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**Barriers and Facilitators to Mental Health Service Access Among South Asian Communities (Indian, Pakistani and Bangladeshi) in the UK: A Review of Existing Evidence**

***Component 2: Written Research Proposal***

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## 1. Title of the Proposed Research

Barriers and Facilitators to Mental Health Service Access Among South Asian Communities (Indian, Pakistani and Bangladeshi) in the UK: A Review of Existing Evidence.

## 2. Prevalence of the Problem

South Asian residents are the biggest minority ethnic population in the UK in 2021, with 5.5 million people falling under Asian ethnic groups in England & Wales, comprising residents with Indian origins reaching 19,27,150; Pakistani origins to 16,62,286; and Bangladeshi origins to 6,51,834 (Office for National Statistics, 2022); the breakdown is provided below the picture shows.

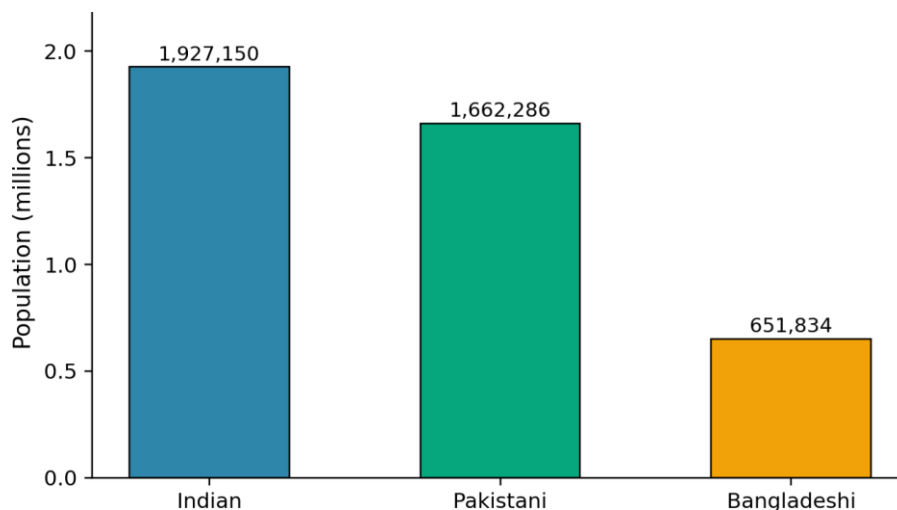


*Figure 1. South Asian population groups in the UK, 2021 Census. Source: Office for National Statistics, 2022.*

Mental health need appears high within these communities: older south-Asian adults have been found to report symptoms of depression at nearly double the rate of white European ones, 15.5% against 9.7% (fig.2). A sizeable share of most ethnic groups of Britain met criteria looking depression during study of Covid pandemic - how widespread common mental orders are clear (Irizar et al., 2024), which was carried out by the University of Manchester, Centre for Economic Performance & Centre for Social Investigation and found 18-20% of most ethnic groups showed signs of depression during a coronavirus study.

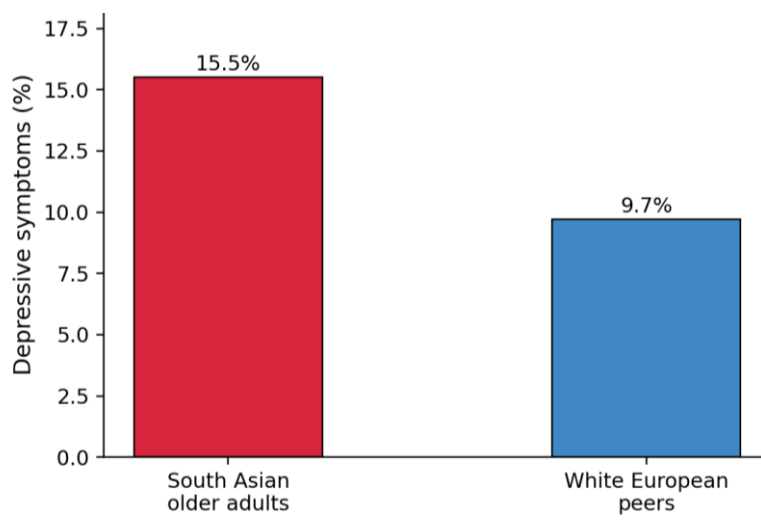


*Figure 2. Depressive symptoms in older South Asian adults compared with White European peers.*

