solidarity and support ties are found to be present in families, within the south Asian community and also with welfare institutions. It is concluded that there although things are far from perfect, assimilation and integration based on dialogue is an observable positive aspect of mental health service provision in the UK.

1 Introduction

When we think of the situation of migrants and immigrants in the United Kingdom, it is generally acknowledged that there is scope for improvement with regard to the services they receive and their status in society. Disadvantage, vulnerability, isolation, exclusion, deprivation, marginalisation and institutional racism (McKenzie and Bhui 2007), are all concepts that have been applied to understand the situation of these groups. Migration itself has been seen as a risk to health (Carballo et al. 1998) and to social capital (Putnam 1995). However, members of immigrant communities have effectively challenged some of these ideas (Mand 2006; Bhugra 2004). Contrary to finding out what constitutes this disadvantage, it was felt that exploring inclusion and solidarity ties amongst disadvantaged groups would provide us with useful insights about the things that are going right and therefore need to be encouraged. It was with this intention that the beliefs about support networks of adult mental health service users of South Asian origin were studied. The rationale for this research is to look at the landscape of solidarity and its implications for social work practice.

The first section of this article explores some theoretical insights about solidarity and community. This is followed by a brief review of relevant literature on welfare state, solidarity and the South Asian community in the UK. The paper then presents the process and findings of a qualitative research project based on first generation South Asian immigrants who have never experienced any mental health problems, are gainfully employed and who have differing levels of knowledge and involvement in the care of mental health service users. The research findings indicate that for the respondents, solidarity ties continue to be strong

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within families, within the community, with traditional institutions as well as with the welfare state. The findings point to the importance of enabling social workers to frame their interventions in ecologically relevant ways. The paper concludes with reflection on the research process and with suggestions for future research.

2 Exploring the theoretical terrain of community solidarity

Solidarity is a concept that resists a clear definition. The fundamental questions that solidarity seems to address are regarding "what it is that makes 'society' possible?" as well as "what makes 'social change' possible?" Solidarity therefore seems to be the basis of both 'status quo' and 'change' in societies. It has been noted that solidarity is used synonymously with ideas such as mutuality, reciprocity and community, although these may be theoretically distinguished (Reedy 2003). However, sociologists, anthropologists and social psychologists, all seem to begin their undertaking of the concept of social solidarity by cautioning students against ascribing 'a warm glow' to the notion as it can lead to totalitarian ideologies such as fascism and extreme nationalism (Nisbet 1953 and Plessner 1924). Moreover, discussions on solidarity also seem to be possible only when we begin to discuss the concept of community. For this purpose of this article therefore we shall concern ourselves with the notions of solidarity as derived from communitarianism, Habermas' theory on communicative action and Beck's idea of the risk society.

Communitarianism

The concern to preserve and promote people's sense of belonging is what forms the unifying thread for the idea of community in Communitarian thought. Inherent to this agenda is an opposition to self-interested behaviour that disregards obligation to others, since other-regarding moral obligations are treated as essential to the successful functioning of community relationships. In turn, community is regarded as vital to people's quality of life because of the impersonality of formal government structures and their association with coercion' (Crowe 2002, 43). This emphasises solidarity, participation, loyalty and commitment (Selznick 1992).

Communitarians have come under severe attack from various quarters regarding their nostalgic approach to community. However, it is important to understand that different variants of communitarianism have very different emphases, and often, strong internal disagreements. There are the communitarians who reject moral individualism and argue for the primacy of the group and a concurrent concern with social ontology and cultural rights of minorities. They propose a 'politics of recognition' that underscores the need for the preservation of cultural communities (Taylor 1994). There are the radical pluralists, who are concerned primarily with the problem of empowering marginal groups (Benhabib 1996; Young 2000). The civic republicans (Putnam 1999) are concerned most with social capital and participation. Their focus is on enabling democracy to thrive by endorsing trust, commitment and solidarity. There is also governmental communitarianism, which is an outcome of the government cashing in on the community band-wagon by explicitly linking policymaking and community and encouraging voluntarism, charitable works and self organised care. The 'technical' incorporation[1] of community into aspects such as policing, regeneration and development are all outcomes of governmental communitarianism.

