Mental Health Issues of the South Indian community in the United Kingdom
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Project: A voluntary, temporary, single handed mental health clinic providing culture specific services to the (South Indian) Telugu community in Preston, United Kingdom.

Objective: In the experience of the presenter, mental health problems are highly stigmatised in South India. This project was aimed at examining the influence of the attitudes of the Telugu population with regards to accessing psychiatric services provided by the NHS (National Health Services) in the United Kingdom.

Methodology: Information leaflets and screening questionnaires were sent to all the 92 families that were registered with the religious community centre in Preston. The information leaflets were also displayed in the community centre by the 'Poojari' (priest) and elderly heads of the community centre spreading word-of-mouth information among the attendants of the centre. A daytime telephone service and a weekly psychiatric clinic were provided over a four month period.

Conclusion: Mental health programmes and policies need to be sensitive to the needs of the local population. Services need to be organised in such a way as to effectively decrease stigma and fear of discrimination within the minority community. Trust and de-stigmatisation of mental disorder play a major role in accepting help from the services. Contemporary second generation immigrants are well used to the main stream NHS and may not benefit from culture specific clinics. However, culture specific services may potentially have disadvantages and advantages which require further discussion and reflection.

Discussion: India has a large government funded health care system, although standards of care and funding vary from state to state. Psychiatry is an evolving speciality. Sub specialities are still in their infancy. The bulk of current psychiatry is general and liaison psychiatry. There are still a considerable number of "asylum era" mental hospitals. Community psychiatry is not yet developed. Traditional medicine and religious beliefs play a large part in the treatment seeking patterns of patients. In rural areas, the majority of the population approaches religious healers.

In India, as in other parts of the world, the traditional approach to the care of the mentally ill during the last 200 years was custodial rather than therapeutic. Although there is a Mental Health Act, use of mental health legislation is virtually non-existent, with most trainees having only read about it. The reasons for less reliance on the mental health law appear to be cultural; family members persuade patients to seek treatment and the advice of the doctor is often seen as binding. The strength of social networks and involvement of the family in the management of the patient probably makes up for the lack of community care to some extent. The family takes responsibility for looking after the patient. Often, patients come to the notice of the doctors or the health care system only when the family cannot cope any longer. Primary care mental health services are not well developed.

Most of the available evidence from the existing literature suggests that prognosis is generally better in the East than in the West. However, in the experience of the author, people with severe mental health problems in the Asian subcontinent are often live isolated existences; recovery is not necessarily promoted. They are more secluded, including their families. It is also not uncommon to see people with mental health problems roaming the streets, often dressed in rags or at times even naked. The public still holds on to the belief that they are dangerous.

Details of the project: I sent a letter of introduction to all the Telugu (Telugu, South Indian regional language) speaking people registered with the Hindu religious community centre specifying that I speak the same language and would like to offer my psychiatric services to members of the Telugu community with mental health problems, free of charge. This was discussed with the President, Treasurer and Secretary of the Telugu Community Association. I obtained their approval to hold a private clinic every Thursday afternoon from 12.30pm – 14.00pm and 17.00 – 18.00pm. The letter also specified that all patient details would remain confidential. I left a brief description of my experience and intention to hold a clinic on the display board in the centre.

I chose the Telugu Community Centre as the venue for my clinic, as it is a religious gathering place, thus providing a familiar and non threatening environment. In my view, people may not be willing to discuss their psychiatric problems in the confines of their homes, because other community members might come to know about the interview.

I obtained a list of all the Telugu speaking people registered with the community centre, in total 92 separate addresses, in Preston. I sent a circular to all addresses, detailing my intentions and my experience in Psychiatry dealing with mental health problems. I enclosed a questionnaire addressing awareness, prevalence, attitudes, opinions and willingness to use the NHS services. The questionnaire also had details about demographics. The letters were sent out in March 2009 to all 92 families. The aim was to run the clinic over a four month period, from May 2009 until August 2009.

I attended a religious gathering on 14th of April 2009, where I introduced myself personally to everybody. 52 families were present on that day. I reminded everyone of the psychiatric clinic that would be held at the religious community in 2 weeks time. I informed the attendees that their personal and clinical details would remain confidential.

A second reminder for the feedback form was sent in the last week of April 2009. Responses were requested to be sent back to the Telugu Community Centre. I received 28 out of 92 forms.

Results from the received questionnaires:
1) Respondents were mainly male, 2ndgeneration, working, with no children and no physical health problems.
2) No form had details about the mental health problems even if the respondends answered ‘YES’ to suffering with major mental health problems.
3) People who are under the primary care services did not wish to be contacted.

4) One response who had secondary care services involved expressed interest to speak on the phone.
5) Most of the 28 respondents were aware of the NHS services and felt comfortable to access these if needed.

Limitations of the survey:

- Only one form per household was sent, although there might be more than one person suffering with mental health problems.
- It is likely that the person who has the most dominant role in the household would get the chance / take the opportunity to complete the questionnaire.
- The perception of the head of the households of the questionnaire may dictate whether the form is filled or not.
- The attitudes and opinions of the dominant person may influence the answers in the feedback forms.
- People who are already aware of and willing to access existing services may have responded.

I attended the centre to run the clinic over 16 weeks, every Thursday 12.30 – 14.00 hours and 17.00 to 18.00 hours. The 12.30 – 14.00 hours clinic was divided into two sessions.