Despite needing it most, only 7.4% of NHS Talking Therapies referrals were Asian or Asian British, well below their respective share of the population, illustrated in Figure 3 (South Asian Therapists, 2025). South Asian people have worse outcomes if they do reach treatment, especially Bangladeshi service users (NHS Race and Health Observatory, 2023). This population faces high need, low and unequal access, highlighting another lasting health inequality that needs investigating further.

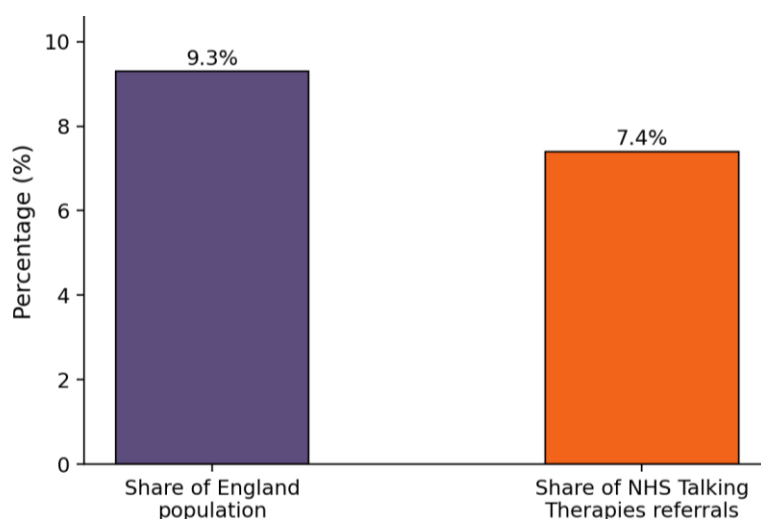


*Figure 3. Population share compared with NHS Talking Therapies referral share for Asian and Asian British groups.*

### **3. Introduction and Literature-Based Background**

British South Asian communities comprise a far from homogeneous group of people, most often of Indian, Pakistani or Bangladeshi origin. Mental illness and support are viewed differently depending on religion, language, generation and income (Prajapati and Liebling, 2022). However, the same trend keeps emerging in research conducted in the UK. South-Asian people use NHS mental healthcare services less than what might be expected from the level of need in these communities (Bhui et al., 2003; Kapadia et al., 2017). Commitments to solve this problem started being made by the government over two decades ago, and one recent rapid evidence review could not find any long-term changes within the health systems of the UK (NHS Race and Health Observatory, 2022).

A key issue highlighted in a recent letter to the British Journal of Psychiatry is that treating South Asian people as one group ignores differences between Indian, Pakistani and Bangladeshi communities and between different generations. People of Bangladeshi descent exhibit low rates of psychosis, compared with others from South Asian backgrounds; old Pakistani and Indian women appear vulnerable to common mental disorders (CMDs) as compared to old white women (Poole et al., 2025). These differences persist through life, with old South Asian adults with dementia being less likely to access support for their illness or being diagnosed later in life when compared with their White British counterparts (Kenning et al., 2017; Co et al., 2020). This indicates the role played by stigma, language barriers to access and differences in cultural beliefs about memory loss. There are analogous barriers to access of perinatal mental health care among Black and South Asian women who mistrust the services or face difficulty obtaining information about available help (Conneely et al., 2023). Age, generation and life-stage all, therefore, play critical roles alongside ethnicity in influencing access to care.