[1] Rose (1999, 79) has traced how sociological ideas fed into interventionist politics which 'tried to re-invent community governmentally' on the assumption that 'the bonds of solidarity could be rendered technical, that is to say, made amenable to a technique' (emphasis in original).

More critical approaches to this stream make explicit the limits of communitarianism by acknowledging that it stresses too much on community as a moral solution to problems that originate in capitalism and changes in the nature of work (Sennett 1998).

Communicative action

Habermas gives central consideration to 'communication' in his undertaking of the concept of community. In him we find the most pliable links for a social psychology of solidarity. He links concerns about justice and solidarity to the moral stages outlined by Kohlberg (1981) and the 'solidarity and ethics of care' arguments posited by Gilligan (1982) when she argues in 'A different voice' claiming that post conventional morality has no rights to claim the highest rank in moral decision making. His principle of discourse banks heavily on Kant's proposal of Universalisation, which Habermas has incorporated as 'intersubjectivity' in his theorising.

Habermas (1984) regards society as a linguistically constructed and sustained entity. He explores the communicative rationality and the communicative structures of modernity. His attempt is to show how a reflexive and critical involvement in communicative processes is the only harbinger of salvation from the forces of capitalism that has modernity in its clutches. This explains his proposal that communicative action is the only way to resist domination and achieve social change.

Habermas lauds the political possibilities of communicative action and further contends that through a commitment to truth, a 'disnterested involvement' and deliberation, consensus can be arrived at. Community is therefore not a moral or civic entity but an emergent product of communicative undertakings. This faith in dialogue resonates with Freire's (1974) conception of dialogue as the only form of relationship that is based on equality. "Engaging in dialogue implies an involvement dedicated to a constant transformation of reality. Dialogue cannot imprison itself in any antagonistic relation...Cultural invasion through dialogue cannot exist because dialogical-manipulation or conquest does not exist. These terms are mutually exclusive" (Freire 1974,113).

Moreover because he conceptualises politics as a dialogic process, he underscores a belief in reaching a shared conception, an intersubjectivity of truth, justice and ethics, through communicative endeavours in the public sphere. He values the 'fallibilism' or the unresolved openness that emerges out of a belief the 'other' can also be right and sees it as a virtue that can resolve communicational deadlocks.

A normative conception of community as is advocated by the communitarians holds diabolic potential for Habermas because this implies that as a moral totality community gets tied down to non-social principles, which are not reflexively realised.

Rather than homogeneity, integrity, and unity, Habermas values democratic debate built on diversity and communicative possibilities. This stand is also taken by Tourraine (1995;1997) who goes on to pose an important and revealing question: 'Has not the pursuit of common good become an obsession with identity and do we not need stronger institutional guarantees of respect for personal liberty and human rights rather than more integrated communities?' (Tourraine 1997,112).

It is important to mention that we are now on the tapestry of the debate about individualism, which is an essential aspect in community related theorising.

Risk society

A further notable strand of criticism about the role of the welfare state is elaborated in the 'Risk Society' by Beck. His central concern in his account is the distinguishing role played by the welfare state in the reshaping of social solidarities. He deems welfare states as propelling the growth of individualisation, which is acerbic for traditional solidarities. Further he contends, in agreement with Marx, that capitalism entails that people are 'uprooted in successive waves and wrested loose from tradition, family, neighbourhood, occupation and culture' (Beck 1992, 95). To him the welfare state engenders 'an experimental arrangement for conditioning ego-centred ways of life' (Beck 1997, 97) and frees individuals from the ties and obligations that necessitated togetherness.

He looks at the communitarian agenda with condescension, saying that to him it represents an endeavour 'to exorcise the evil or egoism with a sanctimonious rhetoric of community spirit, a home remedy from grandma's medicine cabinet which, as we know, costs nothing and is worth every penny' (1998, 13). He holds the communitarians guilty of 'preaching instead of analysing' and thinks of their ideas as a 'flight to an ideal world' (Beck 1998, 148). He offers that the fading away of traditional solidarities paves the way for new modes of arranging life by facilitating flights to 'new niches of activity and identity' (1997,102).

