Improving Access to NHS Talking Therapies Services through Co-production of Referral Pathways for Hindu and Sikh communities

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Thesis Declaration Form

I confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

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Date: 29/07/2025

Overview

Despite the growing evidence of the role of religion in mental health and its influence on help-seeking, collaboration between faith communities and mental health services remains an under-researched area (Leavey et al., 2012). This thesis is presented in three parts and aims to address the gap in knowledge by exploring ways to improve access to mental health services for racially minoritised groups, with a particular focus on Hindu and Sikh communities in the United Kingdom (UK).

Part One is a systematic literature review exploring existing quantitative research on service-level interventions aimed at improving access to mental health services for South Asian groups. The review identified 11 largely medium- to high-quality studies, highlighting promising multi-level strategies such as task sharing, community awareness campaigns, and integrating community-based services into existing healthcare systems. While findings indicated increased service uptake when both demand-side (willingness and ability to seek care) and supply-side (the availability and accessibility of services) approaches were used, most studies were based in South Asia, with limited generalisability to minority South Asian populations in other countries. The review also identified significant gaps in UK-based research and a need for more scalable, context-specific interventions.

Part Two presents a qualitative empirical study that employed Thematic Analysis (TA) to explore the perspectives of Hindu and Sikh service users and religious leaders on access to mental health services. The study aimed to understand the potential role of faith communities in improving engagement to mental health care in the UK. Drawing on data from 23 semi-structured interviews and subsequent co-production workshops, the findings informed the development of culturally responsive referral pathways grounded in collaboration between Hindu and Sikh faith communities and National Health Service (NHS) Talking Therapies services.

Part Three is a critical appraisal reflecting on the research process in Part Two. It discusses the role of reflexivity, personal and professional positionality, and methodological challenges encountered during recruitment, data collection, and analysis. This section also offers insight into the researcher's learning and reflections throughout the research process.

Impact Statement

This thesis project contributed to the growing research looking at mental health service accessibility, specifically in relation to Hindu and Sikh faith communities in the UK. The project was comprised of two key components: a systematic literature review and an empirical study, both of which sought to understand and address the deep-rooted disparities faced by racially minoritised communities when accessing mental health services.

The literature review explored the effectiveness of existing service-level interventions aimed at improving access to mental health services for South Asian populations. It highlighted several single- and multi- component interventions including task-sharing, integrating community-based services into existing healthcare systems and training of lay professionals. The review found that multi-component interventions, which combined both demand- and supply- side strategies, were most effective in increasing service uptake. Despite these encouraging findings, the review also highlighted significant gaps, particularly the lack of UK-based interventions with robust outcome data and limited attention to subgroup differences within South Asian communities. The study underscores a need for further research in this area with a focus on context-specific interventions for different South Asian subgroups, ensuring they are scalable, culturally relevant, and co-produced with communities.

Building on these insights, the empirical paper explored the perspectives of Hindu and Sikh community members and religious leaders in the UK on improving access to mental health services using a qualitative approach. The findings revealed complex interactions between cultural beliefs, stigma, systemic barriers, and experiences of invalidation that deter service access. Importantly, the study identified religion as both a barrier, when mental health is spiritualised or stigmatised, but also offering a meaningful avenue for engagement, healing, and advocacy when trusted faith organisations are involved.

Additionally, through co-production workshops, the study facilitated dialogue between community stakeholders and a NHS Talking Therapies service, aimed to initiate development of referral pathways grounded in collaboration, cultural sensitivity, and mutual learning. These workshops demonstrated the enthusiasm within communities and services for more meaningful engagement, and the value of involving community champions, culturally informed resources, and ongoing collaboration within service design. The process itself was reported as empowering and validating by participants, many of whom had not previously had input in mental health service planning.

This research addresses critical gaps in the literature by focusing on under-researched communities and exploring non-traditional entry points into care, such as religious organisations. Practically, it offers recommendations for NHS services seeking to improve access for its diverse populations. Recommendations for culturally responsive referral pathways included: engaging religious organisations as initial access points, training trusted community volunteers as mental health champions, fostering mutual learning through collaborative training, co-hosting awareness campaigns, ensuring continuity of culturally sensitive care within integrated systems, and providing accessible, faith-sensitive resources. Most importantly, it contributes to the growing evidence base that equitable mental health care cannot be achieved without systemic reform that includes cultural responsiveness, community engagement, and sustained investment in inclusive models of care.

Overall, this thesis not only highlights the perspectives of minority faith communities in the UK but also offers co-producing solutions that are rooted in cultural relevance and community trust. These findings have the potential for informing local and national policy, guiding practitioner training, and ultimately, improving access and outcomes for Hindu and Sikh communities seeking mental health support.

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Part 1: Literature Review

Title: Service-level Strategies to Improve Access to Mental Health Services for South Asian Populations: A Systematic Review

Abstract

Background: South Asian groups face various barriers when accessing services resulting in significant disparities in mental health care access and outcomes. However, there is limited research exploring how this can be improved. This systematic review therefore aimed to (1) review the existing quantitative research on service-level interventions to increase access for South Asian groups; (2) explore the effectiveness of these interventions and (3) highlight important gaps in knowledge and the literature.

Method: Three databases (PsycINFO, MEDLINE, and CINAHL) were searched from inception to November 25th, 2024. Papers were screened and studies that incorporated interventions aimed at improving access to mental health services for South Asian groups with clear pre- and post- data were included in the final synthesis. The studies underwent a quality evaluation process, and the information extracted was synthesised narratively.

Results: The final review included 11 studies: eight cohort studies and three randomised controlled trials, largely rated medium- to high- quality. Interventions either had single- or multiple- components and varied from task sharing, community awareness campaigns, training of lay professionals, and integrating community-based services into existing healthcare systems. Most studies were based in South Asian countries and were regional in scale, with potential for broader implementation. Ten of the studies reported increased mental health service uptake, particularly when both demand- and supply- side strategies were used.

Conclusion: We found some evidence that collaborating with communities, embedding services within existing healthcare systems, and including both demand- and supply-side interventions are promising strategies in improving access within South Asian populations. However, research remains limited and future studies that address gaps in this area are needed. Given the variation in cultural and systemic barriers across different regions, future studies should focus on specific South Asian sub-groups and include scaled up interventions.

Keywords: *South Asian, improving access, mental health services, intervention*

Introduction

It is estimated that mental health disorders are the second largest burden of disease in the United Kingdom (UK; Public Health England, 2019). With mass global migration over the last few decades, racially minoritised people make up approximately 12% of the UK population (Office for National Statistics (ONS); 2012), and these individuals face disproportionate inequalities in mental health service access and outcomes (Lamb et al., 2012; Suresh & Bhui, 2006). This can be compounded by systemic barriers and discrimination, further impacting on mental health and the uptake of services (Raleigh & Holmes, 2021).

South Asian people are estimated to make up around 20% of the global population and are the largest minority group in the UK making up approximately 5.2% of the UK population (ONS, 2012). It is important to note the heterogeneity both between and within different South Asian cultural communities. This generally encompasses those who originate from the Indian Subcontinent and includes the countries India, Pakistan, Bangladesh, Sri Lanka, Nepal, Afghanistan, Bhutan, and the Maldives (Singal & Chopra., 2023). Existing literature highlights the strong influence of social determinants on psychological wellbeing; South Asian communities often face multiple adversities, including the impact of colonisation and early migration to the UK. Later generations, who may hold a more ‘bi-cultural’ identity, can also struggle with acculturation (Pilkington et al., 2012). Thus, it is not surprising that evidence indicates South Asian communities face an increased risk of psychological vulnerability and experience higher levels of psychological distress compared to the White population (Özen-Dursun et al., 2023). For instance, the Adult Psychiatric Morbidity Survey (APMS) found that whereas approximately 17.1% of South Asian adults reported experiencing mental health difficulties, only 4.1% accessed mental health treatment compared to 18.4% of White British adults (National Health Service Digital, 2025).

Despite the evidence that South Asian people experience widespread psychological distress, research indicates they are less likely to access mental health services compared to other racially minoritised groups. When they do engage, they often present with more severe symptoms and are more likely to discontinue treatment prematurely (Harwood et al., 2023; Moller et al., 2019). However, despite various efforts to improve service provision and reduce disparities, mental health systems continue to fail in delivering accessible and equitable services, and mental health inequalities persist (Sewell, 2009). These disparities manifest in lower referral rates from primary care, underrepresentation in talking therapy services, and higher rates of crisis presentations and compulsory admissions (Fernando, 2012). Furthermore, even when they do access support, South Asian people are less likely to receive evidence-based psychological therapies and are more likely to be prescribed medication, which may not align with their treatment preferences (Prajapati & Liebling, 2022). These persistent inequalities have been linked to systemic issues, including the failure of services to meaningfully engage with the cultural understandings of mental health and the social contexts in which distress is experienced (Memon et al., 2016).

In more recent years, research has increasingly focused on understanding the factors that influence help-seeking behaviours among South Asian communities and the barriers they encounter when accessing mental health services. A review by Prajapati & Liebling (2022) identified three core themes that shape these experiences: ‘distanced from services’, ‘dilemma of trust’ and ‘threat to cultural identity’. They argue that while earlier studies often attributed these challenges to community-level factors such as cultural differences (Fernando & Keating, 2008), it is the systemic barriers within services themselves which significantly hinder access and engagement. For many South Asian service users, seeking support involves navigating a complex decision-making process where the potential benefits of care are weighed against perceived threats to their cultural identity. This tension often results in feelings of disconnection, mistrust, and cultural neglect. Furthermore, institutional racism and cultural dissonance within services contributes to further marginalisation, underscoring the urgent need for mental health systems to build trust and promote culturally safe, inclusive practices to improve access and outcomes.

Pathways into and through mental health services differ significantly for racially minoritised groups, including South Asian communities (Bhui et al., 2003). These disparities are often linked to inconsistent access and delays in receiving appropriate care, particularly during the early stages of illness (Sass et al., 2009). Furthermore, South Asian individuals are less prone to engage with first-line services; with general practitioners (GPs) reportedly less likely to identify mental health issues in this group or refer them to specialist care (Alam, 2023). While some evidence suggests that ‘ethnic matching’ of pre-treatment services tailored to specific ethnic groups can enhance access to care, a systematic review found limited high-quality evaluations in this area (Moffat et al., 2009). Creating culturally responsive services throughout the healthcare pathway is therefore increasingly recognised as essential and a key aim of the Delivering Race Equality plan (Department of Health, 2005). Although limited, there are some positive examples of how this can be achieved (Chowdhary et al., 2014; Jameel et al., 2022). For example, Gater et al. (2010) addressed these barriers in Pakistani communities by developing culturally sensitive service models that involved families in care, matched therapists by gender, and delivered services in familiar settings like community centres. More recently, several policies and frameworks such as the black and minority ethnic communities (BAME) Positive Practice Guide (Beck et al., 2019) and the Patient and Carer Race Equality Framework (PCREF; National Health Service England, 2023) aim to reduce mental health disparities and promote ‘culturally competent’ care by encouraging services to be more inclusive, responsive, and reflective of the diverse needs of racially minoritised communities. For example, both frameworks prioritise co-production and meaningful community engagement, empowering service users to contribute to the design and delivery of services. However, the extent to which these policies have translated into sustained, racially equitable service transformation remains uncertain (Bansal et al., 2022). Services still largely rely on individuals seeking out help, and persistent underrepresentation, barriers to access, and poorer outcomes for South Asian groups suggest that more proactive, community-informed, and culturally safe approaches are urgently needed (Mclean et al., 2003).

In addition to studies conducted with racially minoritised South Asian populations in Western countries like the UK, research from South Asia itself offers valuable insights that can inform UK service development. Studies conducted in South Asian countries often evaluate scalable, resource-efficient interventions designed to reach large and diverse populations, including those living in rural or ‘harder to reach’ areas (Singla et al., 2017). These approaches frequently incorporate interventions such as community-based care and involvement of community stakeholders, which can be adapted to improve accessibility, engagement and continuity of care in UK contexts (Chatterjee et al., 2014). Furthermore, such studies can help to disentangle the role of cultural factors in accessing services, such as stigma and explanatory models of distress, from structural barriers that are unique to migration and minority status in the UK (Kirmayer & Pedersen, 2014). This dual focus provides a more nuanced understanding of both culturally rooted beliefs and systemic challenges, supporting the design of interventions that are both culturally appropriate and contextually relevant for South Asian communities in the UK.

Rationale and Aims

There has been growing literature exploring the barriers that South Asian communities face when accessing mental health services, including help-seeking behaviours and strategies for better engagement (Kapadia et al., 2017; Loewenthal et al., 2012; Prajapati & Liebling, 2022). While many studies offer valuable recommendations, there remains a lack of research focused on implementing and evaluating practical interventions aimed at improving service uptake. Therefore, this study sought to fill a gap in the literature by synthesising quantitative data on the effectiveness of applied strategies designed to increase access to services for South Asian groups.

This review aimed to synthesise information on the effectiveness of service-level interventions to improve access to mental health services for people from South Asian populations experiencing mental health difficulties. We answered the following research questions:

1. What service interventions have been tested to increase access for South Asian groups?
2. What is the effectiveness of these interventions in improving access to mental health care for South Asian groups?

Methods

This systematic review was conducted and reported in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Page et al., 2021) and was also informed by guidance by Cherry et al. (2023). The review protocol was developed a-priori and registered online (PROSPERO registration number: CRD420250640221).

Information Sources and Search Strategy

A systematic search of 3 databases (PsycINFO, Medline and CINAHL) was performed on the 25th of November 2024. Search strategies were developed with the support of a librarian and informed by key papers in the field, identified through initial scoping searches (Bhui et al., 2003; Bhui et al., 2018; Prajapati & Liebling, 2022).

An inclusive search strategy was used to maximise sensitivity over specificity. This was to ensure that relevant papers were identified despite the limited literature base. For example, relevant studies could be classified in many ways such as cultural adaptation, awareness, community intervention etc. A stepped, iterative approach was used when searching to test sensitivity in capturing previously identified relevant papers, and both text word and subject heading terms were included. The final search strategy was agreed by the whole research team and broadly mapped onto three clusters: population, setting and access related terms (Table 1). Full search strategies are available in Appendix 1. Additionally, screening of the full reference list of all included studies was carried out.

Table 1. Search Terms

Population	Setting	Access Related Terms
South Asia*	Mental health service*	Access
India*	Psycholog* service*	Accessibility
Pakistan*	Psychiatri* service	underutilis*
Bangladesh*	Communit* mental health service*	underutiliz*
Sri Lanka*		utiliz*

Nepal* Afghan* Bhutan* Maldiv* Buddhis* Hindu* Muslim Islam* Sikh	mental health program* communit* mental health centre* counsel* service* mental health outreach primary mental health* anxiety depression common mental health disorder* schizophrenia psychosis mental health psycholog* distress*	utilis* use of services uptake help-seeking help seeking seek help or "barrier*") adj2 "care") or access* or help seeking or service use

Asterix (*) **denotes truncation which is used to find variant word endings (e.g., South Asia* finds South Asian)**

Study Selection: Inclusion Criteria

All studies reporting strategies specifically designed to improve access and that included a comparison (e.g. pre- post- intervention comparisons or comparison with a control group) were included. There were no restrictions in terms of publication date or country of origin. In terms of the population, although there are problems with homogenising South Asian groups, due to the limited research in this area we applied the broader category of ‘South Asian’ to obtain more results. Further inclusion and exclusion criteria are summarised in Table 2.

Table 2 Inclusion and Exclusion Criteria

Component	Inclusion Criteria	Exclusion Criteria
Population	South Asian groups Adults aged 18+	Non-South Asian groups Children aged 17 and below
Intervention	Strategies specifically aiming to improve speed/ease/likelihood of access.	No mention of access or specific access related strategies.
Outcomes	Primary outcomes are any change strategies that have been implemented related to increasing access to services. Secondary outcomes are clear data measuring effectiveness of these strategies on access.	No clear outcome data relating to increasing access to services or reports of effectiveness e.g. pre- post-data.
Language	English	Non-English
Study design	Quantitative or mixed methods study designs which include a comparison. This can include comparisons with the same group before they received the	Systematic reviews, meta-analyses, case reports, case studies, editorial letters, dissertations, conference abstracts, study protocols,

	interventions, or comparisons with a group that did not receive the intervention or received a different intervention.	qualitative studies, book chapters. Study designs which describe the outcomes of one group at one timepoint (e.g. cross-sectional survey designs).
Context	Mental health services.	Other healthcare services.

Study Selection: Further Screening

The records obtained from the database searches were imported into an EndNote library and de-duplicated. During the first stage of the search, all titles and abstracts were independently screened in duplicate by two reviewers (M.J. and R.J.) using the Rayyan application (Ouzzani et al., 2016) against the inclusion criteria. Full text versions of remaining papers were then retrieved and assessed for eligibility in duplicate by the two reviewers. The papers that did not meet the inclusion criteria were excluded with the reasons noted. In instances of disagreement between the two reviewers, a senior reviewer (P.B.) was consulted and the paper discussed until consensus was reached.

Quality Assessment

Quality of the included studies was assessed using the Critical Appraisal Skills Programme (CASP) tool, which is widely used for assessing the quality of qualitative research but can also be used for quantitative data particularly Randomised Controlled Trials (RCTs), cohort studies and case control studies (CASP, 2018; Long et al., 2020). This tool has been endorsed by Cochrane and the World Health Organization and is reportedly suitable to use for new researchers (Alam et al., 2024).

The CASP checklist consists of several questions that evaluate various methodological aspects of research (Appendix 2). We adapted the checklist for the current review by removing question 11 of the cohort study checklist (“Do the results of this study fit with other available evidence?”), as this is the first systematic review on the topic, and there was limited prior evidence available for comparison. Although the CASP checklist does not provide a formal scoring system, a provisional rating was applied to each study based on the number of criteria rated as ‘yes’ or ‘no’. Consistent with previous research (Singh, 2013), studies were classified as high quality (scores 10–12), medium quality (scores 5–9), or low quality (scores 0–4). The full quality ratings can be found in Table 3. The studies were independently rated by two reviewers and there was overall agreement when comparing scores across all papers. As the number of included studies was limited, it was agreed that all papers will be included with certainty in findings informed by the quality of the contributing evidence.

Data Extraction

Following the full text review, data was extracted from included papers using an excel workbook. Information on author, year, country of study, design, sample characteristics, access related aims and study findings were extracted from each study. Study outcomes extracted included the number or percentage of South Asian individuals who went on to access services and the number of referrals that were made or accepted; if one or more primary outcomes were reported secondary outcomes including any follow up data indicating the longer-term impact of the intervention were also extracted. Another reviewer independently extracted data from 20% of the included studies to ensure correct interpretation of information. There was 100% agreement between the two reviewers, and therefore the remaining studies were extracted by a single reviewer.

Data Analysis and Synthesis

Given the heterogeneity in the study designs, interventions and outcome measures reported, a narrative synthesis was conducted. We organised data as following: a summary of the search results and characteristics of the included studies, a summary of the quality of the studies, a summary of the interventions to improve access, the method used to improve access for South Asian populations and a summary of the outcome data (this information is fully detailed in Tables 3 and 4).

Results

Literature Search

The systematic search returned a total of 7974 relevant papers. Following the removal of duplicates, 5970 papers remained. The titles and abstracts of these were screened against the agreed inclusion criteria. A total of 245 potentially relevant full text papers were identified. After full text screening, 11 papers met the eligibility criteria for inclusion in the review. The full search and screening process is outlined in Figure 1.

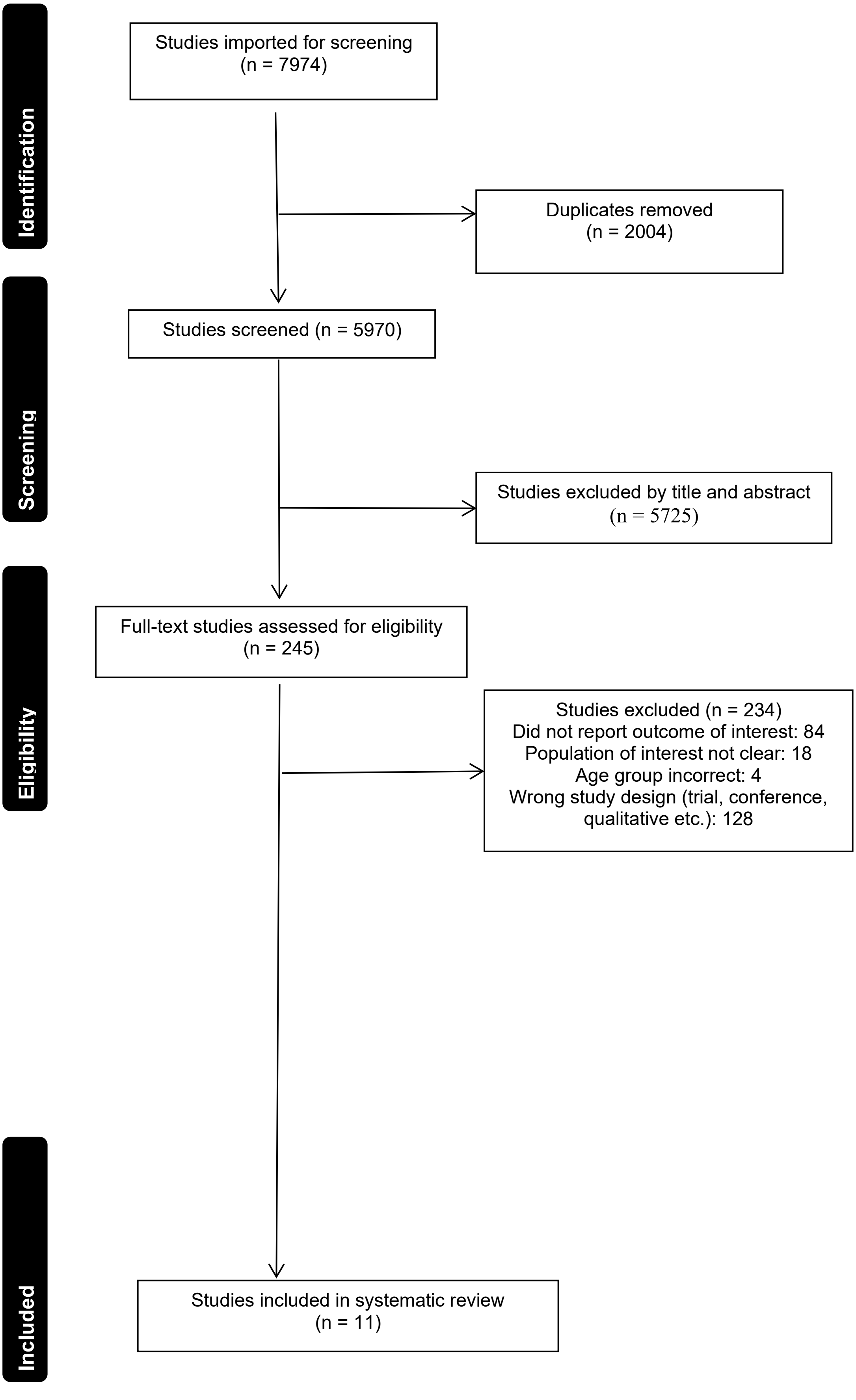


Figure 1. PRISMA flow chart: schematic overview of the selection process for studies eligible for full review

Study Characteristics

The study characteristics have been summarised in Table 3. Six out of 11 studies were published since 2020 (Bashir et al., 2023; Dabholkar et al., 2023; Gaiha et al., 2021; Jordans et al., 2020; Maulik et al., 2020; 2024). Sample sizes ranged from 25 to 22,046. The mean age of participants was 41.97 years, with the proportion of females (56.99%) being higher than males (43.01%). However, three out of 11 studies omitted information on sample age and gender (Gaiha et al., 2021; Jordans et al., 2020; Nimgaonkar & Menon, 2015). All but one study (Jacob et al., 2002), were based in a South Asian country with South Asian participants, however specific breakdown on ethnicity was not included in any of the studies. Of the 11 studies, eight used cohort designs (Bashir et al., 2023; Dabholkar et al., 2023; Gaiha et al., 2021; Jordans et al., 2017; Maulik et al., 2017; 2020; Nimgaonkar & Menon, 2015; Shidhaye et al., 2017) and three were RCTs (Jacob et al., 2002; Jordans et al., 2020; Maulik et al., 2024). Eight of the studies were conducted in India (Bashir et al., 2023; Dabholkar et al., 2023; ; Gaiha et al., 2021; Maulik et al., 2017; 2020; 2024; Nimgaonkar & Menon, 2015; Shidhaye et al., 2017), two in Nepal (Jordans et al., 2017; 2020) and one in the UK (Jacob et al., 2002). The majority of participants were recruited from South Asian countries, rather than from South Asian populations residing in other parts of the world.