The idea of explanatory models (Kleinman, 1980) probably explains only part of the above. People understand distress through their own cultural lens, which affects whether they interpret a problem in medical or religious-cultural terms, and a recent systematic review of South Asian communities across several high-income countries has confirmed that many continue to interpret common mental disorders through religious or moral than a bio-medical model and seek input from family, then services

first or indeed from faith healers than statutory services (Jain et al., 2025). Other often-quoted reasons are stigma and a desire to be self-reliant for any problems (Shukla, 2023).

The literature contains strong evidence of cultural pressure to discourage help-seeking. The concepts of family honor and shame come up repeatedly as reasons for people, women in particular, to avoid mental health services. There is real fear that disclosure might undermine the status of one's family or daughter (e.g. affect marriage prospects adversely) (Howe and Sangar, 2021; Prajapati and Liebling, 2022). Trust is also a delicate issue. Some service users fear that the Whites cannot really understand their non white culture, and some fear that the Asians too belong to the same social networks (Prajapati and Liebling, 2022), where issues as personal as mental illness can get easily transmitted to the community, a dilemma of trust. Faith also adds one more dimension to this situation. Most Muslims, Hindus or Sikhs resort initially to their priests / religious leaders or faith healers rather than approaching the NHS, and these leaders themselves act as informal gatekeepers to formal care (Views of British South Asian Muslim Leaders on Mental Health, 2025).

Cultural barriers are just a fraction, as GPs are less likely to recognize depression in South Asian patients and less likely to refer them through once the problem is identified (Bhui et al., 2001; Bhui et al., 2003). National data revealed the referral rate staying lower with South Asian service users and the higher difference in recovery for Bangladeshi (NHS Race and Health Observatory, 2023). Insufficient interpreting is another barrier coupled with failed effort to involve family in care planning, making the already difficult situation worse (Bowl, 2007; Prajapati and Liebling, 2022).

More encouragingly, there is also evidence of what can help. The ROSHNI-2 trial tested a culturally adapted group therapy programme delivered in participants' native language by trained facilitators who understood their background. More women recovered from postnatal depression than those receiving standard care (Husain et al., 2024). Feasibility work showed that practical help with transport and childcare and a familiar community setting helped women continue attending (Masood et al., 2015). Family support and religious coping along with the involvement of trusted community figures were similarly linked to engagement (Prajapati and Liebling, 2022).

Even if this evidence is accumulating rapidly, there are still some gaps. For one, the most detailed UK review on this topic by Prajapati and Liebling (2022) covers only qualitative studies published up until 2019 and newer national datasets. This also highlights a major problem with much of the literature: it treats South Asian people as all similar, which is not the case, with real differences existing between Indian, Pakistani and Bangladeshi people groups (Prajapati and Liebling, 2022). Differences amongst men and women and young and older generations would also be covered by such overarching descriptions. An updated review covering barrier and facilitator evidence from the last decade would allow for more targeted service design.

## **4. Rationale, Research Question, Aim and Objectives**

### **Rationale**

While access to mental health services in the UK has been a policy commitment for years, utilization levels of its South Asian populations remain lower than those suggested by their level of need. Existing reviews of these inequalities tend to be old, focus almost exclusively on evidence of qualitative type and deal with *South Asians* by addressing them as generally equal, thereby paying less attention to differences which may be exhibited by individuals due to generation, gender and life stage that more recent evidence has shed new light on (Poole et al., 2025). Further, despite such reviews highlighting various barriers to mental health service access and possible ways of overcoming them, an additional one looking into both sides of the issues would help in drawing parallels and making recommendations for a more equitable mental health service provision. The following review can eventually provide grounding evidence for the researcher's dissertation in Term 3.

### **Research Question**

What does existing literature reveal about the barriers and facilitators to mental health service access among South Asian communities in the UK?

### **Research Aim**

To critically review and synthesise existing evidence on the barriers and facilitators affecting mental health service access among South Asian communities in the UK, to

generate recommendations for more equitable and culturally responsive mental health provision.

## **Research Objectives**

- To critically review existing literature on how South Asian communities understand and perceive mental health and mental health services.
- To identify, from existing evidence, the cultural, social and service-related barriers that limit South Asian communities' access to mental health support in the UK.
- To synthesise existing evidence on the factors and sources of support that facilitate South Asian communities' engagement with mental health services.
- To develop evidence-based recommendations for improving culturally appropriate mental health service provision for South Asian communities in the UK.