It would be nice to end the contemplation on a positive note, but it would be imprudent because many other writers are cautious about being sanguine when deliberating on the empowering potential of welfare states. Welfare states today are grudging crutches that depend on means testing and split the community 'into those who give without getting anything in exchange, and those who get without giving…Rationality of interest is thereby set against the ethics of solidarity…The overall effect…is division instead of integration; exclusion instead of inclusion' (Bauman 1998, 50).

3 Exploring links with other relevant research

Despite the great deal of hopelessness in welfare states when looking at the theoretical terrain of solidarity and community, there is a degree of trust that welfare states manage to conjure in their citizens. This mean that despite diminishing social provisions, they continue to be viewed as legitimate institutions. Echoing this sentiment, it has been argued "the welfare state can minimally be denoted as a state system of institutionalised solidarity, which, in varying degrees, caters to the welfare needs of individuals and households"(Gellisen 2000). The non-problematic support for the continued presence of a welfare state in the United Kingdom has also been voiced although diversity along racial lines may not always be accounted for in these analyses (Johnson and Cullen 2000).

Commentators have also speculated extensively on the relationship between ethnic diversity and solidarity within nation states. Banting and Kymlicka (2003) acknowledge that multicultural policies are perhaps a way out of the mistrust that keeps people from developing solidarity ties across ethnic and racial lines. They also successfully challenge the notion that identity politics and recognition based struggles come in the way of economic redistribution.

This empirical research will clarify how a particular group of immigrants perceive the solidarity networks available to them. In doing so, it will add to what is already known about the continuation of support for welfare states and also help clarify what enables this supportive attitude toward the welfare state.

Explaining the research questions:

A very interesting aspect about the metaphors that are used to describe relocation of peoples and cultures is that they have been predominantly ‘botanical’, for instance, ‘transplantation’ (Malkki 1992). However, neat and orderly transplantation is definitely inimical to the experiential accounts of immigrants. ‘[I]mmigration constitutes an epistemological crisis of great magnitude, involving changes in legal and political status, ruptures in families, struggles for economic mobility, and the tensions between older social and cultural values and the norms and values of the new society” (Rayaprol 2002). With regard to the terrain of the South-Asian community, aspects such as differences along the lines of nationality, religion, caste, gender, class, and age are all acknowledged as important within the geographical context of South-Asia (Jodhka 2002), and it is also acknowledged that when geographically estranged, the symbolic dimensions of a community tend to be even more accentuated (Cohen 1985). The differences in gender, ethnicity, class, religion, language, are subtleties that can therefore change the immigration experience even within a single immigrant group.

What can the perceptions of support networks of people with mental health problems tell us about solidarity within a particular community? It is well documented that it is difficult to be the carers of people suffering from mental health problems. It takes a great deal of moral commitment and altruistic involvement to continue to care and be the resilient support for people who are temperamental, moody or perhaps just ‘sad’.

The situation of South-Asian mental-health service users’ support then would be a very interesting one to study. It is a community that is known to have strong boundaries and cultural defences in place in a context that is alien, and is a result of economic migration following the colonial experiences of the community. It would tell us about the social psychological characteristics of the south-Asian community as it struggles with the specific situation it finds itself in. This would be with regard to identity, power and solidarity networks operating in the community in the context of the UK. Moreover, because this is an area where so little is known, this would serve as an exploratory research, helping us demarcate the area and enabling us to outline pitfalls and potentials for future research.

This research is therefore an attempt to gain insight into the social solidarities within the south Asian community in Britain by studying the perceptions about the support mental health service users of a south Asian decent.

The questions of interest can be outlined as follows:

- What solidarity networks underlie the support systems that are available for south Asian people with mental health problems?
- What are the social-dynamics within the south Asian community thatneed to be taken into account in provision of care?
- What social-psychological implications does the Welfare State context of the UK have for the operationalisation of solidarity networks in the lives of South Asian mental health service users?