Table 3. Summary of Study Characteristics

Author, Year and Country of Publication	Inclusion Year	Study Type	Study Setting	Study Aim	Target Population	Number (N)	Mental Health Diagnoses Mentioned	Age and Gender (Male/Female)	Quality Assessment Rating
Bashir et al., 2023; India	Not Reported (NR)	Cohort	Community (one local district)	To train Community Health Workers (CHWs) in overall mental health literacy and to respond and make appropriate referrals for specialised care	CHWs	N=25	Social phobia, Generalized anxiety disorder, Personality disorders, Major depressive disorder, Dysthymia, Agoraphobia, Bipolar disorder and Drug dependence	*AGE*: 26-45 years: 68% (n=17) 46-56 years: 32% (n=8) *GENDER*: Female: 80% (n=20) Male: 20% (n=5)	**Medium**

Dabholkar et al, 2023; India	Two phases: February – July 2013 May – September 2015	Cohort	Community and tertiary care hospitals (one local district)	To design and implement an integrated care pathway between hospitals and the community and explore its effectiveness on individual, family and community levels	Local community population	N=239	Schizophrenia	*AGE*: </= 30: 31.8% (n=76) 31-50: 54.8% (n=131) >50: 13.4% (n=32) *GENDER*: Female: 41.8% (n=100) Male: 58.2% (n=139)	**Medium**
Gaiha et al., 2021; India	NR	Cohort	Community (five states)	Feasibility of pilot awareness program and impact of patient education on understanding of mental health disorders	Local community population	N=1176 (number that attended mental health screening specifically)	Various provisional diagnoses based on International Classification of Disease-10 criteria e.g. mood disorders such as depression	NR	**Low**

				and on treatment-seeking behaviour					
Jacob et al., 2002; United Kingdom	NR	Randomised Control Trial (RCT)	Community (General Practice)	Evaluate the impact of patient education on the understanding and outcomes of depression	Local community population (British Asian Women)	N=70	NR	*AGE*: Experimental group: 47.4 (SD 10.8) Control Group: 48.3 (SD 12.5) *GENDER*: Female (100%)	**High**
Jordans et al., 2017; Nepal	April – May 2014	Cohort	Community (two local districts)	To measure whether a newly developed community informant detection tool used by CHWs increases help-seeking behaviour i.e. how many	Local community population	N = 509 Accessed health care (n=341) Did not access health care (n=168):	Epilepsy, Psychosis, Depression, Alcohol-use Disorder, Anxiety and Bipolar Disorder	*AGE*: Accessed health care: Mean 35.9 (SD 16.8) Did not access health care: Mean 40.1 (SD 16.5) *GENDER*: Accessed health care: Female n=174 (51%)	**Medium**

				accessed support and if they were started on treatment				Male n=167 (49%) Did not access health care: Female n=77 (45.8%) Male n=91 (54.2%)	
Jordans et al., 2020; Nepal	July 2016 – July 2017	RCT	Community (one local district)	To test the benefits of proactive case detection (using the Community Informant Detection Tool) on help-seeking and improving engagement with mental health services	Local community population	Intervention Arm: N= 309 Control Arm: N= 182	Epilepsy, Psychosis, Depression, Alcohol-use Disorder and Mental, Neurological, and Substance use (MNS)	NR	**Medium**

Maulik et al., 2017; India	May 2014 – April 2016	Cohort	Community (one local district)	Training Accredited Social Health Activists (AHSAs) in task-shifting/mobile-based decision support tool to help increase screening and referral of individuals with common mental health disorders	Local community population	Baseline survey: N=5167 Start of intervention: N=5007	Depression & Anxiety	*AGE*: Mean 39.7 (SD 14.69) *GENDER*: Female 58.56% (N=3026) Male 41.44% (n=2141)	**High**
Maulik et al., 2020; India	Intervention Implementation: November 2015 – November 2016	Cohort	Community (local villages)	To evaluate the effectiveness of the intervention in increasing the use of mental	Local community population	Baseline survey: N=22,046 Screened negative	Emotional distress, Bereavement, Depression, Suicide risk, Bipolar disorder, Psychotic features,	*AGE*: Screened negative: Mean – 41.8 (SD 15.83) Screened positive and received formal	**High**

	Post-intervention Date: December 2016 – February 2017		health services and reducing depression and anxiety scores	: N= 21,146 Screen positive and received formal diagnosis by doctor: N= 242 Screened positive but did NOT receive a formal diagnosis by doctor: N= 489 Screened positive but did NOT visit the doctor:	Alcohol/Drug Abuse, Anxiety	diagnosis by doctor: Mean – 47.8 (SD 15.79) Screened positive but did NOT receive a formal diagnosis by doctor: Mean – 53.3 (SD 15.30) Screened positive but did NOT visit the doctor: Mean – 49.4 (SD 16.26) *GENDER:* Screened negative: Female n=11,395 (53.89%) Male n=9751 (46.11%)

	N= 169	Screen positive and received formal diagnosis by doctor: Female n=167 (69%) Male n=75 (31%) Screened positive but did NOT receive a formal diagnosis by doctor: Female n=347 (71.0%) Male n=142 (29.0%) Screened positive but did NOT visit the doctor: Female n=113 (66.9%)	

								Male n=56 (33.1%)	
Maulik et al., 2024; India	September 2020 – December 2021	RCT	Community (2 states and primary health centres)	Building on findings from pilot Maulik et al., 2020 study and implementing this on a wider scale	Local community population	High-risk cohort: Intervention: N=1697 Control: N=1668 Non-high-risk cohort: Intervention: N=3279 Control: N=3284	Depression, Anxiety, Self-harm and Suicide	*AGE*: High-risk cohort Intervention: Mean/SD: 47 (15) High-risk cohort Control: Mean/SD: 46 (15) Non-high risk cohort Intervention: Mean/SD: 41 (16) Non-high risk cohort Control: Mean/SD: 41 (16) *GENDER:* High-risk cohort Intervention:	**High**

Female – n=1139 (67%) Male – n=558 (33%) High-risk cohort Control: Female – n=1156 (69%) Male – n=512 (31%) Non-high risk cohort Intervention: Female – n=1694 (52%) Male – n=1585 (48%) Non-high risk cohort Control: Female – n=1649 (50%) Male – n=1635 (50%)

Nimgaonkar & Menon, 2015; India	2005 – 2008	Cohort	Community (local villages)	To implement and evaluate a task-shifting intervention using CHWs to improve healthcare delivery	Local community population	NR	Schizophrenia, Other psychoses, Delusional disorder, Depression, Bipolar disorder, Somatization disorder, Adjustment disorder, Anxiety disorder, Panic disorder, Other non-psychotic disorder, Conversion reaction, Alcohol abuse/dependence, Suicidal ideation, Drug abuse	NR	**Medium**
Shidhaye et al., 2017; India	December 2013 – March 2014	Cohort	Community (local villages)	To evaluate whether improving mental	Local community population	Baseline Survey N=1456	Depression	*AGE*: Baseline Survey:	**High**

(baseline survey) September – October 2015 (18-month post survey)	health literacy and supply of evidence-based treatments led to an increase in help-seeking for those with depression	18-month post survey N=1887	18-30 years – n=400 (27%) 31-40 years – n=355 (24%) 41-55 years – n=360 (25%) >56 years – n=341 (23%) 18-month post survey: 18-30 years – n=476 (25%) 31-40 years – n=482 (26%) 41-55 years – n=476 (25%) >56 years – n=453 (24%) *GENDER:* Baseline Survey

Female n=694
(48%)

Male n=762
(52%)

18-month post
survey:
Female n=890
(47%)

Male n=997
(53%)

Study Quality

One of three RCT studies was rated as medium quality (Jordans et al., 2020) and 2/3 as high quality (Jacob et al., 2002; Maulik et al., 2024). For the RCTs, bias largely was related to blinding of participants and study personnel and inconsistent reporting of outcome data. One of eight cohort studies was rated as low quality (Gaiha et al., 2021), 4/8 were rated as medium quality (Bashir et al., 2023; Dabholkar et al., 2023; Jordans et al., 2017; Nimgaonkar & Menon, 2015) and 3/8 as high quality (Maulik et al., 2017; 2020; Shidhaye et al., 2017). The most common areas of bias for the cohort designs were missing information around important confounding variables, not accounting for confounding variables in the design or analysis, and the absence of a control or missing outcome data. Additionally, for both designs, attrition, follow up reporting bias and pre- or post- outcome data was unclear or not fully reported in some instances (Dabholkar et al., 2023; Gaiha et al., 2021; Jordans et al., 2017; Nimgaonkar & Menon, 2015).

Diagnosis and Follow-up Data

Two studies targeted individuals with specific diagnoses of Schizophrenia and Depression (Dabholkar et al., 2023; Shidhaye et al., 2017). The remaining studies, apart from Jacob et al., 2002, included a breakdown of various diagnoses data (Bashir et al., 2023; Gaiha et al., 2021; Jordans et al., 2017; 2020; Maulik et al., 2017; 2020; 2024; Nimgaonkar & Menon, 2015). Follow up data was reported in all included studies, with the follow-up time within the studies from pre- to post- intervention ranging from 2 weeks (Gaiha et al., 2021) to a maximum of 3 years (Nimgaonkar & Menon, 2015).

Access Aims

The method of improving access differed between the included studies; several studies incorporated the integration of clinical services with community-based care, aiming to foster collaboration and extend the reach of existing healthcare systems to better serve a wider population. This was implemented either through the development of their own novel programmes, (Maulik et al., 2017; 2020; 2024) or using pre-established regional or national health programmes (Dabholkar et al., 2023; Gaiha et al., 2021; Jordans et al., 2017; 2020; Nimgaonkar & Menon, 2015; Shidhaye et al., 2017). Another method of intervention was the implementation of mobile technology (Maulik et al., 2017; 2020; 2024) or community triage tools (Jordans et al., 2017; 2020) to better identify and refer individuals for further support.

Six studies included interventions with multiple components to improve access which generally involved training professionals, awareness campaigns, using different tools to facilitate screening and working collaboratively within existing health care structures (Dabholkar et al., 2023; Gaiha et al., 2021; Maulik et al., 2017; 2020; 2024; Shidhaye et al., 2017). These largely combined multiple strategies that addressed both demand- (willingness and ability to seek care) and supply- (the availability and accessibility of services) barriers. Eight studies outlined interventions to increase public awareness and knowledge around mental health. The interventions ranged from anti-stigma campaigns to distributing educational leaflets, the aims included increasing mental health literacy, reducing stigma and helping individuals to recognise common symptoms to either refer themselves or someone else (Dabholkar et al., 2023; Gaiha et al., 2021; Jacob et al., 2002; Maulik et al., 2017; 2020; 2024; Nimgaonkar & Menon, 2015; Shidhaye et al., 2017).

Lastly, the concept of ‘task sharing/shifting’ to address treatment gaps within health care teams was emphasised as part of the intervention in ten studies (Bashir et al., 2023; Dabholkar et al., 2023; Gaiha et al., 2021; Jordans et al., 2017; 2020; Maulik et al., 2017; 2020; 2024; Nimgaonkar & Menon, 2015; Shidhaye et al., 2017). This is where specific tasks are transferred from specialised professionals to those with abbreviated training such as lay health workers from the local community, with the aim to make community-based care more widely available. The training of professionals to better identify, screen and deliver more accessible interventions whilst raising knowledge and awareness, was either incorporated within a multicomponent intervention (Dabholkar et al., 2023; Gaiha et al., 2021; Maulik et al., 2017; 2020; 2024; Shidhaye et al., 2017) or as the focused intervention (Bashir et al., 2023; Jordans et al., 2017; 2020; Nimgaonkar & Menon, 2015). For example, Maulik et al., (2017) trained community health workers and doctors in using mobile technology, conducted anti-stigma campaigns and integrated clearer pathways and delivery of treatment within existing systems. In comparison, Bashir et al., (2023) implemented one focused intervention comparing pre- and post- mental health literacy scores following training of community health workers.

The interventions also varied in scale, with some being locally implemented (Bashir et al., 2023; Dabholkar et al., 2023; Jacob et al., 2002; Jordans et al., 2017; 2020; Maulik et al., 2017; 2020; Nimgaonkar & Menon, 2015; Shidhaye et al., 2017) and others extending interventions more nationally (Gaiha et al., 2021; Maulik et al., 2024). Local interventions were often community based and focused on specific villages and urban neighbourhoods or regional level interventions which spanned multiple districts. There were only two national-level interventions, instead most studies looked at piloting interventions within specific locations before considering broader scalability.

Access Outcomes

Table 4 below provides a summary of the access-related interventions and corresponding outcome data evaluating their effectiveness.

Table 4. Summary of Extracted Access Related Data

Author, Year	Intervention to Improve Access	Pre- and post-Comparative Method Utilised	Follow-up Data	Access Related Outcome Data	Applied to a Real Word Setting i.e., patients (Yes/No)
Bashir et al, 2023	5-day training program on mental health for community health workers (CHWs) using a validated training manual	CHWs change in knowledge was assessed using the Mental Health Literacy Scale (MHLS)	Post-training and at 3-months	Knowledge of where to access professional help improved, reduction in scores (mean decreased from ±6.6 to ±4.4)	N
Dabholkar et al, 2023	An integrated care pathway linking hospital services with community-based rehabilitation to support recovery for people with schizophrenia at the individual, family and community levels	Pre-post comparison of treatment coverage among enrolled participants over 24 months	24-months from point of index	• Within 6 months, the majority of participants were on regular treatment - treatment adherence and 83% retention rates were sustained over 24 months • Effective treatment coverage rate of 51.8% • Inpatient admissions showed an 82% reduction over the 24-month period	Y
Gaiha et al, 2021	Assess whether a pilot awareness campaign would	• Conducted initial exit surveys post-campaign activity to assess knowledge/attitu	2 weeks from initial interventi on	Baseline • Of the 219 post-screening surveys, only 6% had received/accessed	Y

	generate demand for mental health screening services in new areas and increase treatment access	de/acceptability of mental health campaigns - Assessment of the number of people who attended screening services at the end of the campaign		mental health services in the past Post-Intervention - 1176 people attended the mental-health screening service with 777 receiving a provisional diagnosis (66%)	
Jacob et al, 2002	An educational leaflet for screen positive individuals identified from initial questionnaire providing information on the nature, causes, prevalence, and treatment options for common mental health disorders	- The experimental group received the education leaflet compared to the control group - Both groups were then contacted at the 2-month follow-up to repeat the General Health Questionnaire (GHQ)	2 months from initial intervention	Baseline – response to the vignette whether they would seek medical help: - Experiment group: n=3 - Control group: n=4 At the 2-month follow up: - Experiment group: n=4 - Control group: n=10 Whether psychological symptoms mentioned to GP: - Experimental Gorup: n=18 - Control Group: n=20 Whether external help sought for emotional problems: - Experimental Gorup: n=28 - Control Group: n=28	Y
Jordans et al, 2017	Training CHWs to implement the Community Informant Detection Tool (CDIT) and to proactively identify individuals and encourage engagement with mental health treatment	- Participants were first identified by the CHWs using the CIDT - They were then followed up at 3 weeks and asked whether they had accessed treatment	3 weeks post-identification by the CIDT	Out of the 509 participants followed up: - 67% (n=341) accessed a health-care facility - 7% of those who accessed care (n=264) received a diagnosis and were started on treatment	Y
Jordans et al, 2020	Training CHWs to implement the CIDT versus standard	Baseline data was collected regarding the number of patients who accessed services	6-months after CIDT intervention	The number of patients registered with mental health facilities increased compared to baseline (baseline n=2 from which	Y

	training; to proactively identify individuals and encourage engagement with mental health treatment	for mental health disorders, and this was compared to the total post 6-months after the implementation of the CIDT		BOTH were from the intervention arm): • N=309 in the intervention arm • N=182 in the standard training arm	
Maulik et al, 2017	Developed Systematic Medical Appraisal Referral and Treatment (SMART) intervention: mobile-based screening tool, interactive voice response follow-up system, and 8-week stigma reduction campaign; evaluated impact on service uptake	Pre- and post-survey exploring the number of 'positive-screened' individuals who accessed mental health services post-intervention	1-3 months post-intervention	During the intervention, n=238 were screened positive • N=30 visited a doctor compared to n=2 pre-intervention • Increase in accessing care from 0.8% to 12.6%	Y
Maulik et al, 2020	SMART intervention: anti-stigma campaign, training of AHSAs to screen for common mental health disorders, training doctors to support with decision making and a recall system to facilitate patient follow ups	Pre- and post-survey exploring the number of 'positive-screened' individuals who accessed mental health services post-intervention	1 month to 1 year	During the intervention, n=900 screened positive and n=843 were successfully followed up • Self-reported prior use of mental health services was 3.3% (n=30) • At the end of the intervention this increased to 81.2% (n=731)	Y
Maulik et al, 2024	SMART intervention: anti-stigma campaign,	Pre- and post-survey exploring proportion of individuals in the high-risk group who	Blinded follow-up at 3, 6	In the high-risk control cohort, only 2.5% reported receipt of mental health treatment at 12 months as	Y

	digital health intervention and multi-tiered staff training	visited a physician at least once in the past 12 months	and 12 months	compared to 94.5% in the intervention group	
Nimgaonkar et al, 2015	Train village healthcare workers (VHWs) to provide mental health education and identify and refer individuals for further treatment, using the pre-existing 3-tiered Association for Health and Welfare in the Nilgiris (ASHWINI) programme	Initial survey to determine attitudes and adherence followed by follow-up 3-years post-intervention	3-years	First year of the programme • 60% of the new patients were referred by the VHWs • 27.1% self-referred The fourth year of the programme • Proportion of self-referrals doubled to 57.1% • Proportion referred by VHWs decreased to 31.4%	Y
Shidhaye et al. 2017	Trained CHWs to raise awareness about mental health, proactively identify and treat individuals and refer on for further support if needed	Baseline community survey and 18-month post survey evaluating proportion of people with depression who sought treatment (contact coverage)	18-month post baseline survey	Contact Coverage: • At baseline this was 4.3% which increased six-fold to 27.2% at the 18-month survey	Y

Several interventions demonstrated a significant increase in service uptake following interventions to better screen, identify and refer individuals for treatment. One medium-quality RCT (Jordans et al., 2020), showed a 47% increase in mental health service use in facilities where a proactive case-detection tool was implemented compared to the control group. Another high quality RCT (Maulik et al., 2024) reported that access to treatment rose dramatically from less than 3% to 94.5% following several multi-component interventions. Two high quality cohort studies that used pre-post- designs, reported an increase in mental health service use in screen positive individuals from 0.8% at the beginning to 12.6% by the end of the intervention in 2017, and from 3.3% to 81.2% in 2020, through implementation of anti-stigma campaigns and digital mental health support systems (Maulik et al., 2017; 2020). Similarly, Dabholkar et al. (2023), a medium quality cohort study, reported improved engagement and an effective treatment coverage rate of 51.8%, with 68.6% of enrolled patients accessing regular treatments over a 24-month period.

Overall, most studies found increased service uptake post-intervention, albeit one where there was no reported change in help-seeking behaviour (Jacob et al., 2002). This included two RCTs (Jordan et al., 2020; Maulik et al., 2024) and eight cohort studies (Bashir et al., 2023; Dabholkar et al., 2023; Gaiha et al., 2021; Jordans et al., 2017; Maulik et al., 2017; 2020; Nimgaonkar & Menon, 2015; Shidhaye et al., 2017). For example, Jordans et al. (2020), found that two thirds of those identified by trained professionals went on to access further treatment, Shidhaye et al. (2017), reported that contact coverage for depression increased six-fold over 18 months, and finally Gaiha et al. (2021) reported 38 new cases per site and 76 per district following a two-week pilot awareness campaign.

Some studies primarily aimed to encourage help-seeking through increasing awareness, reducing stigma and improving mental health literacy. A medium quality cohort study developed community-based training for health workers and hospital staff which resulted in self-referral rates increasing from 27.1% to 57.1% and improved perceptions of mental illness using pre- post- data from the same group of participants (Nimgaonkar & Menon, 2015). Similarly, Bashir et al. (2023) focused on community education through training community health workers to raise awareness and knowledge around mental health, which led to increased recognition of mental health disorders, awareness of risk factors, and knowledge of self-treatment options. Another cohort study with pre- post- comparison data implemented a multi-state awareness campaign and found nearly 66% who attended screening needed further mental health support, resulting in an increase in cases of 76 per district following the two-week intervention (Gaiha et al., 2021). On average, 40 out of 49 people who visited the screening event received a provisional diagnosis. Conversely, Jacob et al. (2002) conducted an RCT that tested the effects of patient education via an informational leaflet. They found no substantial increase in access of care post-intervention either through the GP (n=18) or other referral pathways (n=28) when compared to the control group (n= 20 and n=28 respectively).

Some studies focused on integrating community-based care within existing health structures, task-sharing between professionals and empowering and training locals to bridge gaps in services. Two RCT studies reported that training lay health workers and community informants increased detection rates and subsequent referrals (Jordans et al., 2020; Maulik et al., 2024). For example, Jordans et al. (2020) found a 47% greater increase in patients registered at facilities where volunteers were trained to use the community informant tool versus standard training. Several cohort studies demonstrated similar improved detection results and increased referrals (Jordans et al., 2017; Maulik et al., 2017; 2020). For instance, in Jordans et al.'s (2017) paper, 67% of those identified through a community-based tool sought care, and 77% of them started treatment. Maulik et al. (2017) screened 5,007 individuals following training of lay village health workers, who identified 238 individuals with common mental disorders, and mental health service use increased from 0.8% to 12.6%. Additionally, one medium quality cohort study reported an effective treatment coverage of 51.8% and an 82% reduction in inpatient admissions following a collaborative integration of existing tertiary hospitals with community-based care (Dabholkar et al., 2023). Finally, Shidhaye et al. (2017), a cohort study that employed pre- post- comparisons within the same group, developed a grassroots community-based program that involved collaboration among three tiers of health workers: community health workers, lay counsellors, and physicians. This intervention led to a six-fold increase in contact coverage for depression, which was equitably distributed, alongside significant improvements in various indicators of mental health literacy.

Discussion

Summary of Findings

This review addresses a significant gap in the literature by being the first to systematically examine interventions specifically aimed at improving access to mental health services for South Asian populations. While previous research has often focused on general barriers to access (Prajapati & Liebling, 2022), this review uniquely highlights strategies that have been implemented and their associated outcomes. The results of this narrative synthesis highlighted several important findings, with evidence suggesting that collaborating with communities, embedding services within existing healthcare systems, and including both demand- and supply- focused interventions are promising strategies in improving access for South Asian groups. However, despite growing interest in this area, the review found that clearly reported access-related outcome data remains limited, underscoring the need for more targeted and methodologically robust research in this field. Only one study was conducted in the UK, with the remainder based in South Asian countries.

Many studies have discussed the importance of addressing both supply-side, (the availability and accessibility of services), and demand-side, (willingness and ability to seek care), barriers to reduce mental health treatment gaps (Shidhaye et al., 2017; Singla et al., 2017). Some examples of interventions that incorporated supply-side strategies included the integration of services in the community within existing healthcare structures and task shifting programmes. Ten studies reported the use of task shifting to redistribute certain tasks from trained specialists to non-specialist workers (Bashir et al., 2023; Dabholkar et al., 2023; Gaiha et al., 2021; Jordans et al., 2017; 2020; Maulik et al., 2017; 2020; 2024; Nimgaonkar & Menon, 2015; Shidhaye et al., 2017). This appeared to be an effective strategy to address the shortage of mental health professionals and increase the number of accessible services offered. This aligns with findings in other studies (Bolton et al., 2023; Hoeft et al., 2018), where similar task shifting programmes were implemented successfully for other ethnic groups.

Another key element of these integrated initiatives was the empowerment of local community members to deliver mental health support. This approach fosters greater trust and acceptance of services, as community members are often more attuned to local social dynamics and cultural beliefs (Javed et al., 2021). In line with other research on the positive impact of training non-specialised workers in other cultural (Singla et al., 2017) and low resource contexts (Patel et al., 2010), preliminary evidence suggests that interventions such as task shifting are more effective when embedded within existing mental health systems (Maulik et al., 2017; Nimgaonkar & Menon, 2015). These studies demonstrate promising outcomes in the screening and management of both common and severe mental health conditions.

Overall, task shifting, particularly when combined with community-based care, shows considerable potential for improving access to mental health services in South Asian populations (Maulik et al., 2017; Nimgaonkar & Menon, 2015). This model addresses both supply- and demand- side barriers by enhancing both availability and cultural sensitivity of services. These findings align with previous studies supporting alternative workforce models as a viable strategy for reducing access gaps in under-resourced and culturally diverse communities (Buttorff et al., 2012; Chatterjee et al., 2014). However, while these interventions hold promise, it is essential to ensure that cultural adaptations are made to fit the specific needs of diverse populations. Furthermore, the evidence regarding cost-effectiveness remains mixed (Joshi et al., 2014), underscoring the need for more robust economic evaluations before broader implementation.

Other interventions targeting demand-side barriers focused specifically on increasing access among South Asian individuals by enhancing detection and referral processes. These included training professionals to proactively identify and refer cases, as well as integrating tools such as electronic decision support systems to make referral pathways more efficient and known to communities. These approaches were implemented in seven studies (Jordans et al., 2017; 2020; Maulik et al., 2017; 2020; 2024; Nimgaonkar & Menon, 2015; Shidhaye et al., 2017), many of which reported increased uptake of services following the intervention.

Proactive case detection was particularly associated with improved service use among South Asian individuals in regions where mental health stigma is prevalent and services are still developing (Jordans et al., 2017). This strategy appears to support early engagement, reduce barriers to help-seeking, and contribute to better recovery outcomes in low-resource settings (Thornicroft et al., 2016). While these findings resonate with broader research on task shifting and early intervention (Buttorff et al., 2012; Chatterjee et al., 2014), most existing evidence comes from other low- and middle- income countries. This therefore offers promising potential for similar strategies in South Asian populations but also highlights the need for more region-specific studies to understand contextual influences.

Digital technology support tools were also found to be feasible and effective in several studies, empowering staff to better identify and refer individuals from their own communities, facilitate follow-up care, and support task shifting (Maulik et al., 2017; 2020; 2024). These interventions were linked to increased treatment coverage for South Asian populations and improved care continuity in both rural and urban contexts.

Eight studies incorporated community-facing components to reduce stigma and improve mental health literacy among South Asian communities (Dabholkar et al., 2023; Gaiha et al., 2021; Jacob et al., 2002; Maulik et al., 2017; 2020; 2024; Nimgaonkar & Menon, 2015; Shidhaye et al., 2017). All but one study (Jacob et al., 2002), reported improved awareness, attitudes, and reduced stigma around help-seeking in participants. While some studies showed short-term behavioural changes, the long-term sustainability of these effects remains unclear (Maulik et al., 2024). These results are consistent with research from other regions (Thornicroft et al., 2016), although more long-term evaluations focused on South Asian populations are needed to confirm whether similar outcomes are maintained over time.

Overall, the findings suggest that interventions incorporating supply- and demand- side strategies, particularly those that are culturally tailored and embedded within local systems, are effective in increasing mental health service use among South Asian individuals (Jordans et al., 2017). Several included studies showed some evidence that addressing both supply and demand challenges simultaneously offered a particularly impactful approach to increasing access to services (Jordans et al., 2017; 2020; Maulik et al., 2017, 2020; 2024).

Wider Context

When evaluating how to increase access and build equity into mental health services there have been some overarching recommendations outlined in various studies. It is important to note that most of the included studies in this review are based in South Asian countries therefore the marginalisation and barriers to access will be different compared to South Asian groups living in Western countries like the UK. Hence not all recommendations will be relevant for these different groups but should still be considered when thinking about future research.

There have been consistent recommendations and findings around the benefits of integrating mental health care in established health care structures like primary care settings (Lee-Tauler et al., 2018). This has been shown to increase accessibility to services and has been suggested to increase help-seeking in racially minoritised groups, provide more exposure to mental health care and offer a greater variety of providers delivering care (Holden et al., 2014; Lee-Tauler et al., 2018; Wrenn et al., 2018). Our included studies did this successfully in various ways including integrating existing services with community-based care (Dabholkar et al., 2023), incorporating task shifting (Nimgaonkar & Menon, 2015), integrating digital support systems (Maulik et al., 2017) and collaborating with government health systems and other organisations like local community groups (Gaiha et al., 2021). Consistent with previous research, we found evidence of the effectiveness of telepsychiatry (Aldosari et al., 2023), particularly when this was combined with other interventions like anti-stigma campaigns (Maulik et al., 2017). However, there are still various logistical, monetary and ethical challenges in the implementation of this (Deslich et al., 2013). Notably, a systematic review by Lee-Tauler et al. (2018) identified collaborative care as the most effective intervention for treating racially minoritised groups, outperforming other models of care. In the included studies, several components of collaborative care appeared to positively impact on increased access to services, for example working with the communities in innovative ways to raise public awareness around mental health through musical announcements, quizzes and street plays (Gaiha et al., 2021), and training lay workers in the community to deliver interventions (Jordans et al., 2017).

As well as developing effective models of care it is important to also consider other contextual factors that contribute to disparities in mental health access which can occur at an individual and systemic level. For example, Pakistani women are consistently shown to experience higher levels of psychological distress compared to other South Asian groups but have lower levels of service use (Kapadia et al., 2017). This is attributed to religious, cultural and language barriers (Bowl, 2007). Only one included study developed a targeted intervention at the individual (assessment and diagnostic review), family (support for families like financial skills) and community (awareness campaigns) levels, (Dabholkar et al., 2023). This resulted in a significant increase in treatment coverage which suggests that structural organisational changes should be made alongside interventions that aim to reduce social and cultural barriers. One way this can be addressed is through culturally adapting interventions, a consistent recommendation in several studies (Faheem, 2023; Nwokoroku et al., 2022; Prajapati & Liebling. 2022). Of the 11 studies, one included a culturally and linguistically adapted intervention (Jacob et al., 2002), one mentioned using culturally reliable measurement tools (Bashir et al., 2023) and one used culturally relatable language and scripted stories in their awareness campaigns (Gaiha et al., 2021). It is suggested that mainstream services need to establish ‘cultural safety’ which can be done through collaborative care approaches and developing culturally sensitive interventions and services (Prajapati & Liebling. 2022).

The role of stigma both at an individual and wider societal level can significantly impact on help-seeking, recommendations consistently note the need for more visible promotion around accessing mental health support (Alam et al., 2024). Sancho & Larkin (2020) found that there is lack of relatable and visual promotion around mental health awareness for racially minoritised groups. Improving mental health literacy was incorporated within interventions in eight studies (Dabholkar et al., 2023; Gaiha et al., 2021; Jacob et al., 2002; Maulik et al., 2017; 2020; 2024; Nimgaonkar & Menon, 2015; Shidhaye et al., 2017). This contributed to the improved uptake of services, however apart from one study (Gaiha et al., 2021), most interventions were delivered to community members only. It is suggested that single target group interventions are not enough to reduce stigma significantly and other groups like mental health professionals and policy makers should also be included (Kaur et al., 2021). Another interesting finding in existing literature is the role of religion and spirituality in help seeking; religious and supernatural explanations of mental health have been shown to impact coping and mental health service use within racially minoritised populations (Alam, 2023). It has been found that faith leaders are often the first point of contact for many religious communities (Mayers et al., 2007). However, religion was not mentioned or addressed within the interventions of any of the included studies.

Strengths and Limitations

This systematic review fills an important gap in the literature and is to our knowledge the first to explore this area. Strengths of this review were the inclusion of studies with clear pre- and post- design outcome data and the use of a second reviewer throughout, to ensure rigour.

Despite filling an important gap, this review also has several limitations. Firstly, only one study was from the UK which makes the generalisability questionable. While the themes identified may be broadly relevant worldwide, barriers to access likely differ depending on whether individuals identify with a minority or majority culture (Cook et al., 2017). To ensure reliability, we only included studies with clear outcome data, which reduced the number of eligible papers. Many were excluded for lacking a defined intervention or access-related outcomes. However, we did identify several descriptive studies with components aimed at improving access (Armstrong et al., 2011; Gater et al., 2010), which may provide important data in the future.

The broad scope of the review and the methods used to improve access to services also presented a challenge. This ranged from expanding service reach to training professionals to improving the screening and referral of individuals. To reduce potential effects of bias, the quality of the studies included in this review were all assessed and double rated by an independent researcher. Additionally, access was not always the primary outcome in papers, and distinctions between access and treatment outcomes were not always clear.