## **5. Research Methodology**

The study will undertake secondary research. There are pieces of evidence on the topic which vary across qualitative interviews, quantitative surveys, and literature from government bodies and health organisations as well. Hence, a systematic review, which is in accordance with the PRISMA 2020 reporting standards, has been used (Page et al., 2021). A thematic synthesis and narrative synthesis will be combined in the current review (Popay et al., 2006; Thomas and Harden, 2008). A combined thematic and narrative synthesis approach has been taken in previous such UK reviews of this population and is appropriate for the consideration of barriers and facilitators with their implications rather than a single measurable outcome (Prajapati and Liebling, 2022).

## **6. Research Design**

The literature review and synthesis are a retrospective non-experimental review of published and grey literature. There will not be human participants at this stage. This design was selected because it draws together the published evidence in a transparent way and hence allows the real gaps in evidence to be identified while providing a firm basis for further primary experimental research in the Term 3

dissertation, which will be subjected to the usual research ethics application and approval procedure nearer to the time.

## 7. Recruitment, Sampling and Study Participants

Human participants are not involved in this review. Instead, the sample will consist of a collection of published studies and other documents which meet certain eligibility criteria, using a similar framework to Prajapati and Liebling (2022) following a PICOS framework below.

| Element     | Criteria applied in this review                                                                             |
|-------------|-------------------------------------------------------------------------------------------------------------|
| Population  | South Asian, Indian, Pakistani or Bangladeshi adults living in the UK                                       |
| Concept     | Barriers and/or facilitators affecting access to mental health support                                      |
| Context     | Statutory NHS and community or third sector mental health services in the UK                                |
| Study types | Peer-reviewed qualitative, quantitative and mixed methods studies. Government, NHS and third sector reports |
| Timeframe   | 2015 to 2025 as the primary focus, with seminal earlier studies retained where relevant                     |
| Language    | English language publications only                                                                          |

*Table 1. Eligibility criteria applied to select literature for this review.*

The sampling comprises systematic electronic database searching along with purposive searching of grey literature and checking reference lists of key reviews to identify the literature comprehensively, which is a common approach in the health discipline.

## **8. Materials, Data Collection Methods and Procedure**

What questions will be asked? The review addresses what existing literature reveals about barriers and facilitators to mental health service access among South Asian communities in the UK, structured around the four objectives set out above.

Who will be asked? Rather than human participants, the units of analysis are peer-reviewed articles and grey literature documents meeting the eligibility criteria in Table 1.

How will data be collected? The chosen databases CINAHL, MEDLINE, PsycINFO, Scopus, Web of Science and ASSIA will be initially systematically searched. Other targeted searching will be undertaken for key government and health body websites and literature produced during the last 15 years by relevant Third Sector charities. This targeted search method is commonly named 'grey literature'. Keywords including South Asian, Indian, Pakistani, Bangladeshi, Bengali, Punjabi and Gujarati will be combined with mental health, psychological distress, access, barrier, facilitator, help seeking and utilisation. After completing the search, a PRISMA flow chart will be drawn to record the selection process for each study. On a standard extraction form, key information about each study (author, year, location, design, sample, results which are related with facilitator and barriers to accessing the mental healthcare system) will be put down.

## **9. Proposed Data Analysis Technique**

The studies will be analyzed with thematic synthesis (Thomas and Harden, 2008); which involves line-by-line coding, subsequent development of descriptive themes and finally higher-order analytical themes tied directly to the review objectives. For numbers, statistics on prevalence etc. these together with any grey literature studies, will be narrated (using the narrative synthesis approach by Popay et al. (2006) so that numbers and text all come together under one set of over encompassing themes) Quality of studies to be appraised either with the Critical Skills Appraisals Programme (CASP) checklist (qualitative studies with either Critical Appraisal Skills Programme, Centre for Reviews and dissemination checklists for qualitative studies) or a Joanna Briggs checklist depending on design (Critical Appraisal Skills Programmed, 2018).