4 Methodology

To clarify my position as a researcher, it would be useful to draw from Moring (2001) and state that I fit 'the profiler' mode of a researcher because the ontological orientation informing the research was a critical realism; my epistemological concerns were dealt with in transactional and subjectivist ways and my methodology was primarily inductive. This sort of positioning is often also accompanied by a reflexive stance of the researcher, a stance that I wanted to engage in as well.

In order to shed light on the questions outlined above, a qualitative study based on a thematic analysis of indepth interviews was conducted. Qualitative methods offer methodological options that enable a deeper understanding of social phenomena and their dynamics (Astride-Sterling 2001). The respondents were all first generation immigrants in the United Kingdom and were living with their families in London. All the respondents were gainfully employed for at least 7 years in the UK and had never accessed mental health services themselves. They had differing levels of knowledge about mental health service provision, and differing levels of professional power with regard to mental health services. This kind of purposively chosen sample would be able to draw on their different knowledge bases to answer similar questions. Here is a list of the participants (designation and professional role, followed by country of birth and residence prior to the UK, their pseudonyms, and lastly their gender):

- Consultant Psychiatrist working with a predominantly south Asian community, male, India. Dr. Bhoop Chhabaria, male.

- Mental health social worker working with the south Asian community, male, East Africa. N.K. Prasad, male.

- Social Worker working with a predominantly south Asian community, female, India. Mandira Mahindroo, female.

- Counsellor working with the South Asian community, female, India. Anju Punjabi, female.

- Support worker working with the South Asian community, female, Bangladesh. Rosita Ambett, female.

- South Asian with no involvement in mental health service provision, Male, India. Siddharth Chaudhry, male.

Durkheim himself thought of solidarity as being best studied in a comparative way (Crowe 2002). Although a comparative framework was not adopted for this research, it was hoped that by employing a comparative framework in framing the questions, participants would be encouraged to reflect on whether the support for south Asians would be different from those available to other groups and thereby engage in a comparative analysis.

Semi-structured in-depth interviews were conducted with all 6 participants. A focus group would not have been as effective because of the different levels of professional power that would prevent all members from participating equally. An 'inter-view' (Farr 1982) is an interactional process and therefore researcher reflexivity was an important part of the interviewing process. In order to ensure the validity of the responses, I had intended to use

data from actual mental health service users but due to ethical concerns this data could not be collected directly and have not been presented as part of this paper.

An interview guide was prepared and piloted with two individuals and then changes were made to enable to guide to be more effective. The questions included reflections on how the situation of south Asian people with mental health problems was different from other peoples' experiences; participants' perceptions about trust, motivations and involvement in care of south Asians with mental health problems; questions about the role and types of social support; questions about the relevance of south Asian social structures, religious differences and the role of welfare state were also included.

Therefore, rather than using a focus on welfare states, this study explored solidarity more widely to see whether and how the welfare state interventions would emerge as relevant in the data.

The interviews lasted up to an hour, and were tape recorded and then transcribed. All identifying information was removed from the transcripts and pseudonyms have been used to respect confidentiality of the participants. The transcriptions were thematically studied to identify codes and themes that were based on the original research question, but there was also the flexibility to thematically arrange ideas that emerged from the text but were not part of the original research questions.

5 Results and analysis

In the discussion and analysis of results, first we shall review the emerging themes, drawing heavily from the interview transcripts in order to explore the voices of the research participants. We shall then see how these themes help us unravel the questions we started with.

Solidarity and family

Mental health service users seem to depend primarily on 'Family' for support. The role of extended families is considered central. When asked who they thought would be involved in caring for mental health service users of South Asian descent, 'family' was an obvious choice for respondents. Further, respondents also said that south Asian service users are 'more' likely to be married than what would be expected in other communities.

'Em, the clients I have they are all married, and the partner becomes carer and they carry the load and they struggle for help' (Rosita Ambett).