Limitations within the studies themselves included pre- post- designs without controls, warranting cautious interpretation, as some improvement may occur with any intervention (Bashir et al., 2023; Dabholkar et al., 2023; Gaiha et al., 2021; Jordans et al., 2017; Maulik et al., 2017; 2020; Nimgaonkar & Menon, 2015; Shidhaye et al., 2017). Screening tools often relied on subjective judgement; for instance, Maulik et al. (2017) found poor inter-rater reliability in baseline assessments. This could result in spontaneous remission, which research suggests can occur within 2–3 months

(Whiteford et al., 2013). Additionally, baseline reporting was inconsistent and, in some instances, based on self-report (Bashir et al., 2023), while follow-up periods sometimes experienced attrition, risking selection bias (Shidhaye et al., 2017). Although all studies reported follow-up data, the duration and frequency of follow-up varied considerably across studies, highlighting the need for more longitudinal research (Gaiha et al., 2021; Maulik et al., 2024).

Lastly, two studies found women were more likely to screen positive, and factors like age, education, and marital status were associated with mental health difficulties (Maulik et al., 2017; 2020). This aligns with previous findings (Grover et al., 2010; Kessler & Bromet, 2013), however reporting on individual or systemic moderating factors was inconsistent. Future research should therefore incorporate subgroup analyses and adopt a multi-level approach to address the complex, intersecting barriers racially minoritised groups face in accessing mental health care.

Implications for Research

This review underscores the need for more research on how services can practically improve accessibility for racially minoritised groups. Only one UK-based study with clear outcome data was found, despite evidence of low rates of service use within South Asian populations in the UK (Lindert et al., 2008). There is therefore a clear need for further research in countries where South Asian communities represent a minority, with a focus on implementing and evaluating targeted interventions specifically designed for this population. Future work could build on existing literature on barriers and further explore potential facilitators to access for this population (Prajapati & Liebling, 2022).

Furthermore, more high-quality trials followed by quality improvement projects are needed to drive organisational change and embed effective interventions into routine practice. While several studies were delivered regionally and nationally, their scalability and cost-effectiveness remain unclear, with only one study reporting detailed cost data (Nimgaonkar & Menon, 2015). Notably, few pilot studies have been scaled up, particularly when incorporating technology-based interventions (Tomlinson et al., 2013). However, the studies included in this review demonstrate how such approaches can be successfully implemented, illustrated by the Systematic Medical Appraisal Referral and Treatment (SMART) project, which progressed from pilot testing to local implementation, and ultimately to a national-level RCT (Maulik et al., 2017; 2020; 2024). Other successful examples also exist, such as the community informant detection tool adopted in Nepal's national care packages and scaled to multiple districts (Beaglehole et al., 2008).

Some interventions showed promise in improving access, offering generalisable insights into increasing service uptake. A key finding was the importance of collaboration between services and the communities they serve. Interventions like task sharing, promoting awareness within communities and training lay community members to become part of the care model had a positive impact on treatment coverage and uptake. There have been a couple of noteworthy initiatives where mental health professionals have been involved at grassroot levels to target 'harder to reach' groups (Faisal et al., 2024; Srinivasan et al., 2022). This usually has used digital interventions which can help amplify reach and engagement; although we found positive outcomes when digital technology was utilised, further scalability remains limited (Malathesh et al., 2020). Overall, it seems a combination of interventions is needed, and a multi-pronged approach addressing both demand and supply barriers appears most effective. Although there are some similarities in the gaps in help seeking observed in both Eastern and Western countries, further research is needed to understand whether the findings can be replicated in other countries where individuals may face different individual and systemic barriers.

Finally, qualitative studies were excluded in this review. The inclusion of qualitative studies could have helped to provide more deeper, contextual insights into the experience of interventions to improve access and the barriers and facilitators to service uptake (Tong et al., 2012). For example, Prajapati & Liebling (2022) highlighted key challenges for British South Asian service users, including feeling distanced from services, threats to their cultural identity and mistrust of systems. Insight from qualitative studies is crucial when working with racially minoritised groups, as understanding personal experiences can inform more effective and inclusive policies (Lee-Tauler et al., 2018). Future systematic reviews seeking to understand how best to implement access interventions should build on the findings of this review by focusing on qualitative evidence to capture these nuanced perspectives.

Implications for Practice

This review also highlights important implications for clinical practice. Many of the findings presented, highlight the importance of collaboration with local communities to improve accessibility. The experience of identifying as the ‘other’ can create a gap between the community and services (O’Brien et al., 2021). Therefore, service provision should incorporate community-led approaches that aim to foster mutual trust and empower local communities to build on their existing strengths and resources. Another approach to establishing cultural safety and improving collaboration is to move away from applying Eurocentric concepts of wellbeing and distress to using culturally grounded frameworks that reflect the lived experiences, values, and belief systems of the communities being served. Several studies in this review incorporated culturally adapted interventions (e.g. Gaiha et al., 2021; Jacob et al., 2002). Broader evidence further supports the value of this approach, for example India's Ministry of Health used the term 'tension', a culturally more acceptable and less stigmatising alternative to 'depression', in the rollout of a widely accessible mobile mental health app (Weaver, 2017). This may play a critical role in enhancing engagement and reducing stigma associated with mental health services.

The World Health Organization emphasised the need for integrating clinical and community support to provide comprehensive care for individuals with mental health difficulties (World Health Organisation, 2021). This review found that psychosocial interventions, particularly those embedded within community structures, were associated with increased service uptake (e.g. Gaiha et al., 2021; Dabholkar et al., 2023). Addressing individuals' social and practical needs alongside clinical treatment proved effective, particularly when grounded in strong community engagement. Collaboration with grassroots organisations and community stakeholders, through peer-led networks, community-delivered interventions, and co-produced care models, ensures that support remains meaningful and sustainable (Alam, 2023; O'Brien et al., 2021). Despite being a key outcome of the Delivering Race Equality plan (Department of Health, 2005), there is still a lack of consistent involvement of South Asian service users in service design and development. Therefore, services should embed community participation at all stages, from planning to implementation and evaluation, to ensure that services are both accessible and culturally relevant.

Stigma, whether this is self-stigma or more widely present in society remains a significant barrier to help-seeking (Memon et al., 2016). This review found some evidence that interventions which addressed stigma, particularly when integrated with other multi-level components, positively impacted access (e.g. Maulik et al., 2024). This suggests that mental health services should prioritize visibility and accessibility within these communities, especially as there remains limited awareness in some South Asian populations about where to seek help and what these services involve (Alam, 2023; Rajkumar, 2024). Promoting mental health services via media and community channels, such as social platforms, may continue to reduce stigma and raise awareness (Faheem, 2023). However, promoting services alone is insufficient, services must first create culturally safe environments to avoid reinforcing mistrust and re-traumatisation due to lack of structures and appropriate support (Alam, 2023).

Furthermore, training local community members and lay professionals to deliver interventions emerged as a promising strategy (e.g. Gaiha et al., 2021, Shidhaye et al., 2017). Given that racially minoritised groups often perceive mainstream services as inadequate (Bhui et al., 2018), access to trusted, community-based alternatives must be actively supported. Services should prioritise investment in and collaboration with existing community-led structures that are already embedded within these populations and offer culturally meaningful forms of care. This includes where possible training community members to deliver interventions, diversifying the mental health workforce, and equipping professionals with the skills to provide culturally competent and responsive care. This can promote knowledge exchange, ongoing mutual learning and decision making which can increase the reach and acceptability of services and more typically offered interventions (Nwokoroku et al., 2022). For these approaches to be sustainable, adequate and ongoing funding is essential. At an organisational level, there must be continued commitment to building trust and mutually respectful partnerships with the local community (Alam et al., 2024).

Lastly, this review highlights concrete ways that evidence from studies in South Asia can inform UK service development. Interventions such as task-sharing, community awareness campaigns, and integrating community-based services into existing healthcare systems could be adapted to address the underrepresentation of South Asian people in mental health services in the UK (Gaiha et al., 2021; Maulik et al., 2024), To ensure effectiveness, these strategies must be co-produced with local community stakeholders and tailored to reflect the cultural norms, language needs and service preferences of the diverse South Asian communities (Alam et al., 2024). Services should adopt a proactive approach by embedding pathways into care within trusted community spaces, reducing the burden on individuals to self-navigate complex care systems (Bansal et al., 2022). These community embedded models could help foster trust, normalise help-seeking and address stigma at a population level (Rajkumar, 2024). By prioritising context-specific, scalable and culturally grounded solutions, NHS services can move towards more equitable and accessible care pathways that meet the needs of South Asian populations in the UK.

Conclusion

This systematic review synthesised evidence on the effectiveness of interventions to improve access for South Asian individuals. We found some evidence that collaborating with communities, embedding services within existing healthcare systems, and targeting both demand- and supply- side barriers are promising strategies for reducing disparities such as lower rates of service use and delayed help-seeking. However, most evidence comes from South Asian countries, and there is limited evaluated studies in the UK. Future research should focus on context-specific interventions for different South Asian subgroups, ensuring they are scalable, culturally relevant, and co-produced with communities.

References

Alam, S. (2023). British-Bangladeshi Muslim men: Removing barriers to mental health support and effectively supporting our community. *The Cognitive Behaviour Therapist*, *16*, e38. https://doi.org/10.1017/S1754470X2300034X

Alam, S., O'Halloran, S., & Fowke, A. (2024). What are the barriers to mental health support for racially-minoritised people within the UK? A systematic review and thematic synthesis. *The Cognitive Behaviour Therapist*, *17*, e10. https://doi.org/10.1017/S1754470X24000084

Aldosari, N., Ahmed, S., McDermott, J., & Stanmore, E. (2023). The Use of Digital Health by South Asian Communities: Scoping Review. *Journal of Medical Internet Research*, *25*, e40425. https://doi.org/10.2196/40425

Armstrong, G., Kermode, M., Raja, S., Suja, S., Chandra, P., & Jorm, A. F. (2011). A mental health training program for community health workers in India: Impact on knowledge and attitudes. *International Journal of Mental Health Systems*, *5*(1), 17. https://doi.org/10.1186/1752-4458-5-17

Bansal, N., Karlsen, S., Sashidharan, S. P., Cohen, R., Chew-Graham, C. A., & Malpass, A. (2022). Understanding ethnic inequalities in mental healthcare in the UK: A meta-ethnography. *PLOS Medicine*, *19*(12), e1004139. https://doi.org/10.1371/journal.pmed.1004139

Bashir, A., Khan, B. A., Bhatia, T., Shoib, S., Ali, I., Bashir, U., Khursheed, S., Mcdonald, M., Hawk, M. E., & Deshpande, S. (2023). An Assessment of the Training Program on Mental Health for Community Health Workers in Kashmir, India. *Revista de Cercetare Si Interventie Sociala*, *80*, 7–17. https://doi.org/10.33788/rcis.80.1

Beaglehole, R., Epping-Jordan, J., Patel, V., Chopra, M., Ebrahim, S., Kidd, M., &

Haines, A. (2008). Improving the prevention and management of chronic disease in low-income and middle-income countries: A priority for primary health care. *The Lancet*, *372*(9642), 940–949. https://doi.org/10.1016/s0140-6736(08)61404-x

Beck, A., Naz, S., Brooks, M., & Jankowska, M. (2019). *IAPT: BAME Service User Positive Practice Guide.* BABCP. Retrieved July 7th, 2025, from: https://babcp.com/Therapists/BAME-Positive-Practice-Guide-PDF

Bhui, K., Halvorsrud, K., & Nazroo, J. (2018). Making a difference: Ethnic inequality and severe mental illness. *The British Journal of Psychiatry*, *213*(4), 574–578. https://doi.org/10.1192/bjp.2018.148

Bhui, K. S., & McKenzie, K. (2008). Rates and Risk Factors by Ethnic Group for Suicides Within a Year of Contact With Mental Health Services in England and Wales. *Psychiatric Services*, *59*(4), 414–420. https://doi.org/10.1176/ps.2008.59.4.414

Bhui, K., Stansfeld, S., Hull, S., Priebe, S., Mole, F., & Feder, G. (2003). Ethnic variations in pathways to and use of specialist mental health services in the UK: Systematic review. *British Journal of Psychiatry*, *182*(2), 105–116. https://doi.org/10.1192/bjp.182.2.105

Bhui, K., Warfa, N., Edonya, P., McKenzie, K., & Bhugra, D. (2007). Cultural competence in mental health care: A review of model evaluations. *BMC Health Services Research*, *7*(1). https://doi.org/10.1186/1472-6963-7-15

Bolton, P., West, J., Whitney, C., Jordans, M. J. D., Bass, J., Thornicroft, G., Murray, L., Snider, L., Eaton, J., Collins, P. Y., Ventevogel, P., Smith, S., Stein, D. J., Petersen, I., Silove, D., Ugo, V., Mahoney, J., El Chammay, R., Contreras, C., … Raviola, G. (2023). Expanding mental health services in low- and middle-income countries: A task-shifting framework for delivery of comprehensive, collaborative, and community-based care. *Cambridge Prisms: Global Mental Health*, *10*. https://doi.org/10.1017/gmh.2023.5

Bowl, R. (2007). The Need for Change in UK Mental Health Services: South Asian Service Users' Views. *Ethnicity & Health*, *12*(1), 1–19. https://doi.org/10.1080/13557850601002239

Buttorff, C., Hock, R., Weiss, H., Naik, S., Araya, R., Kirkwood, B., Chisholm, D., & Patel, V. (2012). Economic evaluation of a task-shifting intervention for common mental disorders in India. *Bulletin of the World Health Organization*, *90*(11), 813–821. https://doi.org/10.2471/blt.12.104133

Chatterjee, S., Naik, S., John, S., Dabholkar, H., Balaji, M., Koschorke, M., Varghese, M., Thara, R., Weiss, H. A., Williams, P., McCrone, P., Patel, V., & Thornicroft, G. (2014). Effectiveness of a community-based intervention for people with schizophrenia and their caregivers in India (COPSI): A randomised controlled trial. *The Lancet*, *383*(9926), 1385–1394. https://doi.org/10.1016/s0140-6736(13)62629-x

Cherry, M. G., Boland, A., & Dickson, R. (2023). *Doing a systematic review : a student's guide* (3rd Edition.). SAGE Publications, Incorporated.

Chowdhary, N., Jotheeswaran, A. T., Nadkarni, A., Hollon, S. D., King, M., Jordans, M. J. D., Rahman, A., Verdeli, H., Araya, R., & Patel, V. (2014). The methods and outcomes of cultural adaptations of psychological treatments for depressive disorders: A systematic review. *Psychological Medicine*, *44*(6), 1131–1146. https://doi.org/10.1017/s0033291713001785

Cook, B. L., Trinh, N.-H., Li, Z., Hou, S. S.-Y., & Progovac, A. M. (2017). Trends in Racial-Ethnic Disparities in Access to Mental Health Care, 2004–2012.

Psychiatric Services, *68*(1), 9–16. https://doi.org/10.1176/appi.ps.201500453

Critical Appraisal Skills Programme (2018). Retrieved July 7th, 2025, from: https://caspuk.net/casp-tools-checklists/

Dabholkar, H., Pillai, A., Gaonkar, D., Deuri, S. P., Naik, S., & Chatterjee, S. (2023). Exploring the feasibility and public health impact of integrating a community-based recovery-oriented intervention for people living with schizophrenia in partnership with a tertiary care mental hospital in India. *Implementation Research and Practice*, *4*. https://doi.org/10.1177/26334895231175528

Department of Health. (2005). *Delivering race equality in mental health care: An action plan for reform within services and government response*. Department of Health.

Deslich, S., Stec, B., Tomblin, S., & Coustasse, A. (2013). Telepsychiatry in the 21(st) century: Transforming healthcare with technology. *Perspectives in Health Information Management /.*, *10*(Summer), 1f.

Faheem, A. (2023). ‘ *Not a cure, but helpful* ’ – exploring the suitability of evidence-based psychological interventions to the needs of Black, Asian and Minority Ethnic (BAME) communities. *The Cognitive Behaviour Therapist*, *16*, e4. https://doi.org/10.1017/S1754470X22000599

Faisal, M. R., Salam, F. T., Vidyasagaran, A. L., Carswell, C., Naseri, M. W., Shinwari, Z., Fulbright, H., Zavala, G. A., Gilbody, S., & Siddiqi, N. (2024). Collaborative care for common mental disorders in low- and middle-income countries: A systematic review and meta-analysis. *Journal of Affective Disorders*, *363*, 595–608. https://doi.org/10.1016/j.jad.2024.07.086

Fernando, D. S., & Keating, F. (Eds.). (2008). *Mental Health in a Multi-Ethnic Society* (0 ed.). Routledge. https://doi.org/10.4324/9780203895535

Fernando, S. (2012). Race and culture issues in mental health and some thoughts on ethnic identity. *Counselling Psychology Quarterly*, *25*(2), 113–123. https://doi.org/10.1080/09515070.2012.674299

Gaiha, S. M., Gulfam, F. R., Siddiqui, I., Kishore, R., & Krishnan, S. (2021). Pilot Community Mental Health Awareness Campaign Improves Service Coverage in India. *Community Mental Health Journal*, *57*(5), 814–827. https://doi.org/10.1007/s10597-020-00714-4

Gater, R., Waheed, W., Husain, N., Tomenson, B., Aseem, S., & Creed, F. (2010). Social intervention for British Pakistani women with depression: Randomised controlled trial. *British Journal of Psychiatry*, *197*(3), 227–233. https://doi.org/10.1192/bjp.bp.109.066845

Grover, S., Dutt, A., & Avasthi, A. (2010). An overview of Indian research in depression. *Indian Journal of Psychiatry*, *52*(7), 178. https://doi.org/10.4103/0019-5545.69231

Harwood, H., Rhead, R., Chui, Z., Bakolis, I., Connor, L., Gazard, B., Hall, J., MacCrimmon, S., Rimes, K. A., Woodhead, C., & Hatch, S. L. (2023). Variations by ethnicity in referral and treatment pathways for IAPT service users in South London. *Psychological Medicine*, *53*(3), 1084–1095. https://doi.org/10.1017/s0033291721002518

Hoeft, T. J., Fortney, J. C., Patel, V., & Unützer, J. (2018). Task-Sharing Approaches to Improve Mental Health Care in Rural and Other Low-Resource Settings: A Systematic Review. *The Journal of Rural Health*, *34*(1), 48–62. https://doi.org/10.1111/jrh.12229

Holden, K., McGregor, B., Thandi, P., Fresh, E., Sheats, K., Belton, A., Mattox, G., & Satcher, D. (2014). Toward culturally centered integrative care for addressing mental health disparities among ethnic minorities. *Psychological Services*, *11*(4), 357–368. https://doi.org/10.1037/a0038122

Jacob, K. S., Bhugra, D., & Mann, A. H. (2002). A Randomised Controlled Trial of an Educational Intervention for Depression among Asian Women in Primary Care in the United Kingdom. *International Journal of Social Psychiatry*, *48*(2), 139–148. https://doi.org/10.1177/002076402128783190

Jameel, S., Munivenkatappa, M., Arumugham, S. S., & Thennarasu, K. (2022). Cultural adaptation of cognitive behaviour therapy for depression: A qualitative study exploring views of patients and practitioners from India. *The Cognitive Behaviour Therapist*, *15*. https://doi.org/10.1017/s1754470x22000137

Javed, A., Lee, C., Zakaria, H., Buenaventura, R. D., Cetkovich-Bakmas, M., Duailibi, K., Ng, B., Ramy, H., Saha, G., Arifeen, S., Elorza, P. M., Ratnasingham, P., & Azeem, M. W. (2021). Reducing the stigma of mental health disorders with a focus on low- and middle-income countries. *Asian Journal of Psychiatry*, *58*, 102601. https://doi.org/10.1016/j.ajp.2021.102601

Jordans, M. J. D., Kohrt, B. A., Luitel, N. P., Lund, C., & Komproe, I. H. (2017). Proactive community case-finding to facilitate treatment seeking for mental disorders, Nepal. *Bulletin of the World Health Organization*, *95*(7), 531–536. https://doi.org/10.2471/blt.16.189282

Jordans, M. J. D., Luitel, N. P., Lund, C., & Kohrt, B. A. (2020). Evaluation of Proactive Community Case Detection to Increase Help Seeking for Mental Health Care: A Pragmatic Randomized Controlled Trial. *Psychiatric Services*, *71*(8), 810–815. https://doi.org/10.1176/appi.ps.201900377

Joshi, R., Alim, M., Kengne, A. P., Jan, S., Maulik, P. K., Peiris, D., & Patel, A. A.

(2014). Task Shifting for Non-Communicable Disease Management in Low and Middle Income Countries – A Systematic Review. *PLoS ONE*, *9*(8), e103754. https://doi.org/10.1371/journal.pone.0103754

Kapadia, D., Brooks, H. L., Nazroo, J., & Tranmer, M. (2017). Pakistani women's use of mental health services and the role of social networks: A systematic review of quantitative and qualitative research. *Health & Social Care in the Community*, *25*(4), 1304–1317. https://doi.org/10.1111/hsc.12305

Kaur, A., Kallakuri, S., Kohrt, B. A., Heim, E., Gronholm, P. C., Thornicroft, G., & Maulik, P. K. (2021). Systematic review of interventions to reduce mental health stigma in India. *Asian Journal of Psychiatry*, *55*, 102466. https://doi.org/10.1016/j.ajp.2020.102466

Kessler, R. C., & Bromet, E. J. (2013). The Epidemiology of Depression Across Cultures. *Annual Review of Public Health*, *34*(1), 119–138. https://doi.org/10.1146/annurev-publhealth-031912-114409

Kirmayer LJ, Pedersen D. Toward a new architecture for global mental health. *Transcultural Psychiatry*. 2014;51(6):759-776. doi:10.1177/1363461514557202

Lamb, J., Bower, P., Rogers, A., Dowrick, C., & Gask, L. (2012). Access to mental health in primary care: A qualitative meta-synthesis of evidence from the experience of people from 'hard to reach' groups. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine*, *16*(1), 76–104. https://doi.org/10.1177/1363459311403945

Lee-Tauler, S. Y., Eun, J., Corbett, D., & Collins, P. Y. (2018). A Systematic Review of Interventions to Improve Initiation of Mental Health Care Among Racial-Ethnic Minority Groups. *Psychiatric Services*, *69*(6), 628–647.

https://doi.org/10.1176/appi.ps.201700382

Lindert, J., Schouler-Ocak, M., Heinz, A., & Priebe, S. (2008). Mental health, health care utilisation of migrants in Europe. *European Psychiatry*, *23*(S1), s114–s120. https://doi.org/10.1016/s0924-9338(08)70057-9

Leavey, G., Dura-Vila, G., & King, M. (2012). Finding common ground: The boundaries and interconnections between faith-based organizations and mental health services. *Mental Health, Religion & Culture, 15*(4), 349–362.

Loewenthal, D., Mohamed, A., Mukhopadhyay, S., Ganesh, K., & Thomas, R. (2012). Reducing the barriers to accessing psychological therapies for Bengali, Urdu, Tamil and Somali communities in the UK: Some implications for training, policy and practice. *British Journal of Guidance & Counselling*, *40*(1), 43–66. https://doi.org/10.1080/03069885.2011.621519

Long, H. A., French, D. P., & Brooks, J. M. (2020). Optimising the value of the critical appraisal skills programme (CASP) tool for quality appraisal in qualitative evidence synthesis. *Research Methods in Medicine & Health Sciences*, *1*(1), 31–42. https://doi.org/10.1177/2632084320947559

Malathesh, B. C., Chatterjee, S. S., & Das, S. (2020). Overview of mental health issues of COVID-19: Need of the hour. *General Psychiatry*, *33*(3), e100233. https://doi.org/10.1136/gpsych-2020-100233

Maulik, P. K., Daniel, M., Devarapalli, S., Kallakuri, S., Kaur, A., Ghosh, A., Billot, L., Mukherjee, A., Sagar, R., Kant, S., Chatterjee, S., Essue, B. M., Raman, U., Praveen, D., Thornicroft, G., Saxena, S., Patel, A., & Peiris, D. (2024). Mental Health Care Support in Rural India: A Cluster Randomized Clinical Trial. *JAMA Psychiatry*, *81*(11), 1061. https://doi.org/10.1001/jamapsychiatry.2024.2305

Maulik, P. K., Devarapalli, S., Kallakuri, S., Bhattacharya, A., Peiris, D., & Patel, A. (2020). The Systematic Medical Appraisal Referral and Treatment Mental Health Project: Quasi-Experimental Study to Evaluate a Technology-Enabled Mental Health Services Delivery Model Implemented in Rural India. *Journal of Medical Internet Research*, *22*(2), e15553. https://doi.org/10.2196/15553

Maulik, P. K., Kallakuri, S., Devarapalli, S., Vadlamani, V. K., Jha, V., & Patel, A. (2017). Increasing use of mental health services in remote areas using mobile technology: A pre–post evaluation of the SMART Mental Health project in rural India. *Journal of Global Health*, *7*(1). https://doi.org/10.7189/jogh.07.010408

Mayers, C., Leavey, G., Vallianatou, C., & Barker, C. (2007). How clients with religious or spiritual beliefs experience psychological help-seeking and therapy: A qualitative study. *Clinical Psychology & Psychotherapy*, *14*(4), 317–327. https://doi.org/10.1002/cpp.542

Mclean, C., Campbell, C., & Cornish, F. (2003). African-Caribbean interactions with mental health services in the UK: Experiences and expectations of exclusion as (re)productive of health inequalities. *Social Science & Medicine*, *56*(3), 657–669. https://doi.org/10.1016/s0277-9536(02)00063-1

Memon, A., Taylor, K., Mohebati, L. M., Sundin, J., Cooper, M., Scanlon, T., & De Visser, R. (2016). Perceived barriers to accessing mental health services among black and minority ethnic (BME) communities: A qualitative study in Southeast England. *BMJ Open*, *6*(11), e012337. https://doi.org/10.1136/bmjopen-2016-012337

Moffat, J., Sass, B., Mckenzie, K., & Bhui, K. (2009). Enhancing pathways & mental healthcare for BME groups: Learning between the ideological and operational.

International Review of Psychiatry, *21*(5), 450–459. https://doi.org/10.1080/09540260802202075

Moller, N. P., Ryan, G., Rollings, J., & Barkham, M. (2019). Correction to: The 2018 UK NHS Digital annual report on the Improving Access to Psychological Therapies programme: a brief commentary. *BMC Psychiatry*, *19*(1). https://doi.org/10.1186/s12888-019-2277-2

Naz, S., Gregory, R., & Bahu, M. (2019). Addressing issues of race, ethnicity and culture in CBT to support therapists and service managers to deliver culturally competent therapy and reduce inequalities in mental health provision for BAME service users. *The Cognitive Behaviour Therapist*, *12*, e22. https://doi.org/10.1017/S1754470X19000060

NHS Digital. (2025). *Adult Psychiatric Morbidity Survey: Survey of mental health and wellbeing, England, 2025.* Retrieved July 7th, 2025, from: https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24

NHS England. (2023). *Patient and Carer Race Equality Framework (PCREF)*. Retrieved July 7th, 2025, from: https://www.england.nhs.uk/mental-health/pcref/

Nimgaonkar, A. U., & Menon, S. D. (2015). A task shifting mental health program for an impoverished rural Indian community. *Asian Journal of Psychiatry*, *16*, 41–47. https://doi.org/10.1016/j.ajp.2015.05.044

Nwokoroku, S. C., Neil, B., Dlamini, C., & Osuchukwu, V. C. (2022). A systematic review of the role of culture in the mental health service utilisation among ethnic minority groups in the United Kingdom. *Global Mental Health*, *9*, 84–93.

https://doi.org/10.1017/gmh.2022.2

O'Brien, J., Fossey, E., & Palmer, V. J. (2021). A scoping review of the use of co-design methods with culturally and linguistically diverse communities to improve or adapt mental health services. *Health & Social Care in the Community*, *29*(1), 1–17. https://doi.org/10.1111/hsc.13105

Office for National Statistics (2012). Ethnicity and national identity in England and Wales. Retrieved July 7th, 2025, from: https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/ethnicity/articles/ethnicityandnationalidentityinenglandandwales/2012-12-11

Ouzzani, M., Hammady, H., Fedorowicz, Z., & Elmagarmid, A. (2016). Rayyan—A web and mobile app for systematic reviews. *Systematic Reviews*, *5*(1). https://doi.org/10.1186/s13643-016-0384-4

Özen-Dursun, B., Panagioti, M., Alharbi, R., Giles, S., & Husain, N. (2023). A qualitative study on lived experience of self-harm in South Asians in the UK: From reasons to recovery. *Clinical Psychology & Psychotherapy*, *30*(5), 1179–1189. https://doi.org/10.1002/cpp.2875

Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., Shamseer, L., Tetzlaff, J. M., Akl, E. A., Brennan, S. E., Chou, R., Glanville, J., Grimshaw, J. M., Hróbjartsson, A., Lalu, M. M., Li, T., Loder, E. W., Mayo-Wilson, E., McDonald, S., … Moher, D. (2021). The PRISMA 2020 statement: An updated guideline for reporting systematic reviews. *BMJ*, n71. https://doi.org/10.1136/bmj.n71

Patel, V., Weiss, H. A., Chowdhary, N., Naik, S., Pednekar, S., Chatterjee, S., De Silva, M. J., Bhat, B., Araya, R., King, M., Simon, G., Verdeli, H., & Kirkwood, B. R. (2010). Effectiveness of an intervention led by lay health counsellors for depressive and anxiety disorders in primary care in Goa, India (MANAS): A cluster randomised controlled trial. *The Lancet*, *376*(9758), 2086–2095. https://doi.org/10.1016/s0140-6736(10)61508-5

Pilkington, A., Msetfi, R. M., & Watson, R. (2012). Factors affecting intention to access psychological services amongst British Muslims of South Asian origin. *Mental Health, Religion & Culture*, *15*(1), 1–22. https://doi.org/10.1080/13674676.2010.545947

Prajapati, R., & Liebling, H. (2022). Accessing Mental Health Services: A Systematic Review and Meta-ethnography of the Experiences of South Asian Service Users in the UK. *Journal of Racial and Ethnic Health Disparities*, *9*(2), 598–619. https://doi.org/10.1007/s40615-021-00993-x

Public Health England (2019). *Public mental health: Working age adults*. Retrieved July 7th, 2025, from: https://www.gov.uk/government/publications/better-mental-health-jsna-toolkit/6-working-age-adults

Rajkumar, R. P. (2024). Access to Mental Health Care in South Asia: Variations of Challenges and Ways Forward. In S. M. Y. Arafat & S. K. Kar (Eds.), *Access to Mental Health Care in South Asia* (pp. 155–196). Springer Nature Singapore. https://doi.org/10.1007/978-981-99-9153-2_9

Raleigh, V., & Holmes, J. (2021). *The health of people from ethnic minority groups in England*. The King's Fund. Retrieved July 7th, 2025, from: https://www.kingsfund.org.uk/publications/health-people-ethnic-minority-groups-england

Sancho, T. N., & Larkin, M. (2020). "We need to slowly break down this barrier": Understanding the barriers and facilitators that Afro-Caribbean undergraduates perceive towards accessing mental health services in the UK.