The first session, from 12.30 to 13.15 hours, was intended for anyone who wished to obtain general information about mental health issues. This was more of an open forum with the opportunity to ask questions.

Most of the questions were around

- General information about major mental illnesses like- schizophrenia, depression, and bipolar affective disorder
- How mental health affects physical health and vice versa
- Prognosis of mental health problems
- Mental health medication and their side effects
- Surgical treatments for mental health problems; this included enquiries specifically about lobotomy and interventions such as Insulin therapy
- Electroconvulsive Therapy (ECT) and its indications
- The relationship between violence and mental illness

Due to the timing of the sessions, usually people working on shift pattern or people visiting the temple stayed for the first part of the session and later left.

The second session, for individual/private consultations, went from 13.15 - 14.00 hours. Only 4 people availed themselves of this opportunity in 16 weeks. The consultations lasted for 30 minutes to 40 minutes per person. The consultations mostly took the form of an enquiry about specific or general mental health issues, rather than a discussion of personal mental health problems. Although I tried to direct the questions at their own mental health, it was clear that the questions posed by the attendees were always ‘framed’, in that they would enquire about a third person (“I know about someone who ...”) and not talk about their own mental health or that of a family member.

None of the attendees returned for a second visit to the clinic. I did not receive any written feedback about the sessions but towards the end of the sessions the attendees expressed that they found it useful in general terms of awareness of mental health problems.

The 17.00 - 18.00hours session was intended for individual consultations, like the earlier one from 13.15 - 14.00 hours. Consultations could be either pre-booked or "walk-in". However, there were no attendees throughout the 16 week period at his hour.

[Anonymised 4 case presentations]

At the end of July 2009, I informed the community centre about the impending discontinuation of the project, in line with the original intention. Following completion of the project in August 2009, I visited the temple 2 more times, in September and in October 2009, to attend important religious festivals. There is always a gathering of 40-50 families and usually all the females sit on one side and the males on the other side. Food is prepared by the families and shared. The 'Poojari' is invited to perform the religious ceremony and couples take his blessings at the end. I attended another religious gathering in November 2009 to thank everyone who had responded and I left an open invitation for anyone who wished to contact me in future. On the same occasion, I took public questions, from the 48 families who had attended the gathering. Questions were raised about the following issues:

1) Depression
2) Anxiety disorders
3) Paranoia
4) Feeling "high" and causing problems to those around (hypomania)

I deliberately used laypersons, colloquial language as most of the attendees were first-generation immigrants from a village background, with limited formal education. Younger, second generation attendees, born and brought up in the United Kingdom, clearly had a better understanding of mental issues and awareness of the statutory services available. Consequently, this forum was of much less interest for the younger generation and they did not remain at this open forum for long.

Following this public "question and answer session", I informally spoke to 4 people who expressed on a 1:1 basis. A 1st generation male immigrant, a 2nd generation male, a young professional – recently arrived from India, and a 1st generation female immigrant.

I received 2 phone calls during the four month period. Both of these phone calls were from individuals taking psychotropic medication and experiencing side effects from the medication. In both cases, I provided detailed information and advised the callers to go back to their general practitioner (GP) which they did. In my opinion they needed reassurance and an 'okay' from another psychiatrist to give validity to their complaint before they approached their GP.

I spoke to a retired Consultant Psychiatrist who used to work in the National Health Service (NHS). He had come to Preston around 30 years ago. He attends the religious community centre regularly and meets with the Telugu people on a social basis. Having easy access, trusting relationships and cultural similarity made him more approachable to the Telugu population. He is contacted for informal advice even to date by many families from the Telugu community. He confirmed my impression that most members of the Telugu community are reticent to discuss their mental health issues, unless there is a major concern. The Consultant is respected and trusted. However, the lack of anonymity, i.e. the fact that he is part of a close knit community, may work as a deterrent to people disclosing personal information.

Observations:

- More males than females responded to the questionnaires. All community members who attended the clinic in person were males.

- The younger generations are not keen to talk about their problems in a close network. In contrast to the older immigrant generations, they have a general awareness of the statutory mental health services and know how to obtain professional help. Their familiarity with the internet enables second generation Telugus, many of whom are well educated and work as professionals, to access wider sources of information regarding mental health issues.

- Repeated efforts to remind community members of the services offered (via personal attendances at the community centre gatherings and circular letters) helped to raise awareness and create familiarity with the facilitator. Even so, those who attended the individual clinics usually would phrase their queries as if enquiring about a 3rd person rather than about themselves.

- Somatisation is still a frequent mode of presentation of underlying mental health problems. Individuals who already were in contact with secondary mental health services were more open about their mental health problems. They often were interested in discussing issues related to their medication.

- Fear of stigma and discrimination is still prevalent and more so with the first generation Telugu people, as compared with later generations who were born and brought up in the United Kingdom.

- Family support, followed by community support, plays a very important role, even more so in the older Telugu community as compared to the younger generations.

Questions for discussion:

1) Is it is time to challenge the notion that the prognosis for mental illnesses is better in the developing countries compared to the West?

2) By providing a culture specific service, are we at risk of creating a parallel community, thereby preventing integration into mainstream society?

3) Information from western literature can or cannot be applied without considering the socio-cultural differences.

4) Is it always preferable if mental health services are provided by someone from the same cultural and linguistic background?