'I can count fewer families of other race, or racial background where family involvement is high as far as the patient is concerned and there are more of Asians, so if there are sort of 20 Asian patients I have for example, I can safely say that half of their families will be involved, if they are around, whereas that is not true for the other' (Dr. Chhabaria).

Communitarian notions of obligations to norms seemed to be underlying this trend. The stringent socialisation processes that south Asians go through in order to live up to their societal roles is well documented in anthropology and psychological literature (Wadley 1988; Kakar 1988). For example when one interviewee spoke about people in relationships 'carrying on (despite difficulties)', and was asked to elaborate on her position, she said:

‘Sometimes if think its a cultural stigma as well, like if people say she's a divorcee, that's a, um, a broken family is not seen in a respectable way in our culture, so sometimes they carry on, they cannot break; because of the children's sake, sometimes the marriage carries on; and then there are cases. We have a case where the husband is suffering but the wife does not leave because she says, 'I cannot cope on my own.’ He abuses her and everything but still she says 'I cannot live without him. Can’t live on my own’ (Rosita Ambett).

There were gender differences perceived in terms of who performs the caring role. Care being central role of a ‘wife’ but not necessarily of the ‘husband’ was brought up in one interviewee’s contribution when asked who was likely to support South Asian mental health service users:

‘*If it’s a husband than a wife, if wife, then it could be the husband or it could be her own parents or siblings’* (Mandira Mahindroo).

Most of the responses were worded to fit the ethics of care scenario that Gilligan (1982) contends exists when talking about family involvement but opted for post-conventional morality when describing professional/state involvement, which we shall discuss later. On the other hand, the presence of alternatives, owing to the presence of a welfare state, and therefore the giving up of the caring role has been mentioned in what one respondent said:

‘ there is the care and the caring for each other. Like some people don’t just carry on.

Like one of my clients, he was an accountant, he had a big house, and children and everything running, but when he got a mental health problem, he used to abuse his wife as well, but they left him. The wife, children daughter, they left him and, they moved him out, threw him out and he is living in a sheltered accommodation now’ (Rosita Ambett).

Beck’s (1998) criticism regarding the role of welfare states in disembodying traditional solidarities seems relevant here. However, traditional roles are not necessarily non-problematic or egalitarian and that tension was present in the responses.

Solidarity within the South Asian community

There was mention of the diversity within the south Asian community. Although the respondents were cautious about opting for stereotypical representations of whom south Asian mental health service users might trust, categories of ‘others’ based on aspects such as race and gender, religion and caste were considered important in determining support networks.

I think caste, I think there is a certain degree of casteism being practiced among the Indians, I don’t think the Islamic community has as much of a caste issue as the Hindu communities and Sikh communities. There are different caste gurudwaras, which I did not know existed in the world. Because the Sikhs again like Islam do not believe in caste and the whole point of creating ‘Singh’ was to remove caste but we stuck to surnames. So I think caste does persist, caste differences do persist, in some socio-economic stratas and because they exist they have some bearing (Siddharth Chaudhri).

‘I think the Muslim women, they would refer people to go to prayers, where they wont talk about mental health. That is their preferred way of dealing with it, which is fine but again mental health is ignored.Then there are difference in help available to men and women because I think men are even more reluctant to come forward, its is very macho image or

whatever it is, that I should be able to deal with it, I don't need help. So a lot more work needs to be done there' (Anju Panjabi).

The respondents mentioned voluntary organisations, and religious institutions as other avenues where help could be sought.