Journal of Public Mental Health, *19*(1), 63–81. https://doi.org/10.1108/JPMH-12-2019-0099

Sass, B., Moffat, J., Bhui, K., & Mckenzie, K. (2009). Enhancing pathways to care for black and minority ethnic populations: A systematic review. *International Review of Psychiatry*, *21*(5), 430–438. https://doi.org/10.1080/09540260802204121

Sewell, H. (2009). Leading race equality in mental health. *International Journal of Leadership in Public Services*, *5*(2), 19–27. https://doi.org/10.1108/17479886200900014

Shidhaye, R., Murhar, V., Gangale, S., Aldridge, L., Shastri, R., Parikh, R., Shrivastava, R., Damle, S., Raja, T., Nadkarni, A., & Patel, V. (2017). The effect of VISHRAM, a grass-roots community-based mental health programme, on the treatment gap for depression in rural communities in India: A population-based study. *The Lancet Psychiatry*, *4*(2), 128–135. https://doi.org/10.1016/s2215-0366(16)30424-2

Singal, P., & Chopra, A. (2023). Cultural Aspects of Mental Health in South Asians. *Psychiatric Annals*, *53*(3), 117–121. https://doi.org/10.3928/00485713-20230214-01

Singh, J. (2013). Critical appraisal skills programme. *Journal of Pharmacology and Pharmacotherapeutics*, *4*(1), 76–77. https://doi.org/10.4103/0976-500x.107697

Singla, D. R., Kohrt, B. A., Murray, L. K., Anand, A., Chorpita, B. F., & Patel, V. (2017). Psychological Treatments for the World: Lessons from Low- and Middle-Income Countries. *Annual Review of Clinical Psychology*, *13*(1), 149–181. https://doi.org/10.1146/annurev-clinpsy-032816-045217

Srinivasan, K., Heylen, E., Johnson Pradeep, R., Mony, P. K., & Ekstrand, M. L. (2022). Collaborative care compared to enhanced standard treatment of depression with co-morbid medical conditions among patients from rural South India: A cluster randomized controlled trial (HOPE Study). *BMC Psychiatry*, *22*(1), 394. https://doi.org/10.1186/s12888-022-04000-3

Suresh, K., & Bhui, K. (2006). Ethnic minority patients' access to mental health services. *Psychiatry*, *5*(11), 413–416. https://doi.org/10.1053/j.mppsy.2006.08.005

Thornicroft, G., Mehta, N., Clement, S., Evans-Lacko, S., Doherty, M., Rose, D., Koschorke, M., Shidhaye, R., O'Reilly, C., & Henderson, C. (2016). Evidence for effective interventions to reduce mental-health-related stigma and discrimination. *The Lancet*, *387*(10023), 1123–1132. https://doi.org/10.1016/s0140-6736(15)00298-6

Tomlinson, M., Rotheram-Borus, M. J., Swartz, L., & Tsai, A. C. (2013). Scaling Up mHealth: Where Is the Evidence? *PLoS Medicine*, *10*(2), e1001382. https://doi.org/10.1371/journal.pmed.1001382

Tong, A., Flemming, K., McInnes, E., Oliver, S., & Craig, J. (2012). Enhancing transparency in reporting the synthesis of qualitative research: ENTREQ. *BMC Medical Research Methodology*, *12*(1). https://doi.org/10.1186/1471-2288-12-181

Weaver, L. J. (2017). Tension Among Women in North India: An Idiom of Distress and a Cultural Syndrome. *Culture, Medicine, and Psychiatry*, *41*(1), 35–55. https://doi.org/10.1007/s11013-016-9516-5

Whiteford, H. A., Degenhardt, L., Rehm, J., Baxter, A. J., Ferrari, A. J., Erskine, H. E., Charlson, F. J., Norman, R. E., Flaxman, A. D., Johns, N., Burstein, R., Murray, C. J., & Vos, T. (2013). Global burden of disease attributable to mental and substance use disorders: Findings from the Global Burden of Disease Study 2010. *The Lancet*, *382*(9904), 1575–1586. https://doi.org/10.1016/s0140-6736(13)61611-6

World Health Organization. (2021). Comprehensive mental health action plan 2013–2030. World Health Organization. Retrieved July 7th, 2025, from: https://iris.who.int/handle/10665/345301.

Wrenn, G., McGregor, B., & Munetz, M. (2018). The Fierce Urgency of Now: Improving Outcomes for Justice-Involved People With Serious Mental Illness and Substance Misuse. *Psychiatric Services*, *69*(7), 829–831. https://doi.org/10.1176/appi.ps.201700420

Part 2: Empirical Paper

Title: Improving Access to NHS Talking Therapies Services through Co-production of Referral Pathways for Hindu and Sikh communities

Abstract

Background: Hindu and Sikh communities in the United Kingdom often face significant cultural, systemic, and structural barriers to accessing mental health services. Religious leaders are frequently the first point of contact for individuals in distress, yet their role in mental health pathways remains underexplored. This study aimed to facilitate collaboration between religious communities and mental health services to inform culturally sensitive referral pathways and improve access to NHS Talking Therapies services.

Method: The study used a qualitative design involving semi-structured interviews with 12 religious leaders and 11 service users from Hindu and Sikh communities. Thematic analysis was used to identify key themes related to views around religious beliefs and mental health, barriers, facilitators, and opportunities for improving access to mental health services. These were followed by co-production workshops involving community members, mental health practitioners, and faith leaders aimed to initiate development of referral pathways.

Results: Four main themes, each with multiple subthemes, were elicited through analysis: 1) Barriers to Access; 2) Facilitators and Perspectives on Improving Access; 3) Faith and Mental Health; 4) Potential Role of Religion in Facilitating Access. Workshop participants also proposed suggestions for co-produced referral pathways into services; this included religious organisations acting as key entry points, training trusted community volunteers as mental health champions, collaborative training and two-way mutual learning, joint awareness campaigns and events, continuity of culturally responsive care within integrated systems, and the provision of faith-sensitive, culturally adapted, and accessible resources.

Conclusion: To the author’s knowledge this is the first study to explore the development of a collaborative, culturally responsive mental health referral pathway between Hindu and Sikh services users, faith leaders and mental health services in the UK. Findings suggest that strengthening partnerships between services and religious organisations, alongside systemic reform, is essential to ensure more inclusive, equitable, and trusted pathways to mental health care. This led to important recommendations for service provision for Hindu and Sikh communities. Research implications are also offered.

Keywords: *Hindu and Sikh communities, co-production, referral pathways, mental health access*

Introduction

Mental health inequalities remain a persistent global public health burden, particularly for racially minoritised groups (Bhui et al., 2018). It has been consistently demonstrated that racially minoritised groups are disproportionately impacted by mental health difficulties in the United Kingdom (UK; Alam et al., 2024). Nevertheless, studies have consistently highlighted disparities in these groups accessing and receiving mental health treatment (Bhui & McKenzie, 2008). Delays in accessing the appropriate mental health support can have a significant negative impact on an individual's function and quality of life, leading to worsening of symptoms and reduced chances of recovery (Harwood et al., 2023).

There has been growing research to better understand the barriers racially minoritised people face when interacting with mental health services in the UK. This includes both cultural and systemic barriers such as stigma, poor recognition of mental health needs, long waiting times and cultural insensitivity and discrimination (Memon et al. (2016). This can contribute to mistrust of services and lack of confidence that they can meet the needs of the community. It is also suggested that providing safe and equitable person-centred mental health care for racially minoritised groups requires models that respond to their lived experiences, rather than reflecting broad ethnic categories. It is therefore important to consider intersections related to experiences of migration, systemic racism, trauma, and socio-economic disadvantage, which are reflected in structural biases within healthcare systems (Bansal et al., 2022). Racially minoritised groups are often positioned as the problem and labelled as 'hard to reach', this however overlooks how systemic inequalities limit their access to appropriate mental health care, reflecting broader societal and institutional discrimination (Naz et al., 2019).

In response to the inequitable variation in the use of mental health services, there have been several UK-wide policies and service-level initiatives to address the persistent disparities in mental health care affecting racially minoritised communities. This includes the National Health Service (NHS) Long Term plan (Alderwick & Dixon, 2019), the Patient and Carer Race Equality Framework (PCREF; NHS England, 2023) and an independent body established in 2021 called the NHS Race and Health Observatory (Naqvi et al., 2022). These policies and initiatives promote equity in the access, experience and outcomes of mental health care, emphasising the importance of culturally competent care, co-production with communities, and tackling institutional bias and systemic racism within mental health systems. Furthermore, in response to findings that only a quarter of individuals with common mental health difficulties were receiving the appropriate care (Layard et al., 2007), the NHS Talking Therapies for anxiety and depression (formerly known as 'Improving Access to Psychological Therapies' (IAPT)) was developed to provide inclusive access to evidence-based psychological interventions (Department of Health, 2008). This is often the first point of contact for those accessing support for mild to moderate common mental health difficulties.

Despite these national policies and available services, it has been consistently shown that racially minoritised groups in the UK underutilise mental health services and have poorer outcomes (Bhui et al., 2003). There remains a lack of research into pathways for racially minoritised groups accessing NHS Talking Therapies services, however existing research shows ethnic differences in access and outcome data (Parry et al., 2011). For instance, British Asian people are 14% less likely to contact services, with the Bangladeshi population having the lowest number of referrals compared to the White British population (Alam, 2023). It is suggested that crosscultural differences may account for this variation, while the persistent lack of progress in addressing these inequalities may stem from failure of services to implement existing recommendations and engage in meaningful co-production with local communities (Bansal et al., 2022). Furthermore, services often rely on Eurocentric frameworks that do not account for the lived experiences of racially minoritised groups, resulting in epistemic injustice and disengagement from mainstream care pathways. There also seems to be a lack of knowledge around cultural understandings of mental health and how distress is experienced (Morgan et al., 2004). To ensure mental health care is truly accessible, services should therefore adopt socially informed and anti-racist models of care, investing resources to understand and meet the specific needs of racially minoritised communities, for example, by developing culturally responsive pathways into services (Bansal et al., 2022)

Providing accessible and inclusive referral pathways into care regardless of contextual factors such as ethnicity, is essential to an equitable mental health system. However, evidence indicates that racially minoritised groups are less likely to access Talking Therapy services through self-referral and are more likely to engage with services at the point of crisis, often entering services via community or secondary care referrals, or through the criminal justice system. (Harwood et al., 2023). These groups are also less likely to be referred to specialist services, receive appropriate care at the earliest possible stage, and are more likely to be offered pharmacological interventions over psychological therapies (Lawton et al., 2021). This can exacerbate symptoms, contribute to the development of comorbid conditions, and increase the risk of hospitalisation or suicide. As well as personal and cultural factors impacting on these disparities, mistrust of healthcare systems rooted in historical and ongoing discrimination can play a significant role (Bansal et al., 2022).

Although ‘improving pathways to care’ is a key aim of national policies such as the PCREF (NHS England, 2023), research shows a disconnect between these ideals and their operationalisation at a service level (Naz et al., 2019). There seems to be a lack of practical advice and information available to services and much of the existing evidence-base seems to be from outside the UK (Moffat et al., 2009). A systematic review evaluating interventions aimed to improve care pathways for black and minority ethnic communities (BAME) found some evidence that ‘ethnic matching’ of staff, pre-treatment services focused on specific ethnic groups and culturally adapted educational resources could positively influence access (Sass et al., 2009). However, only one of the included studies was from the UK. Another review focusing on existing grey literature emphasised the importance of co-production with communities, collaboration and facilitating referrals between different sectors and targeted community outreach (Moffat et al., 2009). Overall, although there is evidence of promising practice, more systematic, well-resourced, and long-term approaches are needed to address existing structural barriers.

Many racially minoritised communities in the UK maintain deep-rooted religious traditions, even post-migration (Kiang et al., 2022). Hinduism and Sikhism both originate in India and share similar philosophical and cultural foundations, while maintaining distinct religious identities. The Office for National Statistics (ONS) reported that 46% of England’s population hold a religious affiliation, of these 1.7% identified as Hindu and 0.9% as Sikh (ONS, 2021). Although there is growing interest, research looking at the role of religion on mental health care remains limited. There is some evidence that religion and spirituality play a central role in shaping beliefs about mental health, coping mechanisms, and help-seeking behaviours (Nakash et al., 2019). Furthermore, religious communities may interpret their difficulties through a spiritual lens rather than a psychological one, often turning to their faith to make sense of and manage their distress (Mahmud, 2024). For example, in Hinduism and Sikhism the concepts of ‘karma’ and ‘God’s will’ are often used to explain suffering. There are also beliefs that mental illness is caused by possession of evil spirits, or the ‘evil eye’, and individuals may engage in various rituals to overcome this (Kang, 2010; Singh, 2008). Therefore, seeking professional help can be perceived as conflicting with religious beliefs, and the secular mental health treatments offered are often perceived as misaligned to the needs and values of these communities in the UK (Loewenthal et al., 2012). Considering this, it is not surprising that religious communities prefer to seek guidance from faith leaders over mental health services in times of distress (Leavey et al., 2007). Faith leaders can therefore be seen as gatekeepers to services, as their beliefs and attitudes towards mental health and help-seeking likely have an impact on access to mental health care.

Despite increasing recognition of the importance of religious and spiritual sensitivity in mental healthcare, collaboration between mental health services and faith-based organisations remains limited. Research indicates that community faith leaders frequently regard mental health support as a key aspect of their role, often supporting members of their congregation who are experiencing mental health difficulties (Meran & Mason, 2019). Despite this, in practice, few formal referral pathways exist between religious communities and psychological services, such as NHS Talking Therapies (Vahdaninia et al., 2020). While co-production approaches involving service users have gained traction, there is a notable absence of similar efforts that actively involve faith leaders, particularly from Hindu and Sikh communities, who are underrepresented in the literature (Singh et al., 2023).

Rationale and Aims

Both national policies and academic literature increasingly recognise the significance of religion and spirituality in mental health and stress the importance of services being responsive to the religious needs of individuals accessing mental health support. Despite the UK's religious diversity, the integration of faith leaders into referral and treatment care pathways remains underexplored (Dein et al., 2010). Furthermore, there are limited studies looking at Hindu and Sikh faith groups. Addressing mental health inequalities and the mistrust these communities have towards services requires collaborative approaches. Health professionals must actively engage with racially minoritised communities to co-produce culturally and religiously appropriate services. This study contributes to a growing body of research advocating for community-led design, and that recognises the role of spiritual and religious identity in access to care (Hammad et al., 2020; Loewenthal et al, 2012).

Given the limited research in this area, the purpose of this study was to explore the experiences and perspectives of the Hindu and Sikh religious community regarding collaboration with mental health services. This incorporated both faith leaders and service users, the latter of which had accessed NHS Talking Therapies. The study aimed to support access to psychological care by co-developing improved culturally and spiritually responsive referral pathways. The specific objectives were:

1. To explore how religious beliefs and practices influence understandings of mental health among members of the Hindu and Sikh communities.
2. To identify barriers and facilitators to accessing psychological services, particularly within NHS Talking Therapies services for anxiety and depression.

3. To explore potential strategies to improve engagement with mental health services through community-based collaboration.
4. To initiate collaboration between local Hindu and Sikh communities and NHS mental health services, with the aim of co-producing culturally sensitive referral pathways into NHS Talking Therapies services.

Methods

Design

This study employed a qualitative research design using semi-structured interviews to explore the experiences and perceptions of Hindu and Sikh faith leaders and service users regarding religion and mental health, barriers and facilitators to accessing services and potential collaboration with psychological services. Given the limited research in this area, a qualitative exploratory approach was considered most suitable for capturing meaningful, in-depth, and contextually grounded insights (Pope & Mays, 2006).

Ethical Approval

Ethical approval for this study was granted by the Health Research Authority (HRA) Cambridgeshire and Hertfordshire NHS Research Ethics Committee on the 11th of October 2024: REC Reference- 24/EE/0153 (Appendix 3). Following this, local approval from Central North-West London NHS Foundation Trust to act as a Participation Identification Centre (PIC) was obtained on 3rd February 2025.

Recruitment

A NHS Talking Therapies Service collaborated on this study, supporting participant recruitment by acting as a PIC. The service is located in North-West

London, with the residing borough being recognised as one of the most ethnically and culturally diverse areas in the UK. According to the Office for National Statistics (2021), over 60% of its residents identify as being from racially minoritised backgrounds. The borough also has one of the largest Hindu communities in London and a significant Sikh population. In order to meet the needs of its communities, the service employs community connectors, whose role involves building relationships with local stakeholders to promote awareness and engagement with psychological services.

Faith leaders holding leadership roles within Hindu or Sikh religious organisations in the UK, as well as Hindu or Sikh service users who were currently accessing or had previously accessed the Talking Therapies service, were invited to take part in the interviews. Following this, both groups, along with current Talking Therapies staff, were invited to participate in a follow-up workshop. Additional eligibility criteria for interview and workshop participation included being 18 years or older, and for the workshop participation, proficiency in English was required. Interviews were offered in English or in the participant's preferred language; two were conducted in Hindi by the researcher, and the remainder in English.

The target sample size for interviews was approximately 25 participants, based on established guidance for achieving data saturation in thematic analysis and similar qualitative research using semi-structured interviews (Guest et al., 2006). While there was no fixed sample size for the workshop, prior literature on focus groups and discussions with the research team suggested a minimum of 4-5 participants would be sufficient to generate rich data through group dialogue (Guest et al., 2017). Participants were initially approached by the Talking Therapies service via email or text message (with a link to a Google Form), or in person, which included a study poster (Appendix 4) and information sheet (Appendix 5) designed by the researcher.

These materials outlined the study’s aims, objectives, and inclusion and exclusion criteria. The researcher also attended meetings with the partner organisation to provide further information and support recruitment efforts. In addition, independent recruitment was conducted by the researcher through contacting religious networks such as the *Hindu Mandir Network* and local temples and gurdwaras, to request assistance in identifying and recruiting suitable faith leader participants. Once interviewing had begun, a snowballing procedure was also used to identify potential participants within their networks who met the study’s inclusion criteria.

After being approached, interested participants were asked to share their contact details with the researcher directly or through the community connectors. They were then provided with the consent form (Appendix 6) and given adequate time to review all relevant study forms and raise any questions or concerns. Prior to participation, all individuals provided written informed consent via email. Participants were offered the option to take part in interviews either in person at a community venue, online, or by telephone. All participants opted for online interviews via Microsoft Teams. Following the interview phase, participants were invited to join a follow-up workshop. A separate recruitment process, following the same procedures, was also undertaken to invite additional participants for the workshop phase.

Data Collection and Management

A total of 23 semi-structured interviews were conducted online via Microsoft Teams. Of these, 12 participants were faith leaders and 11 were service users. Interviews lasted between 30 to 70 minutes, with an average duration of approximately 40 minutes, and were audio- or video-recorded with participants' consent. All participants also completed a demographic questionnaire (Appendix 7).

Interview recordings were transcribed verbatim using the built in Microsoft Teams' transcription software, which is approved by the university. The researcher then reviewed and edited the transcripts to ensure accuracy and clarity. All transcripts were anonymised and assigned unique research identification numbers to protect participants' confidentiality. All data was stored according to the University College London GDPR guidelines. At the start of each interview and the workshop, participants also provided recorded verbal consent. Participants were informed of their right to withdraw from the study at any time without consequence and were given the option to take part in either the interview, the workshop, or both. To support recruitment, participants were offered a £15 voucher for taking part in the interview and were entered into a raffle to win one of three £20 vouchers following participation in the workshops. It was made clear that these incentives would be provided regardless of whether participants completed the interview or later chose to withdraw their data from the study.

Interview Schedule

The development of the interview schedule was informed by input from the principal researchers and expert professionals in the field, drawing upon key themes identified in existing literature, such as the barriers to access highlighted by Prajapati & Liebling (2022). To further refine the schedule, a consultation was conducted with a service advisory group, who provided feedback on the structure, sequence of questions, and overall direction of the research. This process led to consensus on the proposed content and the incorporation of additional items, including questions specifically exploring facilitators to accessing care. The advisory group also suggested further prompts relating to practical recommendations for effective collaboration between community organisations and mental health services.

The final semi-structured interview schedule was developed by the research team specifically for this study (Appendix 8). It grouped questions into six main areas:

1. Experience of Care
2. View of Treatment Services
3. Access to Care
4. Views of the Community
5. Barriers and Facilitators
6. Collaboration and Future Implications

Interviews followed a semi-structured format, offering flexibility for the interviewer to adapt questions and explore emerging themes in greater depth. Participants were also invited to share any additional thoughts or reflections beyond the scope of the predefined questions.

Analysis

The data collected in this study was analysed using Thematic Analysis (TA), following the six-phase framework proposed by Braun and Clarke (2006): familiarisation with the data, generation of initial codes, searching for themes from codes, reviewing themes, defining and naming themes and conducting the write-up. This method was selected due to its flexibility and suitability for analysing large, complex qualitative datasets. Given the exploratory nature of this research and the limited existing literature on the role of Hindu and Sikh faith leaders in facilitating mental health access, TA allowed for a rich and nuanced interpretation of participants' views and experiences. The analysis took a primarily inductive (data-driven) approach, whereby themes were closely linked to the content of the data, rather than imposed from a pre-existing theoretical framework. TA is not tied to a single epistemological stance, which made it a suitable method for capturing diverse viewpoints across both service user and faith leader groups (Braun & Clarke, 2023).

The analysis was grounded in a critical realist epistemological stance, which recognises that while there is a reality independent of human perception, our understanding of it is shaped by individual, cultural, and social contexts (Willig, 2013). This acknowledges that both external structures and personal experiences shape a person’s behaviour and experiences, allowing for a deeper understanding of complex psychological issues. This perspective is especially valuable when exploring the experiences of racially minoritised groups, as it considers the impact of cultural and social contexts on their views and behaviours. It is also argued that whilst the data can offer insights into reality, these are always shaped by a person’s perspectives and the researcher’s interpretive lens. As such, researchers must look beyond surface level accounts, drawing on interdisciplinary knowledge to gain a more comprehensive understanding of the wider social, cultural and historical factors that may be influencing an individual’s experiences (Lawani, 2021).

NVivo software (QSR International Pty Ltd., 2020) was used to support the data analysis process, providing a systematic way to organise, code, and interpret data; this is particularly useful for managing the volume of interview material generated. Initial codes were generated using an inductive, data-driven approach, identifying both explicit and underlying meanings. These codes were then clustered into preliminary themes, reviewed and refined for clarity, and mapped using NVivo. Themes were defined and named to reflect key patterns in the data, and illustrative quotations were selected to convey participants' experiences and perspectives within the final narrative.

Workshops

Following the interviews, two 90-minute follow-up workshops were facilitated by the primary researcher. One workshop included religious organisation representatives and service users, while the other was attended by staff from the NHS Talking Therapies Service. Participants included a mix of individuals previously interviewed, along with newly recruited faith leaders, service users, and NHS staff.

The workshops aimed to collaboratively reflect on the preliminary interview findings and generate ideas for co-produced culturally responsive referral pathways into NHS Talking Therapies services. In consultation with the research team and professionals experienced in the field, a flexible structure was agreed upon. This included presenting preliminary interview findings, discussing participants' perspectives on what effective referral pathways might look like, considering whether such approaches could improve access, and exploring participants' interest in contributing to the design process. The sessions were loosely semi-structured to encourage participant-led discussion, with no predetermined outcomes. Recommendations from both workshops were collected, and after initial feedback was gathered from participants, the findings were shared directly with the service.

Researchers' Perspective

Reflexivity is a vital component of qualitative research, as it requires the researcher to actively consider how their personal background, assumptions, and social positioning influence the research process and interpretation of data (Willig, 2008). This philosophical approach allowed exploration of participants' perspectives while also considering broader structural, cultural, and social influences, particularly in relation to community collaboration and mental health support for minoritised faith groups. It was hoped that these insights would inform recommendations to enhance collaboration between faith organisations and services, improve pathways into services for Hindu and Sikh communities, and ultimately contribute to addressing inequalities in mental health care.

I also took time to reflect on the personal experiences that inspired this research. I am a British second-generation Indian identifying as Hindu, I am aware that my own cultural identity and experiences have inevitably shaped how I approached and engaged with this research. My interest in this research was shaped by my personal insight and experiences working in mental health. I have witnessed first-hand how faith, cultural beliefs, and intergenerational attitudes can act as barriers to accessing appropriate psychological support. I have also experienced the limitations of mainstream mental health services, which often lack inclusivity and cultural sensitivity for religious minorities. These experiences motivated my desire to explore how services can work more effectively with communities like my own, especially given the lack of meaningful co-production, outreach, and representation. It was also apparent during initial literature searches in this area that there was a lack of studies focusing on Hindu and Sikh communities. Throughout the research process, I remained aware of how my approach to questioning, communication, and the topics I chose to emphasise during interviews were shaped by my own cultural perspectives and values. I therefore made a conscious effort to remain reflexive, recognising how my positionality influenced the way questions were framed, data was gathered, and findings were interpreted. I maintained a reflective journal and engaged in peer debriefing and supervision to critically evaluate and bracket any biases, ensuring the analysis remained grounded in participants' voices.

Results

Participant Characteristics

A total of 23 participants, 11 service users and 12 faith leaders, took part in the study. The sample included 12 males and 11 females, with ages ranging from 21 to 72 years (M = 46.96, SD = 14.11). The majority of participants identified as British Indian (n = 18), with 4 identifying as Indian and one as White British. In terms of religious affiliation, 18 participants identified as Hindu and 5 as Sikh. Regarding employment status, the majority participants were employed either in full-time (n = 14) or part-time roles (n = 5). There were 11 service users and one faith leader who had previously accessed services. Of these, 3 had accessed services within the past 6 months, 6 within the last year, and 3 over a year ago. The remaining 11 participants had not accessed mental health services. A full summary of this information can be seen in Table 1 below.