' I know their diagnosis and its clear, its depression or whatever, but they don't want to agree with you that it is a mental health situation, they carry on using their own religious thing like tabeez and they come for medical help, they take advise but they do not believe it.' (Rosita Ambett)

Another interviewee mentions another collective belief, that of astrology:

'They would go to, most of them would go to prayers, they don't talk about it and or they would also go to some kind of a healer…. Or herbal and homoeopathic things, herbal mostly because they want quick relief. They will also talk to astrologers, somebody who can tell them that well, you are going through this dark period in your life and when is there going to be light? So they are looking for answers like that....' (Anju Panjabi)

A third interviewee offers:

'I think religion and mental health especially in the South Asian community are heavily and 'majorly' intertwined. The interface between psychology and religion in human beings is very deep. There are rituals for dealing with loss and bereavement which involve religion and therefore people when they are practicing a religion are likely to draw upon more than just science to deal with their situation and to cope. About the south Asian community here it can be said that the profile is such that they are mostly practicing.'(Mandira Mahindroo)

Therefore solidarity ties were felt to exist within the south Asian community and there was mention of differences based on caste, religion, socio-economic status, country of origin and gender. This therefore points to the prevalence of particularistic rather than universalistic notions of community. While Habermas (ibid.) and Kohlberg(ibid.) may have substantiated that this implies a lower level of moral accomplishment, Seyla Benhabib (ibid.), Gilligan (ibid.), all point out that as marginalized communities, it is difficult to take a 'dis'interested view in arriving at consensual decisions, and further have cast doubt on the need to do such a thing. They seem to suggest that universalism is possible only when certain universal basic needs are granted to all. Distrust along ethnic and racial lines which have been found in other researches (see Banting and Kymlica, ibid.) were confirmed by this research as well. One respondent when asked to respond to the matter of trust said that:

'I think (mental health service users would be) weary of white professionals because they don't understand them.

(question: What about the black organisations?)

I think the same applies to them, I don't think they identify with the blacks. South Asian community is in itself so diverse that they feel bad about being lumped with the blacks.'

Unfortunately therefore Habermas' universalistic concerns do not find a voice in the respondents other than a mild one in one interviewee's response, who said:

'And my help came from one of my neighbours, white, who had been through a similar experience.'(Anju Panjabi)

The responses overall seem to fit much better with the communitarian ideologies and theoretical offerings, rather than with Habermas' communicative theory. They also do not seem to voice a doubt about the intentions of the welfare state. This is something we discuss in more detail below.

Solidarity and Institution

The interviewees viewed the institutional set-up of the welfare state as supporting the existence of marginalized South Asians. This support, when mentioned in terms of involvement of professionals, was expressed in 'relationship terms' by those interviewed. Here the mechanisms point to duty and post-conventional morality ties of service providers. However, a concurrent emphasis has been on 'not knowing' and 'not accessing' the systems. It seems from the interviews that 'not knowing' is a powerful discourse that shapes the identity of South Asians in the UK. It is seen as a disempowering discourse and is probably a post-colonial baggage carried by the South Asians.

'*Well, care providers as in outside the family probably want to do something good, and establish a service and establish a reputation and em, do something good because they have a mission statement, because they desire to do what they're out to do'* (Dr. Bhup Chhabaria).

Dependence 'is increased by limits on the supply of close substitutes available outside group boundaries, a lack of information about these alternatives, moving costs, and the existence of strong personal ties among the members' (Hechter 1987). This implies that when welfare state provisions are found inadequate, coercion, compliance and compensation of membership to group could generate solidarity. These aspects are brought to life in some of the responses of the interviewees:

'I'm sure there must be the coercive element as well, in the sense that there is not much else going on, not much else available and so, have to do more about it and they get coerced into doing more about it. So it's kind of, its not maybe very explicit in how it is said but perhaps family members are coerced into doing things. I can think of em, occasional patients but if we try and put together I think there might be more where the coercive factor has also played a part' (Dr. Chhabaria).

I think the voluntary sector is perhaps focussing more on their particular needs. And then it is then falling on to the statutory sector as well, I think places like mind have done a lot to engage with specialist groups.A lot more voluntary sector involvement coming up and also opportunities to mix with people with other cultures, which can help and a lot more help is available for them like, psychiatric help, benefits, there is more available here, which helps people live on their own (N.K. Prasad).

Using the themes to answer the research questions:

- What solidarity networks underlie the support systems that are available for south Asian mental health service users?

- We can glean from the themes that the family, the south Asian community and the welfare state, all continue to provide the solidarity networks for South Asian mental health service users.