Table 1
Demographic Characteristics of Participants

	Count
Total Participants	23
Sex	
Male	12
Female	11
Age (years)	
Range	21-72
Mean	46.96
Standard Deviation	14.11
Ethnicity / Ethnocultural Identity	
Indian	4

	Count
British Indian	18
White British	1
Religion	
Hindu	18
Sikh	5
Current Employment Status	
Full time employment	14
Part time employment	5
Self employed	1
Unemployed	1
Student	2
Previous Access to Mental Health Services	
Yes	13
No	10
Time Since Last Access of Mental Health Services	
Within past 6 months	3
6-12 months ago	6
Over 1 year ago	3
Not applicable	11

Thematic Analysis

The 23 participants shared rich and detailed accounts of their experiences and views on improving access to mental health services within the Hindu and Sikh communities. As many of the interview questions and analysis codes overlapped, the generated themes encompassed both religious leaders and service user groups. Participants' names were removed due to confidentiality; whether they were a service user (SU) or religious leader (RL) is noted, and participants will be referred to as P1/P2 etc. to ensure confidentiality. There were four overarching themes, each with accompanying subthemes, which are presented in Table 2. An example transcript extract with initial codes that were collated to form a theme and sub-theme can be found in Appendix 9.

Table 2
Overview of Themes and Subthemes

Themes	Subthemes
1. Barriers to Access	1.1 Cultural Stigma and Community Barriers
	1.2 Structural and System Level Challenges
2. Facilitators and Perspectives on Improving Access	2.1 Clear, Flexible and Timely Pathways
	2.2 Embedding Cultural Safety and Community Centred Visibility
	2.3 Role of Religious Organisations as Support Structures
3. Faith and Mental Health	3.1 Religious Interpretations and Responses to Mental Health
	3.2 Religious Informed Solutions
	3.3 Shifting Narratives and Hope for Integration
4. Potential Role of Religion in Facilitating Access	4.1 Religious Spaces as Trusted Gateways to Mental Health Support
	4.2 Religious Leaders as Cultural Mediators and Collaborative Partners

Theme One: Barriers to Access

The first theme captures the multifaceted barriers that participants identified in relation to accessing mental health support. There were various overlaps in reported barriers, and this theme was divided into two subthemes to reflect the interplay between culturally rooted stigma and community obstacles and broader structural and systemic challenges. This emphasised the complex interface between personal and community level obstacles individuals faced which are further compounded by wider systemic issues. This often discouraged open dialogues around mental health and delayed help-seeking. Additionally, it highlighted how different personal identities like culture, age and religion can intersect, when exploring barriers and developing pathways to care.

1.1 Cultural Stigma and Community Barriers

The most pervasive barrier to accessing mental health services that emerged across both the religious leader and service user groups was stigma. Participants described both internalised stigma, feelings of shame, denial, or the belief that one's struggles were not "serious enough', and external stigma, which included fear of being judged or socially excluded by family and community members. One participant described: *'If you have mental health problems, you're just sort of seen as like crazy…or like there's something wrong with you…and you're sort of segregated from the community...and it's like, people see you as different.' (P15; RL).* Religious and cultural expectations often contributed to a sense of silence around mental health, discouraging open discussions and help-seeking. As one participant mentioned, *'I feel like sometimes religion is one reason why people or I would have struggled to reach out…like I was scared what the community at the temple would think if they found out…that sort of worry that what will happen if other people find out can really stop someone asking for help.' (P13; SU).*

Several participants highlighted that mental health challenges were sometimes minimised, misunderstood, or explained solely through spiritual or religious frameworks, which could invalidate their experiences or delay access to appropriate care. *'I've noticed that with my family especially growing up, it was like very much* *“don't tell anyone”…their mentality was that we can fix whatever's wrong with you at home.’ (P4; SU).* Religious settings, while seen as important sources of guidance, were not always considered safe spaces for disclosure. Participants reported hesitation in discussing mental health issues within temples or with religious leaders, due to either fear of spiritualising their distress or concern that the support offered would be religious rather than therapeutic. *‘When I did talk to someone at the mandir (temple) they were like you should…read the scriptures or do this prayer…but nothing in terms of NHS services or taking to a therapist.’ (P12; SU).*

1.2 Structural and System Level Challenges

Participants consistently highlighted systemic and structural barriers when accessing mental health support. A recurring issue was the lack of awareness about what services are available and how to seek support; they reflected on the insufficient promotion and visibility of local mental health services, especially in settings where the community naturally gathers, such as places of worship. As one participant summarised, *‘I mean I don't get how the system works. I know how the NHS works in general. But in terms of the mental health services, there is not really any information I feel is available for someone like me.’ (P2; SU).* As a result, many individuals simply did not know where to go or felt services were not ‘for them’. Both service users and religious leaders also noted the lack of straightforward routes into services, and that the existing systems were difficult to navigate and rigid in terms of the support offered: *‘I would say people often fall through the gap…they kept offering me counselling and I had to really fight to be offered something else as I did not think it was the right option for me. They finally said they'll refer me for family support which I felt I needed more* *but I haven't heard back, I've tried two to three times already…it can be exhausting to keep chasing it.' (P11; SU).*

Service users described long waiting times, a lack of follow-up, and delays in accessing support, which often discouraged continued engagement. One participant described being repeatedly offered pharmacological support as the first line of treatment which did not feel appropriate, *'…they were telling me to take medication, and I know medications are not going to help me and I asked if I could talk to someone instead and it took a long time before my GP agreed to refer me for talking therapies. It was difficult because I did not know what I needed to ask for or what the options were.' (P16; SU).* Many felt that professionals often lacked understanding of cultural or religious contexts, which led to experiences of being misunderstood or not fully heard. This disconnect resulted in a lack of trust and reduced confidence in the relevance or usefulness of psychological support. One religious leader described stigmatised views from services, *'Some of the devotees may feel that because the therapist is not religious they would not be able to understand them...I have heard from people that some counsellors have called our organisations a cult or they have other negative views of our beliefs and practices. So there's some cultural barriers I think which will then prevent someone from going to therapy.' (P4; RL).*

Theme Two: Facilitators and Perspectives on Improving Access

The second theme explores participants' views and experiences on what can support better engagement with mental health services for the Hindu and Sikh communities. This theme was further broken down into three interrelated subthemes, emphasising the importance of improved routes into services, a call for services to actively engage with communities in culturally sensitive ways and recognising religious organisations as existing trusted support structures. These insights emphasised a strong desire for culturally informed, community-rooted approaches to service design that reflect the real-world needs and preferences of those they aim to serve.

2.1 Clear, Flexible and Timely Pathways

Participants consistently highlighted the need for more streamlined and responsive pathways into mental health services. Many described current referral pathways as confusing, inflexible, and difficult to navigate, often resulting in delayed access to care. There was a strong call for simplified and more direct routes into services. The majority of participants were initially referred through their GP; they reflected that although they were then referred to NHS Talking Therapies, this felt like yet another hoop to jump through. Several participants reported that having the option to self-refer was therefore a positive facilitator. As one participant mentioned, *'Ease of access to the service is very important, for example my friend who lives in Harrow. I can't just go well call this number, I will tell him to go to his GP…there's then a long process…if it was just easier to access someone on the front line…you know, even if there's just one number you called and then you got triaged immediately it would be much better.' (P13; SU).*

Shorter waiting times were seen as essential, particularly for individuals in distress who may disengage if support is not available promptly. Three participants shared that receiving follow-up support while waiting for treatment helped them feel supported and reassured, rather than forgotten within the system, *'Like recently they didn't use to do this before, but my GP started calling to check up on me. And yeah,* *we had like frequent telephone calls and that kind of really motivated me to continue to reach out and get help because someone was caring I guess.' (P4; SU).*

Participants also emphasised the value of offering varied entry points into care, such as community hubs, religious spaces, and outreach services, to meet people where they are at. As one participant suggested, *'I think talking therapies do not always meet someone's needs, I think actually referring to another charity or community agency that would be able to help and continue to offer support would be a better option for many people.' (P6; RL).*

Additionally, flexibility in service delivery, including culturally adapted options and offering non-traditional therapies was seen as key to accommodating the diverse needs of the Hindu and Sikh communities. For example, several participants suggested involving family members where appropriate, and recognising their vital role as part of the support system could be a key facilitator in engaging individuals, *'I think a lot of the times it's the relationships around a person that is important…so I feel like if I was to do therapy all over again…I would love for like my parents to be involved in the treatment or for my mum to have access to information or ways for her to support me.' (P15; SU).*

2.2 Embedding Cultural Safety and Community Centred Visibility

Participants expressed that a lack of cultural sensitivity in mainstream services often created feelings of mistrust and reduced confidence that they could meet their needs. Embedding cultural safety was seen as critical to fostering a more welcoming and inclusive environment within services. This included employing and training staff with relevant cultural and religious knowledge, understanding faith-based world views, and acknowledging community-specific experiences of mental distress. One participant expressed, *‘It's really important to make it culturally adapted and…there's a lot of nuances within culture as well, so I think it's just having some open mindedness from services to question themselves… most of them don't have the cultural awareness. They may know about the Hindu faith broadly, but not about day-to-day beliefs and practices, so they should be aware of this.’ (P21; RL).*

Participants advocated for services to be visibly present within the community through outreach, education, and collaboration. Visibility within trusted spaces such as temples, community centres, and local events, was seen as a way to reduce stigma and increase awareness: *‘I'm just trying to think of like you know places where people might go like to the fruit and veg shop or the temple…or like adverts on the TV, I’ve seen recently on ITV I think they've got adverts and it's got like all the celebrities saying ‘sometimes it's good to talk to a friend’, I bet that isn't on the Asian channels. That's probably your biggest way of capturing someone because that little moment can trigger someone to think about it, so it's considering where would those people be that they can catch that information and having this in different languages.’ (P10; SU).*

Importantly, participants emphasised that culturally safe services should be more than matching ethnicity or language, but about cultivating a respectful, non-judgmental approach that validates the lived experiences and values of individuals from Hindu and Sikh backgrounds. As one participant mentioned, *‘I think it's important to say you don't have to be an expert in every single religious belief that's not realistic but to have the ability to question and being sort of interested in someone to say, ok, so how does this fit in with this person's normal social life, working practice or whatever and working closely with the local faith communities* *would be really helpful for someone to then better understand their needs.' (P20; RL).*

2.3 Role of Religious Organisations as Support Structures

Religious organisations were consistently recognised as central support structures within the community, often serving as a first point of contact for individuals experiencing various difficulties. Participants described temples and gurdwaras as safe spaces where they felt seen and supported: *'I actually find it quite easy to speak to people, and people will talk to me in the temple. It's really good the way the community works and helps each other.' (P11; SU).* Several faith leaders noted a growing demand for mental health-related guidance but cited a lack of training, clear pathways, or collaboration with formal services as limiting their role. As one faith leader notes, *'I mean we probably speak to, at least we've got 20 enquiries every Sunday. We have signposted them to NHS local services, who also come regularly to advertise their services. But although these services exist out there, there isn't enough support for us at the other end to continue the recovery of the patient and I've heard a lot of them are feeling let down.' (P14; RL).*

Some participants expressed a strong sense of duty and responsibility to provide support and resources to their congregations, viewing mental wellbeing as closely intertwined with their spiritual role*: 'We talk about it which is why we've got a very strong well-being team. The only reason why we've got such a strong team is because we've acknowledged that this is something the community needs especially post-COVID and I think we do need to help in addressing it.' (P2; RL).* In contrast, other religious leaders felt mental health fell outside their remit and preferred to signpost individuals to professional services, often feeling unequipped or under-resourced to offer appropriate support, *'I don't feel it is in our jurisdiction, I don't like to give suggestions on mental health topics. Most people will approach the temple priests first but most of the priests are not aware of how to support someone with mental health issues, they don't have any education or training about it.' (P21; RL).*

While many places of worship had established efforts to address physical health, mental health remained less of a focus, with limited resources or initiatives in place. Nonetheless, the evolving role of religious organisations in supporting mental wellbeing was clear and there was generally enthusiasm for working more closely with services to bridge these gaps in care. As one participant summarised, *'So no, I have never seen anyone talking about mental health in the organisation, they have awareness around physical health like we have events around cancer or diabetes, and I think it would be great to work with mental health services so there is more information about this as well.' (P9; RL).*

Theme Three: Faith and Mental Health

This theme explores how mental health is understood, experienced, and responded to through a religious lens within the Hindu and Sikh communities. Participants shared a range of insights reflecting how religious beliefs, practices, and spaces act both as barriers to help-seeking and potential solutions. This theme is broken down into three subthemes that reflect that while religious frameworks still hold influence, there was also evidence of evolving perspectives and a desire for more integrated and informed approaches.

3.1 Religious Interpretations and Responses to Mental Health

Many participants described how mental health is often interpreted through spiritual or religious frameworks, with explanations commonly rooted in concepts such as karma, loss of faith, or divine testing. One participant described, *'If the person has got some religious beliefs… they may not accept mental health as an issue which can be helped by the GP…. many of them think that it is their karma…others think they have done something wrong somewhere in a past life which is coming back to them.' (P21; RL).* These interpretations influenced how community members responded to distress, sometimes encouraging inward reflection and prayer rather than seeking psychological help: *'They are more likely to take the religious path for support, as they believe 'God is the answer', so they will ask the priest to pray and chant, or look at their horoscopes...they believe doing these activities will help more than just talking to someone.' (P16; RL).*

In some religious settings, mental health difficulties were spiritualised or not fully recognised, contributing to reluctance to discuss these issues openly. One participant reflected on her experience with accessing support in the temple, *'I was told if you're devoted to your faith then you've got everything you need and they're just like well why would you even need a service… those leaders need to be aware that this does not help everyone…some people are still struggling and they need other kinds of support.' (P6; SU).* This led to some participants feeling unsupported or dismissed and they were therefore reluctant to discuss mental health openly in these religious spaces, particularly due to fears around judgement, gossip, or being perceived as spiritually weak. This then made it harder for individuals experiencing distress to seek help within their communities or from professional services. Another participant also summarised her experiences, *'It is easier for men to get support as* *priests cannot speak to women directly, so I had to pass on a message through someone else I wasn't very familiar with. I had to be very careful who I gave this message to because I didn't want that message to be spread around…and I was just given a letter from the priest which quoted scriptures and tried to reassure me it will pass, nothing else was done…you know practically. I had to then do my own research and go to my GP to get the help I needed.' (P12; SU).*

<u>*3.2 Religious Informed Solutions*</u>

On the other hand, several participants reflected on religion playing a constructive and positive role in supporting mental health and that religious organisations often function as important community hubs for guidance and spiritual comfort*. 'Yeah, my dad's brother and their family, they're very proactive and they speak to the priests a lot about like their issues and they find that support very helpful when I've spoken to them.' (P3; SU).* Many found practices such as prayer, 'kirtan' (devotional singing), scriptural reflection and meditation as grounding and psychologically beneficial. These existing practices were often more culturally acceptable and accessible than psychological therapy, especially for older generations. One participant described how religious teachings have been beneficial, *'When you look at scriptures, I think it's just that understanding of like you're part of a bigger picture and that it's temporary…it helps me decode why I am feeling this way and I am able to apply it to my day-to-day thinking.' (P10; SU).* There were suggestions for services to draw on these existing community-based practices which are already well-established and culturally embedded within Hindu and Sikh traditions. One participant suggested: *'I think culturally in terms of mental health we have tools more than lets say the average population…. like meditation and* *yoga…our community knows about these tools and these can be very effective way to engage people and I think services can also use them to engage more people.' (P11; RL).*

There were some reflections on the growing generational gap in how religious teachings are understood and received. Participants expressed awareness that traditional interpretations and delivery of religious messages can feel outdated or disconnected for younger members of the community, which may reduce their effectiveness as a source of emotional or psychological support. In response, some leaders shared that they had begun modernising how religious concepts are communicated, *'our religious scriptures they are very old, and the language is not easy to understand, we are trying to address the transfer of this information so it is more accessible by having smaller teaching groups with people from the same generation teaching these classes.' (P10; RL).* Importantly, participants noted that rather than seeing religion and mental health care as opposing forces, embedding the two could be a more effective model for supporting mental wellbeing of religious groups. One faith leader described how this was being done actively within their organisation. *'It's quite important for us to hold both mental and physical health as core…for example integrating it within the religious discussions and practises…in the mornings when we're doing our morning prayers, we integrate breathing and mindfulness practises with chanting of prayers.' (P18; RL).*

3.3 Shifting Narratives and Hope for Integration

Encouragingly, many participants highlighted evolving narratives within faith communities regarding mental health, especially among younger generations, *'I think there might be a generational gap where the older generation didn't want to talk* *about it, whereas the younger generation are quite open about mental health and will ask for help.' (P5; SU).* Participants described growing recognition among the community that mental health was a serious and legitimate concern that required attention, *'I think people are talking about it more. It's more in the news and on social media…people are just generally admitting they don't feel very well…as a family and particularly my generation of friends and family, I think we've realised that we need to talk about it, we need to be open. So we've kind of built our own social network in a way.' (P13; SU).* Several examples were also given of religious leaders inviting professionals to speak at temples or showing willingness to support mental health initiatives, *'We are kind of in a very privileged position in the sense that we have a lot of people from the community who work in these healthcare sectors. So recently...we hosted a very famous neuroscientist to talk about mental health and some of the symptoms and you know how scientifically it works and how it can be managed…so I think that was very well received.' (P17; RL).*

Participants expressed a strong desire and willingness for services and religious institutions to work more closely together. There was also a sense that education and awareness efforts needed to be ongoing, and not only targeting religious leaders but also families and broader community networks, with reach across different generations, *'I think the push around mental health needs to be universal...it can start in the temples but it really needs to more widely pushed within the community…also not just at one-off events or certain times in the year but putting in more consistent efforts.' (P3; RL).* This gradual shift in community attitudes provided many with the hope that longstanding barriers such as stigma could be dismantled slowly to give way to a more open and compassionate understanding of mental health, one that complements rather than conflicts with religious beliefs.

Theme Four: Potential Role of Religion in Facilitating Access

The final theme captures participants' reflections on the evolving and potentially transformative role that religious organisations and leaders could play in improving access to mental health care. This was broken down into two further subthemes which highlighted opportunities for collaboration and integration between faith and mental health systems.

4.1 Religious Spaces as Trusted Gateways to Mental Health Support

Religious organisations were seen as trusted settings which often served as first points of contact during distress for many community members. Several participants therefore suggested that these spaces could act as accessible gateways to mental health services. One participant reflected, *'I think it would be really helpful for them to work together, I go to the temple like almost every week or every other week...there are lots of others like me and if they see more things around mental health in the temples I think it will really help to raise awareness.' (P5; SU).* The importance of utilising the trust and familiarity already embedded within these spaces to foster mental health awareness and service accessibility was emphasised.

A variety of practical suggestions were offered by participants on how to make mental health support more visible and approachable within religious settings. This included the distribution of accessible educational materials, aligning awareness initiatives with major religious or cultural events, providing mental health trainings to 'mental health champions' and having respected role models in the community to speak openly around mental health. For example, one person suggested*, 'It would be helpful if one or two people were actually trained as a mental health champions or similar... I have not seen those courses, even if it's an introductory course on how* *you deal with a patient or somebody who's got mental health, what signs to look out for, things that they can support people with. I think you know we need to know what's on offer before we can actually educate our community, let's put it that way...if we know more about what services are available rather than just saying, go to the hospital or go to your GP that would be useful.' (P19; RL).*

Importantly, there was also an emphasis on sustainability and community ownership. Many participants felt strongly that while initial involvement from services is crucial, the long-term goal should be to empower the community to support itself. As one participant summarised, *'So how do we co-create...I think once the NHS has done some you know hand holding and steering. They can then, you know, gradually go in the background and communities and local organisations can actually take a lead role in managing and delivering these services. I think that's the service delivery model personally, I want to see.' (P22; RL).* Another participant also echoed this, *'Obviously, there are NHS mental health flyers in different languages but I think that language is just, you know, one aspect. You need to go beyond that, for example, if people talk about, you know, mental health, what kinds of books can I read or music can I listen to that will help. The services obviously won't be able to personalise or translate these books or music to the specific groups. So that is where, you know, communities can take ownership. They would know better than anybody else how to adapt these resources.' (P3; RL).*

4.2 Religious Leaders as Cultural Mediators and Collaborative Partners

Religious organisations and leaders themselves were viewed as key figures in bridging the gap between communities and formal mental health support structures. They were seen as integral to the social and cultural life of their communities which placed them in the unique positions to act as informal mediators. One religious leader shared, '*Yeah I mean lots of the community are reluctant to seek help, but then I think that is where places like temples and these, you know, cultural hubs, have a special role. They are able to help in these cases by sharing information and by bringing the experts to the places so people can easily access support in familiar environments rather than have them seek these kinds of avenues themselves, so it removes those barriers.' (P7; SU).*

Many religious leaders described how their organisations had already taken proactive steps to address mental health. However, while these initiatives were generally well received, several participants noted that they had reached a standstill and expressed a need for further guidance from relevant organisations. One participant shared, *'So we have done a lot of work to break the barriers of mental health stigma and taboo through various projects and workshops…so it's one thing to break that stigma but when people are approaching us with the problems and we're saying, wait, we don't know what service you can go to or I haven't got an expert to tell me what to do about it. I think that's what we need. That's where we are right now. We need organisations to start working with us to help people beyond this now.' (P22; RL).*

Participants generally were willing and open to collaboration with services and emphasised that collaboration should be reciprocal rather than one-sided, with services also taking time to understand the cultural and religious frameworks within which these leaders operate. One participant described how this has been done successfully at their organisation, *'So we offer Holistic well-being in the temple…and by calling the specialist to the temple, we kind of provide the community access to these physical health and also mental health resources. I think it is a win win* *because the NHS people are in the main hall so they can see how the community prays and in the same hall we have the specialists sitting and having conversations with people.' (P17; RL).* Religious organisations were therefore generally seen to have untapped potential to not only be supporters of mental health but as strategic partners in co-producing pathways to care.

Workshop Outcomes

The workshops provided valuable insights that echoed and reinforced many of the themes identified from the interview data. Barriers to accessing mental health support, particularly cultural stigma, lack of awareness, and challenges navigating the system, were again highlighted. A recurrent concern was the lack of adequate resources, such as appropriate funding, within both religious organisations and mental health services, which participants felt limited meaningful collaboration. Several attendees described difficulties in knowing who to contact within services, citing poor visibility and inconsistent communication as key obstacles. Despite these challenges, attendees from both workshops expressed a strong sense of the value in mutual partnership and showed a clear willingness to work collaboratively towards more integrated and culturally responsive approaches.

A central outcome of the workshops was ideas on what a co-produced referral pathway could look like and include. The recommendations were refined through post-workshop feedback and subsequently shared with the mental health service for consideration. Key components included:

1. *Religious organisations as key entry points for mental health conversations and further support*: faith spaces were seen as trusted environments where

early conversations about mental health could be normalised and guided sensitively.

2. *Trusted community volunteers acting as mental health champions*: introduction of respected community members or volunteers trained in mental health awareness to act as bridges between services and the community.
3. *Collaborative training and two-way mutual learning*: joint co-developed training sessions for religious organisations and mental health practitioners to foster mutual understanding and respect for cultural and clinical perspectives.
4. *Joint awareness campaigns and events*: engaging in community outreach for e.g. through co-hosted events during major religious festivals, to promote service awareness and challenge stigma within community spaces.
5. *Continuity of Culturally Responsive Care within Integrated Systems*: ensuring that individuals referred through these pathways receive ongoing, culturally sensitive care through integrated systems, including “warm handovers” (direct, personal transfer of care from one provider to another to maintain trust and engagement) and follow-ups.
6. *Culturally adapted accessible resources that are faith sensitive*: development of accessible and culturally adapted materials distributed through temples, community centres, and local networks, for example incorporating familiar religious concepts and teachings and adapting this to different target communities.

Although this was outside the scope of the current study, participants also acknowledged the need for wider organisation level changes and for this to be along the whole pathway through services from referral to discharge. Some of the suggestions included the need to diversify the workforce, incorporating family structures into treatment and including values-based questions during triage and assessments.

Discussion

Summary of Findings

This study aimed to better understand the role of religion, barriers, facilitators and potential pathways for improving mental health access for the Hindu and Sikh faith communities. Four overarching themes were developed through thematic analysis (Braun & Clarke, 2006), and subsequently preliminary ideas for potential referral pathways into services were collaboratively developed in the workshops. This research was important in addressing a significant gap in the literature around cultural and faith-informed service access, with insights aimed at informing more inclusive, collaborative, and community-rooted service pathways that reflect the needs of these marginalised groups.

Participants identified a range of complex and intersecting barriers to accessing and engaging with mental health services. At the community level, recurring challenges included cultural stigma, differing cultural understandings of mental health, and the spiritualisation of emotional distress. These findings align with previous research, which highlights how stigma operates both at a community and individual level, where fear of being seen as ‘weak’ or a ‘failure’ can often intersect with internalised shame and reluctance to disclose distress (Alam et al., 2024). A common theme across communities was the expectation to keep difficulties within the home or rely on ‘informal’ support systems such as religious organisations, which are often seen as more acceptable sources of help than professional services (Shefer et al., 2013). This reinforces the idea that dominant Western concepts of mental health may not resonate with all cultural groups. As prior research has shown, in many non-Western contexts, emotional wellbeing is not openly discussed and is often understood through religious or spiritual frameworks (Ibrahim & Whitley, 2021; Mantovani et al., 2017). In these contexts, mental health services may be viewed as a last resort, accessed only at points of crisis. It is therefore important to acknowledge how certain aspects of Western therapeutic models may clash with non-Western cultural values, and how culturally competent care must be flexible, guided and adapted meaningfully to the communities they serve.

Alongside cultural and community-level barriers, participants identified significant systemic challenges, including long waiting times, poor service visibility, and difficulty navigating fragmented pathways. These findings align with Corrigan et al.'s (2014) model which highlights how structural elements within systems can act as key obstacles to mental health care. While addressing stigma and mental health literacy at the community level is important, the data suggests this alone is insufficient. As supported in wider literature, a dual approach that addresses both structural and cultural barriers is needed, embedding flexibility, cultural safety, and continuity into care (Harwood et al., 2023; Rose & Kalathil, 2019).

Participants highlighted that faith plays a dual role in shaping mental health experiences; at times, contributing to delays in seeking help due to spiritual or supernatural interpretations of distress, but also offering valuable coping mechanisms through acts such as prayer, meditation, or community belonging. This echoes findings by Alhomaizi et al., (2018) where faith was shown to both facilitate and impede help-seeking. Furthermore, it is suggested that sole reliance on religious or spiritual practices may not always be sufficient, and an individual's active engagement in their own mental health journey is often necessary to effectively manage distress (Alam, 2023). While some participants described religious teachings and solutions as outdated and dismissive of their distress, others noted a positive shift, whereby religious organisations were increasingly recognising the evolving mental health needs of their communities and investing in initiatives that integrate religious beliefs with psychological frameworks, while also empowering individuals to seek additional help when needed. This underscores the importance of both personal agency and institutional adaptation, suggesting that meaningful change requires efforts from individuals, communities, and organisations working collaboratively.

Religious spaces and leaders were described as trusted, culturally familiar access points that could help bridge the gap between communities and mental health services. This aligns with several studies where faith leaders were sought as the first point of call for support with emotional distress instead of healthcare professionals (Dein et al., 2008; Leavey, 2010). For instance, a qualitative study found that 95% of imams reported spending a significant time each week counselling their congregation with mental health difficulties (Ali et al., 2005). However, consistent with the findings of the current study, while religious leaders expressed a willingness to collaborate with mental health services, there remained uncertainty around how to put this into practice, and actual referrals to mental health professionals remain low (Abu-Ras et al., 2008). Religious leaders were seen as influential mediators who, with the right training and collaborative partnerships, could promote help-seeking and reduce stigma. Participants advocated for a model of mutual learning between services and faith organisations, suggestions included using temples for awareness events, offering training to community volunteers and co-developing culturally relevant resources. These findings support previous calls for collaboration between faith-based and healthcare systems to enhance engagement among minoritised communities (Leavey et al., 2012; Loewenthal et al., 2012).

Encouragingly, participants across both interviews and workshops identified key facilitators and opportunities for improving mental health access, highlighting the importance of co-production in developing effective, culturally sensitive pathways. Co-production, where communities and services collaborate as equal partners, has been increasingly recognised as essential for creating sustainable and acceptable mental health interventions within diverse communities (Dowson et al., 2025; Rose & Kalathil, 2019). As an example, a pilot co-production initiative which developed personalised assessment systems for each participant, was successfully shown to achieve a 75% retention rate amongst Black African and Caribbean individuals accessing NHS Talking Therapies services (Lwembe et al., 2017). To build on the growing evidence, the workshops in this study represented an initial step toward co-production, allowing community and service stakeholders to reflect on interview findings and jointly generate practical recommendations for potential referral pathways into services. These approaches align with existing policies like the PCREF (NHS England, 2023) which advocates for community partnership models to address systemic inequalities in mental health service access. Participants expressed various suggestions including embedding mental health awareness and education within religious settings and integrating existing community-based resources like yoga and meditation into care pathways. Moreover, the emphasis on empowering communities to sustain support independently aligns with findings from previous research highlighting the value of community ownership and capacity-building in reducing barriers to care (Bansal et al., 2022; Tribe, 2019).