- What are the social-dynamics for the South Asian community that need to be taken into account in provision of care?

- Again, age, gender, race, religion, region and caste were all social discriminations that were mentioned as being operational in the lives of south Asian immigrants. These discriminations are involved in categorising 'us' and 'them' within south Asian communities and are important boundaries that merit more exploration.

- What social-psychological implications does the Welfare State context of the UK have for the operationalisation of solidarity networks in the lives of South Asian mental health service users?

The themes seem to suggest that in the UK there is currently a 'De-culturalising' of community and 'Multi-culturalising of Institutions'. The interviews suggest that there are contradictory trends being faced by the South Asian community in the UK. On the one hand is a trend that undermines South Asian culture by creating awareness and opportunities that enable transgression –I have named this trend as the 'de-culturing of culture'; on the other hand is a trend that underscore the impact of the migrant culture by ensuring that statutory institutions respond to the cultural requirements of a different community-I have named this trend as the 'multi-culturalising of institutions'. This seems to be the outcome of a struggle between knowledge systems, an outcome that will hopefully lead us to an inter-subjectively created consensus. The welfare state institution of Uk always had a culture, all institutions do- but it is now becoming expressed multi-cultural. The number of South Asian General Practitioners, Social Workers, Counsellors, Psychiatrists, Voluntary Organisations and Nurses, are all increasing in the UK. This seems to be an optimistic aspect for respondents as it makes the welfare state seem more responsive to their cultural needs.

'Some members of the community have been here for like 30 years, some are second generation right, and they are aware of their rights and so on and are accessing the services, so. Yes its becoming easier….The first contact with any kind of, you know, high contact is a community service or community organisations. That is the first port of call, for example, the GP and there are lots of Asian GPs whom people are able to approach for a referral and so it is coming. And also, systems as a whole are becoming more aware of their needs' (N.K. Prasad).

To explain this growing comfort some more, one interviewee when asked whether the support networks of South Asians would be better in the UK or in their country of origin, said:

I think it would probably be better over here as far as the service is concerned purely because I see this society as a society which makes an effort to help people within their cultural and em, whatever whatever backgrounds, so you know,… the country puts in a lot of cultural and monetary resources so I think in that respect that are probably better off here because a poor country like India cannot afford it' (Siddharth Chaudhri).

This view is also substantiated by available evidence (Jacob, 2001) but equally important is the fact that there are innovations with regard to providing mental health care that do operate in the developing countries concerned (Patel and Thara, 2003).

The quotation below is an important one because in it we can clearly see the de-culturalising of community and the severing of communal links that institutions might create:

'I think practical help like welfare benefits and practical help helps, I think when carers are anyway caring and come to know of any practical help, it really benefits them. and at the same time that can also cause a slight friction, or is it perhaps a move away from their duty so they may think of it as if they get paid for it, or they are getting money towards it, it can make it easier for them because they are getting the money and at the same time they might misuse the system by just taking the money. Similar to how it may happen in other communities' (Mandira Mahindroo).

'I think we are integrating more, western values as well as the eastern values. I think the situation will be totally different. I think….em, for the next generation, I don't think there will be a great big problem' (Anju Panjabi).

On the other hand are responses that suggest that institutions are getting more culturally aware, in terms of providing specialist services for South Asians, whether it is in terms of community health support, or hospitalisation. Echoing this, another respondent points to ways in which culture can be incorporated in the institution of the hospital by mapping her anxieties if she were to ever access mental health services:

'Maybe when I go to the hospital, maybe I am more aware, but I would not like to share a room with men, women, like a mixed ward, I would not like that. And especially the food basis as well, I would like my culture food, I would not like maybe boiled food everyday. Maybe, it will be helpful for me if I see an Asian face, a worker who will come and give me advise and what kind of support I can get on this. If I don't see all of this, I'll be angry, I'll feel like there is nothing for me here' (Rosita Ambett).