Strengths and Limitations

This study offers valuable insights into the perspectives of Hindu and Sikh communities on accessing mental health and what can be done to improve pathways into care. The qualitative methodology was strengthened by a sufficient sample size reported for thematic analysis and the use of validity checks, including independent coding by a second researcher to enhance credibility and trustworthiness (Braun & Clarke, 2013). The inclusion of both service users and community stakeholders, including religious leaders and mental health professionals, allowed for a multifaceted understanding of the issues. Furthermore, the combination of interviews and workshops allowed for triangulation and deeper exploration of key themes. Importantly, the study contributes new and underexplored knowledge to the literature, particularly regarding faith-informed pathways and collaborative approaches to address inequalities in mental health care for Hindu and Sikh faith groups, with clear clinical and policy implications.

However, several limitations must be acknowledged. Firstly, despite efforts to ensure trustworthiness, the interpretive nature of qualitative analysis and the researcher’s own positionality may have shaped how the findings were understood and presented. Secondly, this study did not make any distinctions between Hindu and Sikh groups; it is important to recognise the heterogeneity within and between these religious and cultural communities, which may have masked important differences in beliefs and experiences. Furthermore, although not intentional, the majority of participants identified as Hindu and of Indian background, limiting the ethnic and religious diversity of the sample and potentially overlooking the distinct experiences of Sikh communities and more specifically other Hindu or Sikh minority ethnic groups.

The sample was also largely composed of English-speaking participants, which may have excluded the voices of non-English speakers who often face additional barriers to access. The mean participant age was 46, and most were technologically literate, possibly limiting the generalisability of findings to older individuals or those less comfortable with digital platforms. The study was also limited to one NHS Talking Therapies service in a single geographical region, and all service user participants had previously accessed treatment. As such, the perspectives of those who dropped out or never accessed services remain underrepresented and it is difficult to generalise the findings to other mental health services. Lastly, religious leaders were recruited through established partnerships with the service or through personal connections and snowball sampling, therefore those recruited were likely already interested in the topic and open to collaboration. This creates potential bias, as voices with conflicting views may be underrepresented.

While these limitations are important to consider, it is important to note that qualitative research does not seek to make generalisable claims (Willig, 2008). Instead, it offers in-depth insights into the lived experiences of participants. Although the findings reflect the views of a specific group, there were clear themes across different accounts, which can inform more culturally responsive services and guide future partnership work and research.

Implications for Practice

The findings of this study highlight several important implications for mental health practice, particularly in the context of improving access for Hindu and Sikh faith groups. There was strong support for positioning religious organisations as legitimate and effective entry points into mental health care. As previous studies have shown, community members often express trust and comfort in discussing emotional wellbeing within faith contexts (Dein, 2020; Meran & Mason, 2019). These settings can therefore serve as vital gateways, particularly for individuals who may be hesitant to approach professional services directly. Embedding services within these trusted community spaces can help bridge this divide; the *Faith in Mental Health project and Spirit in Mind* are examples of successful community-led collaborative faith-sensitive models (Abrar & Hargreaves, 2023). Services should collaborate proactively with faith leaders and prioritise community outreach, recognising them not as gatekeepers to be educated, but as co-educators and co-designers of services (Parkes & Gilbert, 2010).

A recurring theme was the need to empower communities to take ownership of their mental wellbeing. Participants emphasised that while external support from services is important, long-term change requires building capacity within the community. Training trusted community volunteers as mental health champions provides a scalable and culturally appropriate model of early intervention. Co-produced mental health projects like that developed by Lwembe et al. (2017) demonstrate how empowering individuals with lived experience can dismantle barriers and increase engagement. Participants also emphasised the need for continuity once someone engages with services, hence, community champions could therefore fill this gap. These champions should not operate in isolation however, but in coordination with services, ideally forming a visible referral bridge between the community and service.

The findings reaffirm that effective collaboration is built on *two-way* mutual learning. Health professionals must be given space for reflective practice, and training on religious literacy, cultural humility, and systemic barriers such as racism and stigma (Beck et al., 2019; Rae, 2014). Integrating community expertise into professional development, such as consulting religious leaders, developing workshops and training sessions, or engaging with local mental health initiatives, should be routine. As highlighted by Abrar & Hargreaves (2023), models such as the *Greater Manchester Mental Health Spiritual Care Strategy* can be referred to as successful practical examples of this. Furthermore, service engagement is compromised when care is experienced as culturally unsafe. Several studies highlight how services often fail to meet the intersectional needs of service users from racially minoritised communities (Bhattacharyya & Benbow, 2013; Memon et al., 2016). Services must therefore prioritise developing safe spaces where faith and culture are welcomed. One way services may achieve this is to diversify and culturally equip their workforces, ensuring minoritised communities are represented and have more choice in who they see (Rae, 2014).

Effective service design must include visible and inclusive awareness efforts that address stigma and misinformation. The findings suggest that faith-sensitive campaigns co-designed with religious groups and delivered in familiar spaces such as gurdwaras and temples and platforms such as community TV channels are more likely to resonate (Sancho & Larkin, 2020). Involving trusted community leaders who have a genuine commitment to community wellbeing and are well placed to encourage engagement was seen as essential in building trust and relevance (Gafari et al., 2024). Furthermore, more media visibility of lived experiences of religious minority groups accessing support such as on service websites could help to challenge stigma and normalise help-seeking (Alam et al., 2024).

There is an urgent need for culturally adapted, faith-literate resources that do not pathologise difference but integrate community strengths. These resources should be co-designed with community input, as credibility of messages can be determined by who is communicating and what is being said (Clabburn et al., 2025). Service providers must fund existing grassroots organisations that hold the cultural knowledge and credibility to co-produce such interventions. This needs to move beyond tokenistic consultation and toward equitable partnership, recognising the validity of community-based expertise (Clabburn et al., 2025; Nakash et al., 2019).

Although the need for clearer and accessible referral pathways is clear from the findings in this study, to fully address inequalities in mental health access, systems must move from addressing individual symptoms to focusing more attention on the systemic and structural barriers that uphold these disparities (Bansal et al., 2022). Mental health services must first explore barriers to meaningful co-production and build the capacity to work effectively with communities to prevent increased referrals leading to disengagement due to inadequate or harmful support. The BAME positive practice guide outlines essential action on how Talking Therapies services can offer culturally safe and effective care (Beck et al., 2019). As highlighted in several studies, equity cannot be achieved without a shift in power, where healthcare systems centre lived experiences, decolonise healthcare, and promote anti-oppressive and anti-racist practice (Clabburn et al., 2025; Prajapati & Liebling, 2022).

Implications for Research

There are important ways in which this study can be expanded and other areas of interest which can be explored based on the findings. Firstly, future research can build on the initial recommendations for the co-produced pathway by continuing to develop and implement this at a local level. A longitudinal study is needed to evaluate the long-term efficacy and sustainability of this pathway on access outcomes to NHS Talking Therapies services for Hindu and Sikh faith groups. This process must be rooted in ongoing community and service collaboration, adapting the intervention to local contexts while maintaining a core framework of shared understanding, mutual respect, and cultural relevance.

This study contributes to a growing body of work that highlights the critical role of faith-based models and interventions that support the mental health needs of religious minority communities. However, the current lack of UK-based empirical evidence on mental health pathways for racially minoritised communities such as Hindu and Sikh faith groups has been widely noted (Clabburn et al., 2025; Sass et al., 2009). Much of the existing research, especially in the grey literature, is poorly evaluated, lacking a research framework or systematic data collection (Moffat et al., 2009). High-quality, mixed-methods research is therefore needed to assess processes of service co-production between faith organisations and services, document cultural and faith adaptations, and evaluate their outcomes. This may include developing culturally valid outcome measures that capture the impact of community co-produced models and interventions.

Furthermore, faith leaders appeared to actively encourage Hindu and Sikh communities to access mental health support and even offer this internally. However, more research is needed to explore how these judgements are made in practice, how they interact with clinical frameworks, and what consequences these decisions hold for individuals in distress i.e. whether individuals actually act on these recommendations. Understanding the lived experience of help-seeking in this space, including the satisfaction of Hindu and Sikh individuals who have approached faith leaders for mental health support ,would offer valuable insights into both community expectations and gaps in provision. Finally, as this study explored Hindu and Sikh participants as a broader group, future research could investigate the distinct perspectives and experiences of specific communities within these faiths, such as Gujarati Hindus or Punjabi Sikhs, and examine how intersecting factors like migration history, trauma, and social context influence access to and experiences of care. Taking an intersectional approach will help ensure that interventions are grounded in the real-world complexity of people's lives.

Conclusion

In conclusion, to the authors' knowledge, this is one of the first studies in the UK to explore the perspectives of service users, mental health professionals and religious leaders on co-producing referral pathways to mental health care for Hindu and Sikh communities. These findings provide new insights into how cross-sector collaboration can address long-standing barriers to access and improve trust in services. Some key contributions include a clearer understanding of how religious leaders currently support mental health needs, the various training and partnerships that could enhance this support and identification of opportunities to embed mental health promotion and literacy within religious and community spaces in ways that are culturally and faith sensitive.

Importantly, the study highlights the value of co-production, shared decision-making, and mutual learning between statutory services and faith-based organisations. The process of building trust and relationships emerged as central to meaningful, sustainable change. While the study outlines the initial steps of pathway development, it lays the groundwork for further development, implementation, and evaluation, acting as the first step on an important journey. Ultimately, improving access and outcomes for religious minority groups will require not just adaptation but structural change, achieved through collaboration, anti-oppressive practices, and community leadership.

References

Abrar, S., & Hargreaves, J. (2023). Mental health services for Muslim communities in England and Wales: Developing a more collaborative model. *Mental Health, Religion & Culture*, *26*(9), 925–940. https://doi.org/10.1080/13674676.2023.2283116

Abu-Ras, W., Gheith, A., & Cournos, F. (2008). The Imam's Role in Mental Health Promotion: A Study at 22 Mosques in New York City's Muslim Community. *Journal of Muslim Mental Health*, *3*(2), 155–176. https://doi.org/10.1080/15564900802487576

Alam, S. (2023). British-Bangladeshi Muslim men: Removing barriers to mental health support and effectively supporting our community. *The Cognitive Behaviour Therapist*, *16*, e38. https://doi.org/10.1017/S1754470X2300034X

Alam, S., O'Halloran, S., & Fowke, A. (2024). What are the barriers to mental health support for racially-minoritised people within the UK? A systematic review and thematic synthesis. *The Cognitive Behaviour Therapist*, *17*, e10. https://doi.org/10.1017/S1754470X24000084

Alderwick, H., & Dixon, J. (2019). The NHS long term plan. *BMJ*, l84. https://doi.org/10.1136/bmj.l84

Alhomaizi, D., Alsaidi, S., Moalie, A., Muradwij, N., Borba, C. P. C., & Lincoln, A. K. (2018). An Exploration of the Help-Seeking Behaviors of Arab-Muslims in the US: A Socio-ecological Approach. *Journal of Muslim Mental Health*, *12*(1). https://doi.org/10.3998/jmmh.10381607.0012.102

Ali, O. M., Milstein, G., & Marzuk, P. M. (2005). The Imam's Role in Meeting the Counseling Needs of Muslim Communities in the United States. *Psychiatric Services*, *56*(2), 202–205. https://doi.org/10.1176/appi.ps.56.2.202

Bansal, N., Karlsen, S., Sashidharan, S. P., Cohen, R., Chew-Graham, C. A., & Malpass, A. (2022). Understanding ethnic inequalities in mental healthcare in the UK: A meta-ethnography. *PLOS Medicine*, *19*(12), e1004139. https://doi.org/10.1371/journal.pmed.1004139

Beck, A., Naz, S., Brooks, M., & Jankowska, M. (2019). *IAPT: BAME Service User Positive Practice Guide.* BABCP. Retrieved July 7th, 2025, from: https://babcp.com/Therapists/BAME-Positive-Practice-Guide-PDF

Bhattacharyya, S., & Benbow, S. M. (2013). Mental health services for black and minority ethnic elders in the United Kingdom: A systematic review of innovative practice with service provision and policy implications. *International Psychogeriatrics*, *25*(3), 359–373. https://doi.org/10.1017/S1041610212001858

Bhui, K., Halvorsrud, K., & Nazroo, J. (2018). Making a difference: Ethnic inequality and severe mental illness. *The British Journal of Psychiatry*, *213*(4), 574–578. https://doi.org/10.1192/bjp.2018.148

Bhui, K. S., & McKenzie, K. (2008). Rates and Risk Factors by Ethnic Group for Suicides Within a Year of Contact With Mental Health Services in England and Wales. *Psychiatric Services*, *59*(4), 414–420. https://doi.org/10.1176/ps.2008.59.4.414

Bhui, K., Stansfeld, S., Hull, S., Priebe, S., Mole, F., & Feder, G. (2003). Ethnic variations in pathways to and use of specialist mental health services in the UK: Systematic review. *British Journal of Psychiatry*, *182*(2), 105–116. https://doi.org/10.1192/bjp.182.2.105

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101.

https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. SAGE Publications.

Braun, V., & Clarke, V. (2023). Toward good practice in thematic analysis: Avoiding common problems and be(com)ing a *knowing* researcher. *International Journal of Transgender Health*, *24*(1), 1–6. https://doi.org/10.1080/26895269.2022.2129597

Clabburn, O., Stone, T., Anwar, N., Saleem, T., Khan, S., Hewat, V., Grieve, U., Dawson, L., Farr, M., Redwood, S., & Selman, L. E. (2025). Co-production in practice: A qualitative study of the development of advance care planning workshops for South Asian elders. *Palliative Medicine*, *39*(1), 126–138. https://doi.org/10.1177/02692163241302678

Corrigan, P. W., Druss, B. G., & Perlick, D. A. (2014). The Impact of Mental Illness Stigma on Seeking and Participating in Mental Health Care. *Psychological Science in the Public Interest*, *15*(2), 37–70. https://doi.org/10.1177/1529100614531398

Dein, S. (2020). Religious healing and mental health. *Mental Health, Religion & Culture*, *23*(8), 657–665. https://doi.org/10.1080/13674676.2020.1834220

Dein, S., Alexander, M., & Napier, A. D. (2008). *Jinn* , Psychiatry and Contested Notions of Misfortune among East London Bangladeshis. *Transcultural Psychiatry*, *45*(1), 31–55. https://doi.org/10.1177/1363461507087997

Dein, S., Cook, C. C. H., Powell, A., & Eagger, S. (2010). Religion, spirituality and mental health. *The Psychiatrist*, *34*(2), 63–64. https://doi.org/10.1192/pb.bp.109.025924

Department of Health (2008), IAPT Implementation Plan: National Guidelines for

Regional Delivery, *Department of Health*, London.

Dowson, M., Edge, D., & Morris, L. (2025). ‘That feels alien to me, to be honest’: Using Applied Thematic Analysis to co-produce a culturally adapted psychosocial intervention with Sikh carers of people living with dementia. *Aging & Mental Health*, *29*(7), 1321–1328. https://doi.org/10.1080/13607863.2025.2478521

Gafari, O., Bahrami-Hessari, M., Norton, J., Parmar, R., Hudson, M., Ndegwa, L., Agyapong-Badu, S., Asante, K. P., Alwan, N. A., McDonough, S., Tully, M. A., Calder, P. C., Barker, M., & Stokes, M. (2024). Building trust and increasing inclusion in public health research: Co-produced strategies for engaging UK ethnic minority communities in research. *Public Health*, *233*, 90–99. https://doi.org/10.1016/j.puhe.2024.05.007

Guest, G., Bunce, A., & Johnson, L. (2006). How Many Interviews Are Enough?: An Experiment with Data Saturation and Variability. *Field Methods*, *18*(1), 59–82. https://doi.org/10.1177/1525822X05279903

Guest, G., Namey, E., & McKenna, K. (2017). How Many Focus Groups Are Enough? Building an Evidence Base for Nonprobability Sample Sizes. *Field Methods*, *29*(1), 3–22. https://doi.org/10.1177/1525822X16639015

Hammad, J., El-Guenuni, A., Bouzir, I., & El-Guenuni, F. (2020). 20201218. *Journal of Muslim Mental Health*, *14*(2). https://doi.org/10.3998/jmmh.10381607.0014.202

Harwood, H., Rhead, R., Chui, Z., Bakolis, I., Connor, L., Gazard, B., Hall, J., MacCrimmon, S., Rimes, K. A., Woodhead, C., & Hatch, S. L. (2023). Variations by ethnicity in referral and treatment pathways for IAPT service users in South London. *Psychological Medicine*, *53*(3), 1084–1095.

https://doi.org/10.1017/S0033291721002518

Ibrahim, A., & Whitley, R. (2021). Religion and mental health: A narrative review with a focus on Muslims in English-speaking countries. *BJPsych Bulletin*, *45*(3), 170–174. https://doi.org/10.1192/bjb.2020.34

Kang, C. (2010). Hinduism and Mental Health: Engaging British Hindus. *Mental Health, Religion & Culture*, *13*(6), 587–593. https://doi.org/10.1080/13674676.2010.488427

Kiang, L., Stein, G. L., & Juang, L. P. (2022). Ethnic and racial identity of immigrants and effects on mental health. *Current Opinion in Psychology*, *47*, 101424. https://doi.org/10.1016/j.copsyc.2022.101424

Lawani, A. (2021). Critical realism: What you should know and how to apply it. *Qualitative Research Journal*, *21*(3), 320–333. https://doi.org/10.1108/QRJ-08-2020-0101

Lawton, L., McRae, M., & Gordon, L. (2021). Frontline yet at the back of the queue – improving access and adaptations to CBT for Black African and Caribbean communities. *The Cognitive Behaviour Therapist*, *14*, e30. https://doi.org/10.1017/S1754470X21000271

Layard, R., Clark, D., Knapp, M., & Mayraz, G. (2007). Cost-benefit analysis of psychological therapy. *National Institute Economic Review*, *202*, 90–98. https://doi.org/10.1177/0027950107086171

Leavey, G. (2010). The Appreciation of the Spiritual in Mental Illness: A Qualitative Study of Beliefs Among Clergy in the UK. *Transcultural Psychiatry*, *47*(4), 571–590. https://doi.org/10.1177/1363461510383200

Leavey, G., Dura-Vila, G., & King, M. (2012). Finding common ground: The boundaries and interconnections between faith-based organizations and mental health services. *Mental Health, Religion & Culture, 15*(4), 349–362.

Leavey, G., Loewenthal, K., & King, M. (2007). Challenges to sanctuary: The clergy as a resource for mental health care in the community. *Social Science & Medicine*, *65*(3), 548–559. https://doi.org/10.1016/j.socscimed.2007.03.050

Loewenthal, D., Mohamed, A., Mukhopadhyay, S., Ganesh, K., & Thomas, R. (2012). Reducing the barriers to accessing psychological therapies for Bengali, Urdu, Tamil and Somali communities in the UK: Some implications for training, policy and practice. *British Journal of Guidance & Counselling*, *40*(1), 43–66. https://doi.org/10.1080/03069885.2011.621519

Lwembe, S., Green, S. A., Chigwende, J., Ojwang, T., & Dennis, R. (2017). Co-production as an approach to developing stakeholder partnerships to reduce mental health inequalities: an evaluation of a pilot service. *Primary health care research & development*, *18*(1), 14–23. https://doi.org/10.1017/S1463423616000141

Mahmud, A. (2024). Addressing inequalities in accessing mental health services for Muslim university students in the United Kingdom: Implications for attainment and wellbeing. *Journal of Beliefs & Values*, 1–16. https://doi.org/10.1080/13617672.2024.2320013

Mantovani, N., Pizzolati, M., & Edge, D. (2017). Exploring the relationship between stigma and help-seeking for mental illness in African-descended faith communities in the UK. *Health Expectations*, *20*(3), 373–384. https://doi.org/10.1111/hex.12464

Memon, A., Taylor, K., Mohebati, L. M., Sundin, J., Cooper, M., Scanlon, T., & De Visser, R. (2016). Perceived barriers to accessing mental health services among black and minority ethnic (BME) communities: A qualitative study in

Southeast England. *BMJ Open*, *6*(11), e012337. https://doi.org/10.1136/bmjopen-2016-012337

Meran, S., & Mason, O. (2019). Muslim Faith Leaders: De Facto Mental Health Providers and Key Allies in Dismantling Barriers Preventing British Muslims from Accessing Mental Health Care. *Journal of Muslim Mental Health*, *13*(2). https://doi.org/10.3998/jmmh.10381607.0013.202

Moffat, J., Sass, B., Mckenzie, K., & Bhui, K. (2009). Enhancing pathways & mental healthcare for BME groups: Learning between the ideological and operational. *International Review of Psychiatry*, *21*(5), 450–459. https://doi.org/10.1080/09540260802202075

Morgan, C., Mallett, R., Hutchinson, G., & Leff, J. (2004). Negative pathways to psychiatric care and ethnicity: The bridge between social science and psychiatry. *Social Science & Medicine*, *58*(4), 739–752. https://doi.org/10.1016/S0277-9536(03)00233-8

Nakash, O., Lambez, T., Cohen, M., & Nagar, M. (2019). Religiosity and barriers to mental healthcare: A qualitative study among clients seeking community mental health services. *Mental Health, Religion & Culture*, *22*(5), 437–452. https://doi.org/10.1080/13674676.2018.1489377

Naqvi, H., Gabriel, M., & Adebowale, V. (2022). The critical role of the NHS Race and Health Observatory. *BMJ Leader*, *6*(2), 130–131. https://doi.org/10.1136/leader-2021-000505

Naz, S., Gregory, R., & Bahu, M. (2019). Addressing issues of race, ethnicity and culture in CBT to support therapists and service managers to deliver culturally competent therapy and reduce inequalities in mental health provision for BAME service users. *The Cognitive Behaviour Therapist*, *12*, e22.

https://doi.org/10.1017/S1754470X19000060

NHS England. (2023). *Patient and Carer Race Equality Framework (PCREF)*. Retrieved July 7th, 2025, from: https://www.england.nhs.uk/mental-health/pcref/

NHS Race and Health Observatory. (2022). *Ethnic inequalities in healthcare: A rapid evidence review*. Retrieved July 7th, 2025, from: https://www.nhsrho.org/publications/ethnic-inequalities-in-healthcare/

Office for National Statistics. (2021). *Census 2021*. Retrieved July 7th, 2025, from: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/censusbasedstatisticsuk2021

Parkes, M., & Gilbert, P. (2010). Gods and gurdwaras: The Spiritual Care Programme at the Birmingham and Solihull Mental Health Foundation NHS Trust. *Mental Health, Religion & Culture*, *13*(6), 569–583. https://doi.org/10.1080/13674676.2010.488437

Parry, G., Barkham, M., Brazier, J., Dent-Brown, K., Hardy, G., Kendrick, T., Rick, J., Chambers, E., Chan, T., Connell, J., Hutten, R., Lusignan, S. D., Mukuria, C., Saxon, D., Bower, P., & Lovell, K. (2011). *An evaluation of a new service model: Improving Access to Psychological Therapies demonstration sites 2006-2009*. National Institute for Health Research. https://doi.org/10.13140/2.1.2983.0726

Pope, C., & Mays, N. (Eds.). (2006). *Qualitative Research in Health Care* (1st ed.). Wiley. https://doi.org/10.1002/9780470750841

Prajapati, R., & Liebling, H. (2022). Accessing Mental Health Services: A Systematic Review and Meta-ethnography of the Experiences of South Asian Service Users in the UK. *Journal of Racial and Ethnic Health Disparities*, *9*(2), 598–

619. https://doi.org/10.1007/s40615-021-00993-x

Rae, S. (2014). *Somali male refugees: Perceptions of Depression and Help-Seeking*. https://doi.org/10.13140/RG.2.2.29682.15049

Rose, D., & Kalathil, J. (2019). Power, Privilege and Knowledge: The Untenable Promise of Co-production in Mental “Health”. *Frontiers in Sociology*, *4*, 57. https://doi.org/10.3389/fsoc.2019.00057

Sancho, T. N., & Larkin, M. (2020). “We need to slowly break down this barrier”: Understanding the barriers and facilitators that Afro-Caribbean undergraduates perceive towards accessing mental health services in the UK. *Journal of Public Mental Health*, *19*(1), 63–81. https://doi.org/10.1108/JPMH-12-2019-0099

Sass, B., Moffat, J., Bhui, K., & Mckenzie, K. (2009). Enhancing pathways to care for black and minority ethnic populations: A systematic review. *International Review of Psychiatry*, *21*(5), 430–438. https://doi.org/10.1080/09540260802204121

Shefer, G., Rose, D., Nellums, L., Thornicroft, G., Henderson, C., & Evans-Lacko, S. (2013). ‘Our community is the worst’: The influence of cultural beliefs on stigma, relationships with family and help-seeking in three ethnic communities in London. *International Journal of Social Psychiatry*, *59*(6), 535–544. https://doi.org/10.1177/0020764012443759

Singh, D. R., Sah, R. K., Simkhada, B., & Darwin, Z. (2023). Potentials and challenges of using co-design in health services research in low- and middle-income countries. *Global Health Research and Policy*, *8*(1), 5. https://doi.org/10.1186/s41256-023-00290-6

Singh, K. (2008). The Sikh spiritual model of counseling. *Spirituality and Health*

International, *9*(1), 32–43. https://doi.org/10.1002/shi.331

Tribe, R. (2019). Using co-production within mental health training when working with refugee or migrant community groups. *International Journal of Mental Health*, *48*(4), 330–337. https://doi.org/10.1080/00207411.2019.1693087

Vahdaninia, M., Simkhada, B., Van Teijlingen, E., Blunt, H., & Mercel-Sanca, A. (2020). Mental health services designed for Black, Asian and Minority Ethnics (BAME) in the UK: A scoping review of case studies. *Mental Health and Social Inclusion*, *24*(2), 81–95. https://doi.org/10.1108/MHSI-10-2019-0031

Willig, C. (2008). *Introducing qualitative research in psychology: Adventures in theory and method* (2nd ed.). Open University Press.

Willig, C. (2013). *Introducing qualitative research in psychology* (3rd ed.). Open University Press.

Part 3: Critical Appraisal

Introduction

In this critical appraisal, I will reflect on my experience of carrying out the empirical study in part two of this thesis. The reflections I will present will aim to discuss the concept of reflexivity, how this was accounted for within the research and how my own positions and preconceptions may have impacted the research process. I will also discuss some of the challenges I experienced during recruitment, interviews and the data analysis stages. Lastly, I will reflect on some of the professional and personal insights I have gained throughout this process.

Reflexivity and Influences on Research

Reflexivity is a foundational aspect of qualitative research, referring to the ongoing critical examination of how the researcher's own positionality, assumptions, and values influence every stage of the research process (Berger, 2015; Olmos-Vega et al., 2023). It acknowledges that the researcher is not a neutral observer but an integral part of the research instrument itself (Mitchell et al., 2018). In this sense, knowledge is understood as co-constructed, shaped by personal, methodological, and contextual factors. My own positionality may differ from the socio-cultural frameworks through which racially minoritised groups view emotional wellbeing and distress. For example, participants may interpret mental health through religious or spiritual lenses, which may contrast with my own clinical background. Additionally, my communication style, the questions I asked, and the areas I chose to explore during data collection were inevitably influenced by my own cultural lens and theoretical learning. Recognising this, I engaged in continuous introspection regarding how my perspectives could shape the findings.

Bracketing, an approach that involves attempting to suspend preconceptions to maintain objectivity, has traditionally been suggested as a way to enhance credibility. However, this view has evolved, with many qualitative researchers arguing that complete neutrality is neither attainable nor necessarily beneficial. Instead, they advocate for openly acknowledging and critically engaging with researcher subjectivity (Fischer, 2009). Reflexivity is therefore not a one-off exercise but a continuous process (Tufford & Newman, 2012). In this study, I adopted both individual and collaborative reflexivity strategies, such as keeping reflective notes, seeking regular supervision, and discussing my analysis with peers. Importantly, I shared preliminary themes with participants during the workshops as a way to not only seek feedback but to foster dialogue and challenge my interpretations. As Hofmann & Barker (2017) note, reflexivity addresses the reciprocal influence between the researcher and all aspects of the study, including the participants, the data, and the findings themselves. By acknowledging my positionality and engaging reflexively, I aimed to enhance the transparency and credibility of this research.