However, governmental communitarianism cannot change the terrain by itself and at an interpersonal level, Habermas' notion of intersubjectivity is probably instrumental in creating solidarity with the welfare state. It is also important to not ignore Beck's critique since 'integrating cultures' in a dialogical sense is a difficult process and the task is far from complete. One interviewee's response to the frightfulness of difference makes this clear:

'I think living in England, first time coming, especially (for) women I think, (who have) never been to school, college, (they have only been in their) mother's house, then in-laws house, (they have) never been to the towns even, and then they come here and they see all different coloured peoples and dress and language, everything, everything is different, and its very shocking and very scary for them, its very very, especially some area there is racism because as soon as they come out in their cultural dress, people call them names so its scary for them. …They wont go to (the) park, they wont go anywhere, because of the cultural pressure as well, they won't change their clothing, if they are wearing sarees, (a change to) wearing salwar kameez is difficult because they have in-laws here and they wont like them wearing other things. There is pressure everywhere. No place to escape for them' (Rosita Ambett).

6 To conclude

This paper has highlighted the resilience that immigrant communities may show in the face of adversities and has also demonstrated how the provisions of the welfare state have a human face sometimes. It has demonstrated that albeit slow, there are positive changes in the situation of immigrant communities. Although the 'de-culturalising of community' seems like a negative thing, it points to the evolution of new communities and the multi-culturalising of institutions is its welcomed comrade.

This trend is a positive one for the peaceful co-existence of diverse communities and if encouraged, it is likely to respond to the race equality mandate of the UK government. However, it is important not to equate the need for professionals from different cultures to mean race-specific service provision (Patni 2006) and to underscore a commitment to intersubjectivity, which is often operationalised as reflexivity and empathy in social work interactions.

Therefore, this research suggests that when providing south Asians with interventions, it would be useful to take into account their existing support networks which include their families, the extended networks in their community, institutional support based on their religion but also to be aware of the discriminatory attitudes that people may have toward people of other religions and castes and regions. This again underscores the position that merely providing 'south Asian social workers' does not equate to good practice.

At the same time, this research indicates that a growing number of racially diverse mental health professionals may lead to a generally improved service delivery as professionals and institutions will gradually become more comfortable with difference as a result of their multi-cultural staff. This comfort with difference would enable social work interventions to be framed in a coherent and relevant manner. This would enable a continuing dialogue between a community and the state institutions. Most of all, this research acknowledges some of the 'positive' progress that is being made in welfare-service delivery to diverse groups of users. Continuation of the dialogical 'micro-actions' would help design more appropriate services. Organisational policies must now reflect a commitment to this dialogue by creating appropriate spaces for it.

7 Limitations of the research

The interviews have opened up doors for further exploration. The themes that I have outlined are not mutually exclusive and in fact, could perhaps benefit from a computerised analysis assisted with software for qualitative data. However, given the fact that this has been a relatively deprived area of research, I think this project has outlined a potentially interesting terrain, and suggestions drawn from the responses would help understand the complexity of being a South Asian better and thereby enable interventions to be more successful.

It is important to note that the patients with psychosis seem to overcome their symptoms better in low income countries, where there tends to be an appreciation or community based and religious/spiritual ways of engaging with mental health problems. While respondents mentioned the preference for astrology and religious/spiritual support, the responses do not clearly question the hegemony of western scientific interventions in the treatment of people with mental health problems (Jablensky 2000 cited in Raguram et al. 2002). This could be because the interview questions did not allow them the space to explore this area but it could also explain how respondents, who have cognitive polyphasia (Wagner et al. 2000) talk about certain presentable perspectives in interviews!

Looking back on the research now I also feel that studying these aspects from a medical anthropology perspective would have highlighted the kinds of conflicts that people experience when they undergo universal, pharmacological treatments which may not be in alignment with their particular world-view. I also feel that this research has not been able to draw on the perspectives of the second generation of migrants owing to the group interviewed.

For future research, this study could be developed to see how the views of the second-generation south Asians cohere with what is presented in these findings. Interviewing service users would be another potentially advantageous exercise.

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