‘Insider research’ involves conducting research with groups with whom the researcher shares an identity or lived experience (Dwyer & Buckle, 2009). While this can help build trust and rapport, it also presents challenges such as whether to disclose one’s position. This might enhance openness but also risk assumptions of shared understanding, potentially limiting the depth and clarity of participants’ accounts (Hofmann & Barker, 2017; Valentine, 2007). The topic of this study was chosen predominantly due to my own interests in religion and spirituality, and from my experiences of being part of the Hindu community and noticing the lack of representation of Hindu and Sikh groups in services in my many years of working in mental health. This is something I had to reflect on throughout the research process and I spent some time debating how much of my position to disclose to participants, as to not wanting to bias responses. From my experience, I felt one of two things could happen: (1) participants might feel more comfortable opening up to me, due to sharing a similar cultural background and therefore being able to better understand the context of their experiences, or, (2) some might also feel more hesitant, concerned that my connection to the same community could raise fears about confidentiality or judgment therefore closing some avenues of conversation. However, I felt not being honest with participants, who I was asking to share some of their in-depth personal experiences, felt uncomfortable and against the main theme of collaboration which the study centred around. I therefore decided to be open about my motivations and background to those who directly asked, trying to defer this to the end of the interviews so it would not impact on the discussions. I also found that once participants had read through the study information, they were generally eager and willing to be open about their experiences. Additionally, being open and honest with participants about my background really helped to build trust in the relationship which is particularly important due to the mistrust these communities have towards services and professionals.

It is important to note that, although there were many similarities between my experiences as a British Indian from a Hindu religious background and those of the participants, important differences also existed. Maintaining a critical distance was therefore essential to avoid making assumptions or projecting my own perspectives onto their narratives, and to ensure that each participant's unique viewpoint was understood and represented on its own terms. This led me to reflect on the dichotomy of the 'insider' and 'outsider' position. Dwyer & Buckle (2009) suggest that rigid distinctions between 'insider' and 'outsider' perspectives overlooks the nuanced and shifting nature of identity and experience. Reflecting on my own position, I found myself occupying a ‘space in between’, sharing some commonalities with participants while also maintaining professional and observed differences due to my role and training. This fluid position highlights the complexity of researcher identity and the importance of acknowledging how researchers both influence and are influenced by the research process (Breen, 2007; Dwyer & Buckle, 2009).

NHS Ethics and Recruitment Process

As with many research projects, I encountered several unforeseen practical challenges throughout the study. One of the more significant hurdles was navigating the National Health Service (NHS) ethics approval process; this was something I had not encountered before and I found the process to be time-consuming and, at times, frustrating. Although my study did not involve a clinical intervention, I felt it was still subjected to a high level of scrutiny, reflecting the cautious approach of ethics committees towards research. There seemed to be a lot of back and forth and hoops to go through before ethics approval was eventually obtained. While I appreciated the importance of safeguarding participants and maintaining high ethical standards, the experience made me reflect on how the complexity and intensity of the process might deter future trainees or researchers from pursuing similar work. This might also be one of the explanations for the lack of research clinical psychologists conduct following qualification.

After some consideration, I decided to recruit through an NHS Talking Therapies service as I had several years of experience working in these services before training, which gave me a better understanding of how the system operates and the well-documented issues around inequitable access. These services are also usually the first point of contact for individuals seeking support for common mental health difficulties, making them a relevant setting for this research. My familiarity with these services also allowed me to consider how staff often perceive research as an added burden amidst existing pressures, so I took care to ensure the research process was as minimally disruptive as possible.

Recruitment for the study proved to be one of the most challenging and time-consuming aspects of the research process. The initial low response rate and limited uptake from potential participants felt disheartening and, at times, demotivating. Although the NHS Talking Therapies service supported the study as a Participation Identification Centre, the anticipated responses from local religious leaders and faith-based organisations were minimal. This led me to pursue independent recruitment, reaching out to a wide range of Hindu and Sikh community organisations across the UK, both in-person and remotely. However, gaining access to these communities came with many obstacles. In many cases, unless I had an existing contact within the organisation, progress was stalled. Often, participation decisions had to be approved by entire committees, and proposals were passed through multiple layers of leadership causing significant delays. I also found that it was because of my own lived experiences and familiarity with these communities that gained me initial access and allowed me to build trust. I reflected on how this process mirrored many of the same barriers that community members might face when attempting to access support from organisations and services. A key breakthrough came when a national faith-based forum and a large community organisation agreed to support recruitment, which significantly increased participation. This experience highlighted the importance of services taking the time to understand the structure, values, and decision-making processes within religious organisations. It also underscored the value of working with individuals who are embedded within the community, speak the language, and understand cultural nuances, factors that can be instrumental in building trust and initiating meaningful partnerships.

In deciding which religious groups to focus on, Hindu and Sikh communities were selected due to shared cultural and spiritual frameworks, which provided a basis for exploring common themes while also aiding recruitment by drawing from a larger potential participant pool. Additionally, while searching existing literature there was a lack of research on these communities and given the exploratory nature of the study, the aim was to gain an initial understanding of experiences and perceptions that future research could build upon. However, it is important to acknowledge the limitations of grouping minority faith communities together, as this risks homogenising diverse populations and missing important within-group differences (Gerrish, 2000). Future studies should therefore aim to explore the unique experiences of specific religious minority sub-groups to better reflect the heterogeneity that exists within and between these communities.

Another key challenge in this research was developing a recruitment strategy that could effectively recruit ‘hard to reach’ service users. Initially, I considered recruiting from communities regardless of service use. However, given the premise that this group underutilises services, I anticipated that many of the same barriers might also prevent participation in the study. As a result, I focused on individuals who had already accessed mental health services as these records were already routinely collated by the Talking Therapies service. While this meant their barriers had been overcome or were less prominent, it allowed the study to explore both obstacles and the factors that facilitated access, offering a more balanced and potentially service-relevant perspective than previous literature.

Interviews and Analysis

As this study was exploratory and there was limited research specifically focusing on this participant group, the development of the interview schedule therefore drew on themes identified in existing literature involving other populations. I also included areas that have received less attention, such as facilitators to mental health service access, in order to capture a broader understanding of participants' experiences. While this approach generated rich and wide-ranging data, on reflection, I may have tried to explore too many topics within a single interview, which made the analysis process more complex and at times overwhelming. Additionally, in the early stages of data collection, I was quite rigid in adhering to the interview schedule, feeling the need to ask every question. This sometimes resulted in lengthy interviews that may have impacted the flow of conversation. However, as the interviews progressed, I became more confident in using the schedule as a flexible guide rather than a script. I began to follow participants' lines of thought more naturally, which helped foster better flow and depth in the interviews. I also learned to better judge which areas warranted deeper exploration, resulting in more focused and balanced conversations over time.

Throughout the research process, I was mindful of how my clinical training could shape my approach to the interviews, particularly the tendency to manage emotions and offer support. I tried to remain focused on the distinct aims of research, resisting the urge to interpret or intervene, though it became especially challenging when participants asked for advice or reassurance about their experiences. Conducting the interviews was at times emotive and challenging. There were times where I slipped into my therapist role, blurring the boundaries between researcher and clinician. Conversely, there were interviews where participants offered brief or limited responses, which initially left me feeling anxious about the richness of the data. Reflecting on this, I recognised how my clinical training had shaped expectations around insight and emotional expression, expectations that not all participants shared. Through journaling and bracketing, I came to accept that each account was valid, regardless of depth or detail. I also learned the importance of using my clinical skills to support participants in sharing their stories at a pace and depth that felt safe, while remembering that, unlike therapy, the role of the researcher is not to intervene but to hold space and listen.

I also faced some challenges in adopting a qualitative approach, particularly as it required a different way of thinking and engaging with the data compared to my previous experience with quantitative research. I noticed when engaging with and applying Thematic Analysis (TA) that I was approaching the data too objectively, which limited my ability to identify meaningful codes and develop relevant themes. Discussing my initial analysis with the research team offered a valuable shift in perspective and helped me begin to interpret the underlying meaning in participants' accounts. This changed how I approached both coding and theme development. Re-engaging with the data for a second round of coding allowed me to form a deeper, more reflective relationship with the material. This experience highlighted the importance of taking the time to fully understand the analytical method being used, particularly in qualitative research, where one’s values, beliefs, and epistemological stance are closely intertwined with the interpretative process.

Professional and Personal Learning

Engaging in this research had an impact on me both personally and professionally. Many of the participants’ stories deeply resonated with my own lived experiences, creating a strong sense of connection. At the same time, hearing their perspectives helped me uncover new insights I had not previously considered, likely shaped by my position as a clinician. While I anticipated accounts of barriers and challenges in accessing mental health support, I was also struck by the positive reflections participants shared, particularly around the importance of feeling safe and listened to. These moments reaffirmed the importance of my role as a clinician in creating a therapeutic space where people feel heard, validated, and empowered, reminding me of the meaningful impact that such relationships can have. I was also left with a sense of hope and inspiration, seeing the genuine passion and willingness of the community to engage with this work. This made me reflect on the potential of meaningful co-production and the possibilities that emerge when services truly collaborate with the communities they aim to support.

Throughout the research process, I felt a strong sense of responsibility to take the work forward in a meaningful and impactful way. I was acutely aware of the trust participants had placed in me, particularly as some shared experiences of engaging with previous research that had not led to visible change. This was difficult to sit with, and I often found myself questioning whether I was doing enough. I came to recognise that while research can be a powerful tool for change, progress is often slow, and systemic barriers are deeply embedded which can take time to dismantle. Nonetheless, this experience reinforced for me the value of research and the importance of thinking beyond data collection, for example, considering how findings can be meaningfully disseminated, how they can inform practice and policy, and how the process itself can be a helpful and empowering experience for participants. Although it is difficult to know precisely how each person experienced the interviews and workshops, for many, it appeared to be a meaningful and helpful process. A number of participants shared during the interviews and workshops that they were glad to have been involved, and that the space allowed for community connection, shared reflection, and a sense of collective agency to begin initiating change from within.

Conclusion

Reflecting on the research process, there were a number of methodological and conceptual challenges that required ongoing reflection. As a clinician-researcher exploring mental health access among underrepresented communities, I became increasingly aware of how my dual roles could both enrich and complicate the research process. The choices made at each stage were shaped by underlying assumptions that needed to be acknowledged rather than overlooked. This process highlighted the importance of maintaining critical reflexivity throughout, particularly when researching culturally sensitive experiences from a Western clinical lens. Engaging in reflective activities, including journaling and supervisory discussions, helped me examine how my own values and professional background might influence the data and its interpretation. Ultimately, I found the research to be engaging and personally meaningful, offering a valuable opportunity to hear directly from participants and reflect on my experiences as a researcher, an area that is often overlooked.

References

Berger, R. (2015). Now I see it, now I don't: Researcher's position and reflexivity in qualitative research. *Qualitative Research, 15*(2), 219-234.

Breen, L. J. (2007). The researcher 'in the middle': Negotiating the insider/outsider dichotomy. *The Australian Community Psychologist, 19*(1), 163-174.

Dwyer, S. C., & Buckle, J. L. (2009). The Space Between: On Being an Insider-Outsider in Qualitative Research. *International Journal of Qualitative Methods*, *8*(1), 54–63. https://doi.org/10.1177/160940690900800105

Fischer, C. T. (2009). Bracketing in qualitative research: Conceptual and practical matters. *Psychotherapy Research*, *19*(4–5), 583–590. https://doi.org/10.1080/10503300902798375

Gerrish, K. (2000). Researching ethnic diversity in the British NHS: Methodological and practical concerns. *Journal of Advanced Nursing*, *31*(4), 918–925. https://doi.org/10.1046/j.1365-2648.2000.01357.x

Hofmann, M., & Barker, C. (2017). On researching a health condition that the researcher has also experienced. *Qualitative Psychology*, *4*(2), 139–148. https://doi.org/10.1037/qup0000066

Mitchell, J., Boettcher-Sheard, N., Duque, C., & Lashewicz, B. (2018). Who Do We Think We Are? Disrupting Notions of Quality in Qualitative Research. *Qualitative Health Research*, *28*(4), 673–680. https://doi.org/10.1177/1049732317748896

Olmos-Vega, F. M., Stalmeijer, R. E., Varpio, L., & Kahlke, R. (2023). A practical guide to reflexivity in qualitative research: AMEE Guide No. 149. *Medical Teacher, 45*(3), 241-251. https://doi.org/10.1080/0142159X.2022.2057287

Tufford, L., & Newman, P. (2012). Bracketing in Qualitative Research. *Qualitative*

Social Work, *11*(1), 80–96. https://doi.org/10.1177/1473325010368316

Valentine, C. (2007). Methodological Reflections: Attending and Tending to the Role of the Researcher in the Construction of Bereavement Narratives. *Qualitative Social Work*, *6*(2), 159–176. https://doi.org/10.1177/1473325007077237

Appendices

***Appendix 1**: Search strategies derived from Medline, PsycINFO and CINAHL*

Medline: N= 2695
PsycINFO: N= 2819
CINAHL: N= 2460 (with Duplicates)

Without Duplicates: Total= 5970

	PsycINFO	**MEDLINE**	**CINAHL**
Text Word Terms: Population	("South Asia*" or "India*" or "Pakistan*" or "Bangladesh*" or "Sri Lanka*" or "Nepal*" or "Afghan*" or "Bhutan*" or "Maldiv*" or "Buddhis*" or "Hindu*" or "Muslim" or "Islam*" or "Sikh*").ti,ab,id.	("South Asia*" or "India*" or "Pakistan*" or "Bangladesh*" or "Sri Lanka*" or "Nepal*" or "Afghan*" or "Bhutane*" or "Maldiv*" or "Buddhis*" or "Hindu*" or "Muslim" or "Islam*" or "Sikh*").ti,ab,kw.	TI (("South Asia*" or "India*" or "Pakistan*" or "Bangladesh*" or "Sri Lanka*" or "Nepal*" or "Afghan*" or "Bhutanese*" or "Maldivian*" or "Buddhis*" or "Hindu*" or "Muslim" or "Islam*" or "Sikh*")) OR AB (("South Asia*" or "India*" or "Pakistan*" or "Bangladesh*" or "Sri Lanka*" or "Nepal*" or "Afghan*" or "Bhutan*" or "Maldiv*" or "Buddhis*" or "Hindu*" or "Muslim" or "Islam*" or "Sikh*"))
MeSH Terms: Population	religious groups/ or religious communities/ or south asian cultural groups/ or minority groups/ or "racial and ethnic groups"/	south asian people/ or minority groups/ or "Ethnic and Racial Minorities"/	(MH "South Asians+") or (MH "minority groups") or (MH "Asia, Southern") or (MH "ethnic groups") or (MH "religion and religions")

Text Word Terms: Setting	("Mental health service*" or "Psycholog* service*" or "Psychiatri* service*" or "Communit* mental health service*" or "mental health program*" or "communit* mental health centre*" or "counsel* service*" or " mental health outreach" or "primary mental health*" or "anxiety" or "depression" or "common mental health disorder*" or "schizophrenia" or "psychosis" or "mental health" or "psychological* distress*").ti,ab,id.	("Mental health service*" or "Psycholog* service*" or "Psychiatri* service" or "Communit* mental health service*" or "mental health program*" or "communit* mental health centre*" or "counsel* service*" or " mental health outreach" or "primary mental health*" or "anxiety" or "depression" or "common mental health disorder*" or "schizophrenia" or "psychosis" or "mental health" or "psychological* distress*").ti,ab,kw.	TI (("Mental health service*" or "Psycholog* service*" or "Psychiatri* service" or "Communit* mental health service*" or "mental health program*" or "communit* mental health centre*" or "counsel* service*" or " mental health outreach" or "primary mental health*" or "anxiety" or "depression" or “common mental health disorder*” or "schizophrenia" or "psychosis" or “mental health” or “psychological* distress*”)) OR AB (("Mental health service*" or "Psycholog* service*" or "Psychiatri* service" or "Communit* mental health service*" or "mental health program*" or "communit* mental health centre*" or "counsel* service*" or " mental health outreach" or "primary mental health*" or "anxiety" or "depression" or “common mental health disorder*” or "schizophrenia" or "psychosis" or “mental health” or “psychological* distress*”))
MeSH Terms: Setting	Mental Health Services/ or Community Mental Health Services/ or Mental Health Programs/ or Community counselling/ or Crisis Intervention services/ or culturally adapted interventions/ or Community Mental Health Centers/ or	psychotherapy/ or community mental health services/ or hospitals, psychiatric/ or "counseling"/ or mental health services/	(MH "Mental Health Services+") OR (MH "Counseling+") OR (MH "Emergency Services, Psychiatric+") OR (MH "Rehabilitation, Psychosocial+") OR (MH "Community Mental Health Services+") OR (MH "Psychotherapy")

	Counseling/ or community psychiatry/		
Text Word Terms: Access	((("access" or "accessibility" or "underutilis*" or "underutiliz*" or "utiliz*" or "utilis*" or "use of services" or "uptake" or "help-seeking" or "help seeking" or "seek help" or "barrier*") adj2 "care") or "access*" or "help-seeking" or "service use").ti,ab,id.	((("access" or "accessibility" or "underutilis*" or "underutiliz*" or "utiliz*" or "utilis*" or "use of services" or "uptake" or "help-seeking" or "help seeking" or "seek help" or "barrier*") adj2 "care") or "access*" or "help-seeking" or "service use").ti,ab,kw.	TI (((("access" or "accessibility" or "underutilis*" or "underutiliz*" or "utiliz*" or "utilis*" or "use of services" or "uptake" or "help-seeking" or "help seeking" or "seek help" or "barrier*") adj2 "care") or "access*" or "help-seeking" or "service use" or "treatment barrier*"))) AND AB (((("access" or "accessibility" or "underutilis*" or "underutiliz*" or "utiliz*" or "utilis*" or "use of services" or "uptake" or "help-seeking" or "help seeking" or "seek help" or "barrier*") adj2 "care") or "access*" or "help-seeking" or "service use" or "treatment barrier*")))
MeSH Terms: Access	treatment barriers/ or health care access/ or health care seeking behavior/ or health care utilization/ or health service need/ or health care delivery/	Culturally Competent Care/ or "Delivery of Health Care"/ or Health Resources/ or Health Services Accessibility/ or "Health Services Needs and Demand"/	(MH "health care delivery") or (MH "health care reform") or (MH "health resource utlization") or (MH "health services accessibility")

Glossary:

***MeSH term**. Subject headings are assigned descriptors used in databases to uniformly describe a concept and help identify relevant items related to the topic.*

***OR** = Boolean operator*

***AND** = Boolean operator*

***Asterix (*)** = truncation It is used in advanced searching to find variant word endings e.g., South Asia* finds South Asian*

***ti/ab/kw** = searchable fields: title, abstract and keywords*

***Adj** = adjacency operator (also known as proximity operator). Adj finds the words if they are maximum n words apart from one another regardless of the order in which they appear.*

Appendix 2: *Quality Assessment Criteria (Critical Appraisal Skills Programme, 2018).*

Randomised Controlled Trial:

1. Did the trial address a clearly focused issue?
2. Was the assignment of patients to treatments randomised?
3. Were all of the patients who entered the trial properly accounted for at its conclusion?
4. Were patients, health workers and study personnel ‘blind’ to treatment?
5. Were the groups similar at the start of the trial?
6. Aside from the experimental intervention, were the groups treated equally?
7. How large was the treatment effect?
8. How precise was the estimate of the treatment effect?
9. Can the results be applied to the local population, or in your context?
10. Were all clinically important outcomes considered?
11. Are the benefits worth the harms and costs?

Cohort Study:

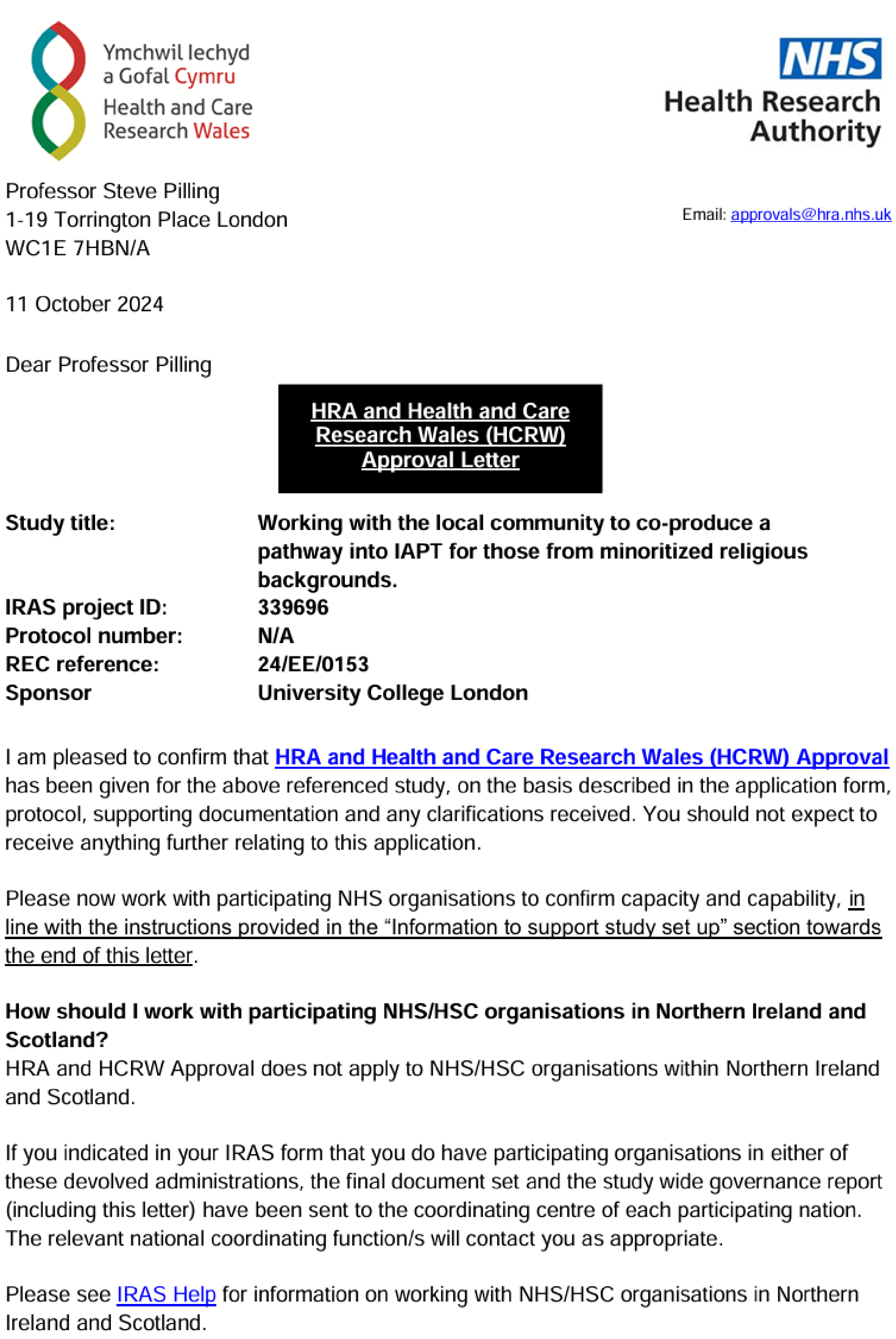
1. Was there a clear statement of the aims of the research?
2. Is a qualitative methodology appropriate?
3. Was the research design appropriate to address the aims of the research?
4. Was the recruitment strategy appropriate to the aims of the research?
5. Was the data collected in a way that addressed the research issue?
6. Has the relationship between researcher and participants been adequately considered?
7. Have ethical issues been taken into consideration?
8. Was the data analysis sufficiently rigorous?
9. Is there a clear statement of findings?
10. How valuable is the research?

~~11. Do the results of this study fit with other available evidence?~~

12. What are the implications of this study for practice?

Note: Question 11 was removed as this is the first systematic review on the topic, and there was limited prior evidence available for comparison

Appendix 3: *HRA and HCRW Ethics Approval Confirmation Letter*



Ymchwil Iechyd
a Gofal Cymru
Health and Care
Research Wales

NHS
Health Research
Authority

Professor Steve Pilling
1-19 Torrington Place London
WC1E 7HBN/A

Email: approvals@hra.nhs.uk

11 October 2024

Dear Professor Pilling

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Working with the local community to co-produce a pathway into IAPT for those from minoritized religious backgrounds.**
IRAS project ID:	**339696**
Protocol number:	**N/A**
REC reference:	**24/EE/0153**
Sponsor	**University College London**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?

HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The standard conditions document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **339696**. Please quote this on all correspondence.

Yours sincerely,
Nicole Quelch

Approvals Specialist

Email: approvals@hra.nhs.uk

Copy to: *Pushpen Joshi*

Appendix 4*: Study Posters*

Service Users (Interviews):

Do you want to help recommend improvements to the mental health support for the local community?

RESEARCH PARTICIPANTS NEEDED

ABOUT THE STUDY

Research suggests that minority ethnic groups experience increased challenges when accessing and engaging with mental health treatment, with the role of religion being largely ignored. We are therefore interested in working alongside local communities to co-produce broader pathways into mental health services to improve engagement and outcomes.

WHAT IT INVOLVES

- 60-minute interview either online or in person at Brent Talking Therapies services to explore your views on mental health and religion
- Option to engage with a follow up workshop to co-produce referral pathways into mental health services

BENEFITS

- £15 voucher
- Contributing to the co-production of improved referral pathways into mental health services for those from Hindu/Sikh religious backgrounds

ELIGIBILITY

- Age 18 +
- English speaking
- Hindu/Sikh faith background
- Currently accessing or previously accessed mental health services

HOW TO PARTICIPATE

Please contact the research student Manisha Jha on [redacted] information, with no obligation to take part.

Principal Researcher's Contact Details:
Professor Stephen Pilling - [redacted]

Ethics approval for this study has been obtained from the UCL/NHS REC committee
ID Number: 339696
Data protection ID Number: Z6364106/2024/02/53
Date of submission: 06/03/2025 Version 0.2

Religious Leaders (Interviews):

Do you want to help recommend improvements to the mental health support for the local community?

RESEARCH PARTICIPANTS NEEDED

ABOUT THE STUDY

Research suggests that minority ethnic groups experience increased challenges when accessing and engaging with mental health treatment, with the role of religion being largely ignored. We are therefore interested in working alongside local communities to co-produce broader pathways into mental health services to improve engagement and outcomes.

WHAT IT INVOLVES

- 60 minute interview either online or in person to explore your views on mental health and religion
- Option to engage with a follow up workshop to co-produce referral pathways into mental health services

BENEFITS

- £15 voucher
- Contributing to the co-production of improved referral pathways into mental health services for those from Hindu/Sikh religious backgrounds

ELIGIBILITY

- Age 18 +
- English speaking
- In a position of leadership within Hindu/Sikh religious organisations

HOW TO PARTICIPATE

Please contact the research student Manisha Jha [redacted] information, with no obligation to take part.

Principal Researcher's Contact Details:
Professor Stephen Pilling - [redacted]

Ethics approval for this study has been obtained from the UCL/NHS REC committee
ID Number: 339696
Data protection ID Number: Z6364106/2024/02/53

Date of submission: 06/03/2025 Version 0.2

NHS Staff (Workshop):

Do you want to help recommend improvements to the mental health support for the local community?

RESEARCH PARTICIPANTS NEEDED

ABOUT THE STUDY

Research suggests that minority ethnic groups experience increased challenges when accessing and engaging with mental health treatment, with the role of religion being largely ignored. We are therefore interested in working alongside local communities to co-produce broader pathways into mental health services to improve engagement and outcomes.

WHAT IT INVOLVES

- 60- 90 minute workshop over Microsoft Teams
- Aim to co-produce improved referral pathways into mental health services with the local community

BENEFITS

- Raffle with a chance to win one of three vouchers worth £20
- Contributing to the co-production of improved referral pathways into mental health services for those from Hindu/Sikh communities

ELIGIBILITY

- Age 18 +
- English speaking
- You are currently working for an NHS Talking Therapies service

HOW TO PARTICIPATE

Please contact the research student Manisha Jha [redacted] information, with no obligation to take part.

Principal Researcher's Contact Details:
Professor Stephen Pilling - [redacted]

Ethics approval for this study has been obtained from the UCL/NHS REC committee
ID Number: 339696
Data protection ID Number: Z6364106/2024/02/53

Date of submission: 06/03/2025 Version 0.2

***Appendix 5**: Participant Information Sheet*

Interviews:

UCL DIVISION OF PSYCHOLOGY
AND LANGUAGE SCIENCES

Participant Information Sheet- Interviews

UCL Research Ethics Committee Approval ID Number: 24/EE/0153

YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET

Title of Study: Co-producing referral pathways into NHS Talking Therapies services with the Hindu/Sikh community.
Department: Research Department of Clinical, Educational and Health Psychology
Name and Contact Details of the Researcher(s): Manisha Jha

Name and Contact Details of the Principal Researcher: Professor Stephen Pilling

Telephone:

1. **Invitation**
   You are being invited to take part in a research project. Before you decide to take part, it is important for you to understand why the research is being done and what participation will involve. Please take your time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information (contact details are stated below). Thank you for reading this.

2. **What is the project's purpose?**
   This study aims to explore community religious leaders'/service users' **(delete as appropriate)** views around the relationship between religion and mental health, barriers/facilitators to accessing mental health services and how to increase collaboration with services. Following this, we will aim to work with faith leaders, service users and NHS staff to co-produce referral pathways to support access to services for people from minoritised religious communities.

3. **Why have I been chosen?**
   Service users: You have been chosen as you are from a Hindu/Sikh faith background, you have used or are using NHS Talking Therapies services and are aged 18 or over.

   Faith Leaders: You have been chosen as you are in a position of leadership within a Hindu/Sikh religious organisation and you are aged 18 or over.
   (Delete as appropriate)

You are amongst up to 28 people that will be asked to participate in this study. You have been invited because you responded to an advert for this study or have been contacted directly by researchers and/or NHS staff and you indicated that you would be happy to be contacted further to potentially participate in this research.

4. **Do I have to take part?**
   It is up to you to decide whether or not to take part. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. If you change your mind about taking part in any aspect of the study, you can withdraw at any point without having to provide a reason for your withdrawal. There are no consequences to deciding that you no longer wish to participate in the study. If you do decide to withdraw at any point, any data provided up to that point in the interview will be anonymised and may be used in the study, and your consent form will be retained. Any answers given during the study prior to your withdrawal will be unidentifiable. We will retain your consent form until September 2025, after which it will be destroyed.

5. **What will happen to me if I take part?**
   We will arrange a time for you to attend a 60-90 minute interview either remotely over Microsoft Teams or in person at X NHS Talking Therapies. The interview will take place in a private location where the discussion will not be overheard. All questions asked will be optional and there are no right or wrong answers- we are interested in your experience and opinions. Following the interview, you will be sent an additional email, asking if you would like to participate in a follow-up workshop. This will be completely optional and will not impact your participation in the interview. An additional information sheet and consent form will be provided.

6. **How will we use information about you?**
   We will need to use information from you for this research project.
   This information will include your: *initials, gender, ethnicity, your history of accessing mental health services and employment information*. This information is voluntary, and you can refuse to provide any of the above information.
   People will use this information to do the research or to check your records to make sure that the research is being done properly.
   People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead.
   We will keep all information about you safe and secure.
   Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.
   We will also ask for your consent to retain your contact details (name and email/phone number) for future contact about follow up studies and studies of a similar nature. This will be kept secure by the research team and will be deleted once follow up work has been completed.

7. **Will I be recorded and how will the recorded media be used?**
   The video recordings of your interview will be used to produce verbatim (word-for-word) transcripts. These transcripts will be produced by the built in facility on Microsoft Teams. However, they will not have access to data linking the video file to your personal information. These transcripts will be used only for analysis; no other use will be made of them without your written permission. The interviews will be recorded through the online platform Microsoft Teams. This data will be transferred from Microsoft Teams to password protected computers at UCL. If necessary, they will be transported via password protected encrypted USB sticks. Your data file will be stored under a pseudonym that will be linked to your name using a key in a

separate data file that will also be password protected and stored separately. Any names mentioned during interviews will be removed from transcripts and replaced with a pseudonym.

8. **What are the possible disadvantages and risks of taking part?**
   As part of the research, you will be asked questions about your views on mental health, religion and/or spirituality. This could cause some distress. However, you are not required to answer any questions you do not wish to, and we will provide information on how to seek further support should the need arise (please see the contact details provided at the end of this Information Sheet). We also encourage participants who feel any distress from the interview to contact their GP, or another mental health professional. We do not foresee any other discomforts, disadvantages or risks related to participating in this research, however, should the need arise you are encouraged to bring any difficulties resulting from this research to the attention of the principal investigator (Professor Stephen Pilling).

9. **What are the possible benefits of taking part?**
   You will be reimbursed vouchers worth £15 for your time participating in this study. It is also hoped that this work will enable the co-production of improved referral pathways into mental health services for those from minortised religious backgrounds.

10. **What if something goes wrong?**
    In the event that you would like to raise a complaint or discuss an aspect of the research further, please contact Manisha Jha on or Stephen Pilling on. If you are not satisfied with the response, you may contact the Chair of the UCL Research Ethics Committee at ethics@ucl.ac.uk.
    In the event that something does go wrong and you are harmed during the research, and this is due to someone's negligence then you may have grounds for a legal action for compensation against UCL, but you may have to pay your legal costs. The normal National Health Service complaints mechanisms will still be available to you.

11. **Will my taking part in this project be kept confidential?**
    All the information that we collect about you during the course of the research will be kept strictly confidential. Any data which may identify you will be stored in a separate location in a password protected document on secure UCL servers. Only members of the research team will have access to data which is not fully anonymised. You will not be able to be identified in any ensuing reports or publications. If you decide to participate in the follow-up workshop, individual answers in interviews will not be discussed, only overarching, anonymous themes arising from the data. However, confidentiality could be reduced through other community members or NHS staff being present. This focus group is optional, and you may decline to participate when contacted regarding participation, without penalty.

12. **Limits to confidentiality**
    Confidentiality may be limited and conditional. The researcher has a duty of care to report to the relevant authorities possible harm/danger to the participant or others: if a participant reaches out reporting self-harm or suicidal thoughts, the researcher is obliged by law to report to the relevant authorities. In this circumstance, participant contact details, but not their specific responses to questions, will be passed on to appropriate professional support services. All participants will be informed of this should it be deemed necessary.

13. **What will happen to the results of the research project?**
    The results of the research will be presented within a PhD thesis and potentially submitted to a journal for publication. Results could also be presented at relevant conferences, seminars or press articles. There will be no identifiable information provided.

14. What are your choices about how your information is used?

- You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have.
- We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.
- If you agree to take part in this study, you will have the option to take part in future research using your data saved from this study.

15. Where can you find out more about how your information is used?

You can find out more about how we use your information

- at www.hra.nhs.uk/information-about-patients/
- our leaflet available from **www.hra.nhs.uk/patientdataandresearch**
- by asking one of the research team

by sending an email to

16. Who is organising and funding the research?

This research is being funded by University College London as part of a PhD in Clinical, Educational and Health Psychology.

16. Contact for further information

Should you want further information on the project, you may contact the researcher Manisha Jha using the following details:
Email:

Thank you for reading this information sheet and for considering taking part in this research study. You will be given a copy of this information sheet to keep for your records.

Further Support Services

- *Samaritans:* a free, 24-hour confidential listening and support service for people experiencing feelings of distress (call 116 123).
- *Shout:* for free, confidential support, 24/7, text SHOUT to 85258. If you are struggling to cope and need to talk, trained Shout volunteers are available day or night.
- *Mind:* offer an information line to answer questions about types of mental health problem, where to get help, drug and alternative treatments and advocacy Call the Mind Infoline on 0300 123 3393 (UK landline calls are charged at local rates, and charges from mobile phones will vary considerably). Or email info@mind.org.
- *Calm Helpline and webchat:* provides listening services, information and support for anyone who needs to talk including a web chat. Call the CALM helpline on 0800 58 58 58 or use their webchat here: https://www.thecalmzone.net/get-support#open-calmbot.

If you feel like you need further support with your mental health, you can discuss this with your GP. If you feel at risk of harming yourself, please discuss this with your GP, or go to a hospital A&E department.

Workshops:

**UCL DIVISION OF PSYCHOLOGY
AND LANGUAGE SCIENCES**

Participant Information Sheet- Pathway Development Workshop

UCL Research Ethics Committee Approval ID Number: 24/EE/0153

YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET

Title of Study: Co-producing referral pathways into NHS Talking Therapies with the Hindu/Sikh community.
Department: Research Department of Clinical, Educational and Health Psychology
Name and Contact Details of the Researcher(s): Manisha Jha

Name and Contact Details of the Principal Researcher: Professor Stephen Pilling

Telephone:

17. **Invitation**
    You are being invited to take part in a research project. Before you decide to take part, it is important for you to understand why the research us being done and what participation will involve. Please take your time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information (contact details are stated below). Thank you for reading this.

18. **What is the project's purpose?**
    This study aims to explore community religious leaders' and service users' views around the relationship between religion and mental health, barriers/facilitators to accessing mental health services and how to increase collaboration with services. Following this, we will aim to work with faith leaders, service users and NHS staff to co-produce a referral pathway to support access to services for people from minoritised religious communities.

19. **Why have I been chosen?**

    You have been chosen because you participated in an interview exploring your views on mental health and religion, and you agreed to be contacted regarding a follow up workshop. We are hoping the workshop will include a mixture of community faith leaders and current/past service users and NHS staff.

    Or
    Service users: You have been chosen as you are from a Hindu/Sikh faith background, you have used or are using NHS Talking Therapies services and are aged 18 or over.

Faith Leaders: You have been chosen as you are in a position of leadership within a Hindu/Sikh religious organisation and you are aged 18 or over.
NHS staff: You have been chosen as you currently working for an NHS Talking Therapies service, and you are aged 18 or over.
(Delete as appropriate)

20. **Do I have to take part?**
    It is up to you to decide whether or not to take part. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. If you change your mind about taking part in any aspect of the study, you can withdraw at any point without having to provide a reason for your withdrawal. There are no consequences to deciding that you no longer wish to participate in the study. If you do decide to withdraw at any point, any data provided up to that point in the interview will be anonymised and may be used in the study, and your consent form will be retained. Any discussions during the study prior to your withdrawal will be unidentifiable. We will retain your consent form until September 2025, after which it will be destroyed.

21. **What will happen to me if I take part?**
    We will arrange a time for you to come attend a workshop either remotely over Microsoft Teams or in person at X NHS Talking Therapies. The discussions will take place in a private location where it will not be overheard. The aim of the workshop will be to co-produce referral pathways into NHS Talking Therapies services, and this will be facilitated by discussions from the attendees in the workshop. Following the focus group, we will ask that all discussions had not be discussed with others, however this cannot be guaranteed.

22. **How will we use information about you?**
    We will need to use information from you for this research project.
    This information will include your: *initials and employment information*.
    People will use this information to do the research or to check your records to make sure that the research is being done properly.
    People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead.
    We will keep all information about you safe and secure.
    Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.
    We will also ask for your consent to retain your contact details (name and email/phone number) for future contact about follow up studies and studies of a similar nature. This will be kept secure by the research team and will be deleted once follow up work has been completed.

23. **Will I be recorded and how will the recorded media be used?**
    No recordings will be made of the discussions in the workshop. Some notes may be written to help guide the development of the referral pathway. These will be anonymised and kept in a secure filing cabinet at UCL. This data may be used in reports, no other use will be made of them without your written permission. Any names mentioned during discussions will be removed from notes and replaced with a pseudonym.

24. **What are the possible disadvantages and risks of taking part?**
    As part of the research, we will discuss topics around mental health, religion and/or spirituality. This could cause some distress. However, you are not required to answer any questions or participate in any discussions that you do not wish to, and we will provide information on how to seek further support should the need arise (please see the contact details provided at the end of

this Information Sheet). We also encourage participants who feel any distress from the interview to contact their GP, or another mental health professional. We do not foresee any other discomforts, disadvantages or risks related to participating in this research, however, should the need arise you are encouraged to bring any difficulties resulting from this research to the attention of the principal investigator (Professor Stephen Pilling).

25. What are the possible benefits of taking part?

You will be entered into a raffle and will have a chance to win one of three vouchers worth £20. It is also hoped that this work will result in improved referral pathways for better access to services for those from Hindu/Sikh minortised religious backgrounds.

26. What if something goes wrong?

In the event that you would like to raise a complaint or discuss an aspect of the research further, please contact Manisha Jha on or Stephen Pilling on. If you are not satisfied with the response, you may contact the Chair of the UCL Research Ethics Committee at ethics@ucl.ac.uk.

In the event that something does go wrong and you are harmed during the research, and this is due to someone's negligence then you may have grounds for a legal action for compensation against UCL, but you may have to pay your legal costs. The normal National Health Service complaints mechanisms will still be available to you.

27. Will my taking part in this project be kept confidential?

All the information that we collect about you during the course of the research will be kept strictly confidential. Any data which may identify you will be stored in a separate location in a password protected document on secure UCL servers. Only members of the research team will have access to data which is not fully anonymised. You will not be able to be identified in any ensuing reports or publications. However, confidentiality could be reduced through other community members or NHS staff being present in the workshop. Therefore, this workshop is optional, and you may decline to participate when contacted regarding participation, without penalty.

28. Limits to confidentiality

Confidentiality may be limited and conditional. The researcher has a duty of care to report to the relevant authorities possible harm/danger to the participant or others: if a participant reaches out reporting self-harm or suicidal thoughts, the researcher is obliged by law to report to the relevant authorities. In this circumstance, participant contact details, but not their specific responses to questions/discussions, will be passed on to appropriate professional support services. All participants will be informed of this should it be deemed necessary.

29. What will happen to the results of the research project?

The results of the research will be presented within a PhD thesis and potentially submitted to a journal for publication. Results could also be presented at relevant conferences, seminars or press articles. There will be no identifiable information provided.

30. What are your choices about how your information is used?

- You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have.
- We need to manage your records in specific ways for the research to be reliable. This means that we won’t be able to let you see or change the data we hold about you.
- If you agree to take part in this study, you will have the option to take part in future research using your data saved from this study.

31. Where can you find out more about how your information is used?
You can find out more about how we use your information

- at www.hra.nhs.uk/information-about-patients/
- our leaflet available from **www.hra.nhs.uk/patientdataandresearch**
- by asking one of the research team
- by sending an email to

32. Who is organising and funding the research?
This research is being funded by University College London as part of a PhD in Clinical, Educational and Health Psychology.

33. Contact for further information
Should you want further information on this project, you may contact the researcher Manisha Jha using the following details:
Email:

Thank you for reading this information sheet and for considering taking part in this research study. You will be given a copy of this information sheet to keep for your records.

Further Support Services

- *Samaritans:* a free, 24-hour confidential listening and support service for people experiencing feelings of distress (call 116 123).
- *Shout:* for free, confidential support, 24/7, text SHOUT to 85258. If you are struggling to cope and need to talk, trained Shout volunteers are available day or night.
- *Mind:* offer an information line to answer questions about types of mental health problem, where to get help, drug and alternative treatments and advocacy Call the Mind Infoline on 0300 123 3393 (UK landline calls are charged at local rates, and charges from mobile phones will vary considerably). Or email info@mind.org.
- *Calm Helpline and webchat:* provides listening services, information and support for anyone who needs to talk including a web chat. Call the CALM helpline on 0800 58 58 58 or use their webchat here: https://www.thecalmzone.net/get-support#open-calmbot.

If you feel like you need further support with your mental health, you can discuss this with your GP. If you feel at risk of harming yourself, please discuss this with your GP, or go to a hospital A&E department.

Appendix 6: *Participant Consent Form*

Interviews:

UCL DIVISION OF PSYCHOLOGY
AND LANGUAGE SCIENCES
1-19 TORRINGTON PLACE
WC1E 7HB

CONSENT FORM -INTERVIEW

Please complete this form after you have read the Information Sheet and/or listened to an explanation about the research.

Title of Study: Co-producing referral pathways into NHS Talking Therapies with the Hindu/Sikh community.

Department: Research Department of Clinical, Educational & Health Psychology

Name and Contact Details of the Researcher: Manisha Jha
Telephone:
Email:

Name and Contact Details of the Principal Researcher: Professor Stephen Pilling
Telephone:

This study has been approved by the UCL Research Ethics Committee.
Project ID number: 339696

Thank you for considering taking part in this research. The person organising the research must explain the project to you before you agree to take part. If you have any questions arising from the Information Sheet or explanation already given to you, please ask the researcher before you decide whether to join in. You will be given a copy of this Consent Form to keep and refer to at any time.

I confirm that I understand that by ticking/initialling each box below I am consenting to this element of the study. I understand that it will be assumed that unticked/initialled boxes means that I DO NOT consent to that part of the study. I understand that by not giving consent for any one element that I may be deemed ineligible for the study.

		Tick Box
1.	I confirm that I have read and understood the Information Sheet for the above study. I have had an opportunity to consider the information and what will be expected of me. I have also had the opportunity to ask questions which have been answered to my satisfaction and would like to take part in:	

	- an interview about my views on mental health, religion and/or spirituality.	
2.	I understand that my data gathered in this study will remain confidential and it will be stored pseudo-anonymously and securely on University College London (UCL) servers. It will not be possible to identify me in any publications. The recorded file on Microsoft Teams will be transferred onto password protected computers at UCL. It will be transported via password-protected encrypted USB sticks. The file will be labelled using a pseudonym that will be linked to your name in a separate file stored in a separate place under password protection.	
3.	I understand that my pseudo-anonymised information may be subject to review by responsible individuals from the University (Professor Steve Pilling) for monitoring and audit purposes.	
4.	I understand that my participation is voluntary and that I am free to withdraw at any time without giving a reason, without my legal rights being affected. I understand that if I decide to withdraw, my consent form will be retained, and all other identifying information about me will be deleted, but that any data provided up to that point will be anonymised and may be used in the study. This data will not be traced back to me.	
5.	I understand the potential risks of participating and the support that will be available to me should I become distressed during the course of the research.	
6.	I understand the direct/indirect benefits of participating.	
7.	I understand that a video recording of the interview will be made available to the UCL approved Microsoft Teams platform, and that pseudo-anonymised data will be solely the responsibility of the researcher(s) undertaking this study.	
8.	I understand that I will not benefit financially from any possible outcome this study may result in in the future.	
9.	I understand that I will be compensated in full for the study even if I choose to withdraw during or after the interview.	
10.	I understand that the information I have submitted will be anonymised and may form part of data published in a PhD thesis and submitted to a journal for publication. Results could also be presented at relevant conferences, seminars or press articles. I understand that the information I have submitted will be written up as a report and I wish to receive a copy of it. Yes/No	
11.	I consent to my interview being video recorded and understand that the recordings will be destroyed immediately following transcription. To note: If you do not want your participation recorded you can still take part in the study.	
12.	I am aware of who I should contact if I wish to lodge a complaint.	
13.	I voluntarily agree to take part in this study.	
14.	I understand that my pseudo-anonymised information will be stored under password protection. I agree that data I provide to be archived at UCL in password protected UCL computers. I understand that my data will be stored in a separate place to my name.	

If you would like your contact details to be retained so that you can be contacted in the future by UCL researchers who would like to invite you to participate in follow up studies to this project, including a workshop to co-produce referral pathways into mental health services, or in future studies of a similar nature, please tick the appropriate box below.

	Yes, I would be happy to be contacted in this way (no obligation to take part)	
	No, I would not like to be contacted	

____________________________	__________________	_____________________
Name of participant	Date	Signature
____________________________	__________________	_____________________
Researcher	Date	Signature

Workshops:

**UCL DIVISION OF PSYCHOLOGY
AND LANGUAGE SCIENCES
1-19 TORRINGTON PLACE
WC1E 7HB**

CONSENT FORM -PATHWAY DEVELOPMENT WORKSHOP

Please complete this form after you have read the Information Sheet and/or listened to an explanation about the research.

Title of Study: Co-producing referral pathways into NHS Talking Therapies with the Hindu/Sikh community.

Department: Research Department of Clinical, Educational & Health Psychology

Name and Contact Details of the Researcher: Manisha Jha
Telephone:
Email:

Name and Contact Details of the Principal Researcher: Professor Stephen Pilling
Telephone:

**This study has been approved by the UCL Research Ethics Committee.
Project ID number: 339696**

Thank you for considering taking part in this research. The person organising the research must explain the project to you before you agree to take part. If you have any questions arising from the Information Sheet or explanation already given to you, please ask the researcher before you decide whether to join in. You will be given a copy of this Consent Form to keep and refer to at any time.

I confirm that I understand that by ticking/initialling each box below I am consenting to this element of the study. I understand that it will be assumed that unticked/initialled boxes means that I DO NOT consent to that part of the study. I understand that by not giving consent for any one element that I may be deemed ineligible for the study.

		Tick Box
1.	I confirm that I have read and understood the Information Sheet for the above study. I have had an opportunity to consider the information and what will be expected of me. I have also had the opportunity to ask questions which have been answered to my satisfaction and would like to take part in:	

	- a workshop with the aim of co-producing referral pathways into NHS Talking Therapies services.	
2.	I understand that my data gathered in this study will be stored pseudo-anonymously and securely on University College London (UCL) servers. It will not be possible to identify me in any publications.	
3.	I understand that my pseudo-anonymised information may be subject to review by responsible individuals from the University (Professor Steve Pilling) for monitoring and audit purposes.	
4.	I understand that my participation is voluntary and that I am free to withdraw at any time without giving a reason, without my legal rights being affected. I understand that if I decide to withdraw, my consent form will be retained, and all other identifying information about me will be deleted, but that any data provided up to that point will be anonymised and may be used in the study. This data will not be traced back to me.	
5.	I understand the potential risks of participating and the support that will be available to me should I become distressed during the course of the research.	
6.	I understand the direct/indirect benefits of participating.	
7.	I understand that I will not benefit financially from any possible outcome this study may result in in the future.	
8.	I understand that I will be compensated in full for the study even if I choose to withdraw during or after the workshop.	
9.	I understand that the information I have submitted will be anonymised and may form part of data published in a PhD thesis and submitted to a journal for publication. Results could also be presented at relevant conferences, seminars or press articles. I understand that the information I have submitted will be written up as a report and I wish to receive a copy of it. Yes/No	
10.	I am aware of who I should contact if I wish to lodge a complaint.	
11.	I voluntarily agree to take part in this study.	
12.	I understand that my pseudo-anonymised information will be stored under password protection. I agree that data I provide to be archived at UCL in password protected UCL computers. I understand that my data will be stored in a separate place to my name.	

If you would like your contact details to be retained so that you can be contacted in the future by UCL researchers who would like to invite you to participate in follow up studies to this project, including further workshops, or in future studies of a similar nature, please tick the appropriate box below.

	Yes, I would be happy to be contacted in this way (no obligation to take part)	
	No, I would not like to be contacted	

___________________________ ________________ ____________________
Name of participant Date Signature

___________________________ ________________ ____________________
Researcher Date Signature

Appendix 7: *Participant Demographic Questionnaire*

The following questions are used to collect demographic data to helps us to understand who is accessing mental health services. If you would prefer not to disclose any information, please leave the question blank.

Demographic questions	
Gender	
Age (years)	
Ethnicity /ethnocultural identity	
Religion	
Current employment status	
Have you accessed mental health services previously?	
When was the most recent time that you accessed services?	
Which services have you accessed?	

Appendix 8: *Interview Schedule*

TOPIC GUIDE

[Before recording]
-introduce self, re-explain what the study is about, consent, confidentiality, no right or wrong answers, right to withdraw at any time
[turn on Teams recording]

1. EXPERIENCE OF CARE
    1. Could you tell me about your experience of accessing mental health services e.g. NHS Talking Therapies services? Can you summarise your experience, whether good or bad and share anything you want to feed back to the services?
        - Can you describe an example?
        - E.g. range of treatment options? Availability of services? Treatment provider?
        - Who referred you?
        - Was there anything that didn't meet your needs during the whole process?
        - Is there anything that could have helped you access the services sooner?

2. VIEW OF TREATMENT SERVICES
    1. What support are you aware of for people with mental health disorders?
        - If some awareness: who provided the information? Was this useful, examples of support that was offered?
        - If limited awareness: what information do you have? Who would you go to for more information?
    2. What do you think of the services that are available currently?

3. ACCESS TO CARE
    1. Prior to seeking support/referring someone, what were your expectations of the support you would receive? High/Low/Neutral
        - How were you referred? Was the process easy? Did it make sense?
        - Waiting times?
        - Range of treatment options?
        - Availability and flexibility of services?
        - Discussion around cultural background such as religion?
        - How did the support match/not match your prior expectations?
        - How long did you have the symptoms before you accessed services?

4. VIEWS OF YOUR COMMUNITY AROUND MENTAL HEALTH CARE
    1. What do friends/family etc. think of mental health? What are their views on the support currently offered?
    2. How openly can you talk about MH in your family/community/social circles?
    3. Are you religious? How do your religious views shape your beliefs about MH? How much did this play a role in your accessing support?
    4. Service Users: Have you spoken to your faith leader about mental health? How was this? What support was offered?

5. Faith Leaders: have mental health issues been an important feature in your current duties as a faith leader? What are some examples of this?
    - Can you tell me about working with someone at the temple who has disclosed mental health problems?
    - What are your views/experiences of working with mental health services to support a congregation member who has mental health problems?
    - Have you had any training in providing mental health support?

5. BARRIERS AND FACILITATORS

Service Users/Faith Leaders

1. Did you experience any barriers to receiving support?
    - E.g. was there anything that stopped you seeking support sooner?
2. Did you stop receiving support before you would have liked for any reason? Or know of anybody else?
3. What are your thoughts on stigma in terms of mental health?
    - Impact on seeking support?
    - Can you think of anything services could do to reduce this?
    - Did you feel the support was adapted to your cultural/religious needs? Would this have been helpful?

Faith Leaders

4. What has facilitated or got in the way of working with mental health services?
    - Examples of times it has/ has not gone well
5. What have the barriers been?
    - How did you seek help? Who did you liaise with? What hampered successful collaboration?
    - What would help or stop you from working within the mental health system again for e.g. with a psychologist?

6. COLLABORATION AND FUTURE IMPLICATIONS
    1. What are views around mental health services and religious organisations collaborating? Do you think this would be helpful?
    2. What would you like to see happen if services and religious spaces did collaborate?
    3. Would you seek support again, recommend services to other people?
    4. What needs to change if you would not access or recommend these services again?
    5. Is there anything else you'd like to share that I didn't ask you today?

-Thank you so much for your time today, just before we finish up the interview is there anything else you would like to add to the above?
-Do you have any questions for me?
-OK I'm going to switch off the recording now
[switch off Teams recording]
-thank participants for their time, arrange payment, any other questions now recorder switched off

Appendix 9: *Example of transcript excerpt and development of codes, themes and subthemes*

Excerpt of Transcript: P20	Initial Codes	Theme	Sub-theme
I: What might get in the way of you or someone else in the community accessing services?			
P: Personally, if the services were not culturally adapted…I think if they didn't know where I'm coming from or what I'm saying could be construed in different way that could become an issue, I think. But also thinking wider people who language barriers… also words like for example, depression may not mean exactly the same in other languages.	Limited Cultural and/or spiritual understanding Language barriers	Barriers to Access	Structural and System Level Challenges
I: When you talk about cultural adaption, what does this mean to you and what would you like to see?			
P: Well, a quick example I can think of is when someone passes within the Hindu faith the way the mourning process works…there is a period where people may not eat or sleep on the bed or may not talk to other family members. When externally viewed by people who don't have that awareness, they may think this person is depressed. So those are some nuances that are important for people to know within cultures and for services to spend some time getting to know more about.	Language barriers Western conceptualisation of mental health	Barriers to Access	Structural and System Level Challenges
I: You talked about there being nuances between culture and religion can you give me some examples of this?			
P: So within the Hindu religion and probably within the temple…we would have people coming from different backgrounds. What I mean by that, there might be people who have roots from Gujarat or from a different part of India and they will have their own cultural ways of interacting, socialising, whatever it is and different beliefs within them. So even within Gujaratis, there will be very different belief systems as well. So just because someone is a Hindu does not mean they all do the same things. So I think it's just knowing that variations happen and…it's about understanding where they're coming from and then exploring further and then knowing whether this is a change from the normal kind of way of interacting and stuff.	Limited Cultural and/or spiritual understanding	Barriers to Access	Structural and System Level Challenges
I: What do you feel is the view in the community around how easy or hard it to access mental services currently? P: I think it varies really between age groups but I would say the most which we've found from people asking us for help…is that the waiting times are quite significant. Also… another challenge for people who are not brought up in the UK, there's a lot of stigma associated with mental health. So in the temple sometimes we don't call things mental health, we just call it feeling sad. But I think the stigma and being misunderstood is a big one where people say, well, they thought that I'm mad because I said that I believe in this or whatever particular cultural or religious belief…it is usually a normal belief but then they might get viewed as if they're unwell.	Long Waiting Times Feeling misunderstood Limited Cultural and/or spiritual understanding Stigma	Barriers to Access	Structural and System Level Challenges Cultural Stigma and Community Barriers Structural and System Level Challenges