## **10. Ethical Considerations**

As this is secondary research which builds on already published research, no direct human participants will be recruited and no new personal data collected, which reduces direct risk of harm. However, several ethical issues remain important. First and foremost, academic integrity. Representation of the source material will be accurate and appropriately attributed. Paraphrasing will be used instead of verbatim copying, and Harvard referencing will be used consistently. Any use of AI tools in writing will also be declared in line with university AI guidance for students and the requirement of the assignment brief.

Representation matters too. Because of the risk in lumping South Asian people into one group, discussed above, representation will be explicitly outlined in the review as defined differences in faith, generation, gender and country of origin of original material and in the included studies (Prajapati and Liebling, 2022). Representation also must be carefully attended to in the research as well. Because of the risk of enforcing outsider interpretative frameworks on minoritised communities' experiences explored above, the researcher's own background and assumptions will be reflected on by the researcher in her analysis.

Data protection is the fourth point. Statistics accessed from ONS or NHS are all public/anonymized/aggregated before use according to UK GDPR and university policy; no attempt will be made to identify individuals. Finally, is Formal approval. NHS Research Ethics Committee approval is not likely to apply for the proposed research as the subject of the research is merely a literature-based review (not with patient contact, samples, data etc.) However, university ethical approval in the form of a completed PG2 form will still need to be obtained before work begins, as set out in this document for the Term 3 dissertation.

## **11. Implications of Research**

The review should result in evidence-based recommendations relating to policy, practice and future research. These will most likely include the wider use of culturally adapted psychological therapies, delivered by trained bilingual practitioners according to the model used in the Positive Health Programme (Husain et al., 2024). An increase in workforce training (for GPs, for instance, to improve recognition and referral of South

Asian patients), an improvement in interpretation services and closer cooperation between statutory services and community faith-orientated organisations (stronger, properly resourced partnerships, to increase trust and decrease stigma) are amongst other desirable outcomes (Bhui et al., 2001; Bhui et al., 2003) (Prajapati and Liebling, 2022). In addition, taking age and stage of life into account rather than just ethnicity when designing referral and outreach services would also help older members of South Asian communities, who face discrimination beyond belief for dementia and memory services despite receiving it (Kenning et al., 2017; Co et al., 2020).

In the longer term, the improved recording of data on ethnicity would allow the monitoring of possible inequality (and the impact of changes over time to the above or new policies) (Care Quality Commission, 2023). At a policy level, this review will feed back onto the sampling strategy, data collection instruments and design of the researchers' Term 3 dissertation. Hopefully allowing the first phase study to meet an actual evidence-based gap instead of overlapping with previous research on mental health care and ethnicity. They could also be of use for people who are running or want to run NHS Talking Therapies services and have ethnic inequality in mental healthcare to change their practices, as has been suggested by the (NHS Race and Health Observatory, 2023).

## 12. Plan of Work and Time Schedule

Table 2 and Figure 4 set out the planned schedule of work, aligned to the module timeline covering Weeks 7 to 12.

| Activity                                        | Wk 7 | Wk 8 | Wk 9 | Wk 10 | Wk 11 | Wk 12 |
|-------------------------------------------------|------|------|------|-------|-------|-------|
| Refine search strategy and eligibility criteria | X    |      |      |       |       |       |
| Database and grey literature searching          | X    | X    |      |       |       |       |
| Title and abstract screening                    |      | X    |      |       |       |       |
| Full text retrieval and screening               |      | X    | X    |       |       |       |
| Quality appraisal                               |      |      | X    |       |       |       |
| Data extraction                                 |      |      | X    | X     |       |       |
| Synthesis and drafting                          |      |      |      | X     |       |       |
| Supervisor feedback and redrafting              |      |      |      | X     | X     |       |
| Submit written proposal on Turnitin             |      |      |      |       | X     |       |
| Submit Ethics form PG2                          |      |      |      |       |       | X     |

*Table 2. Plan of work by module week.*

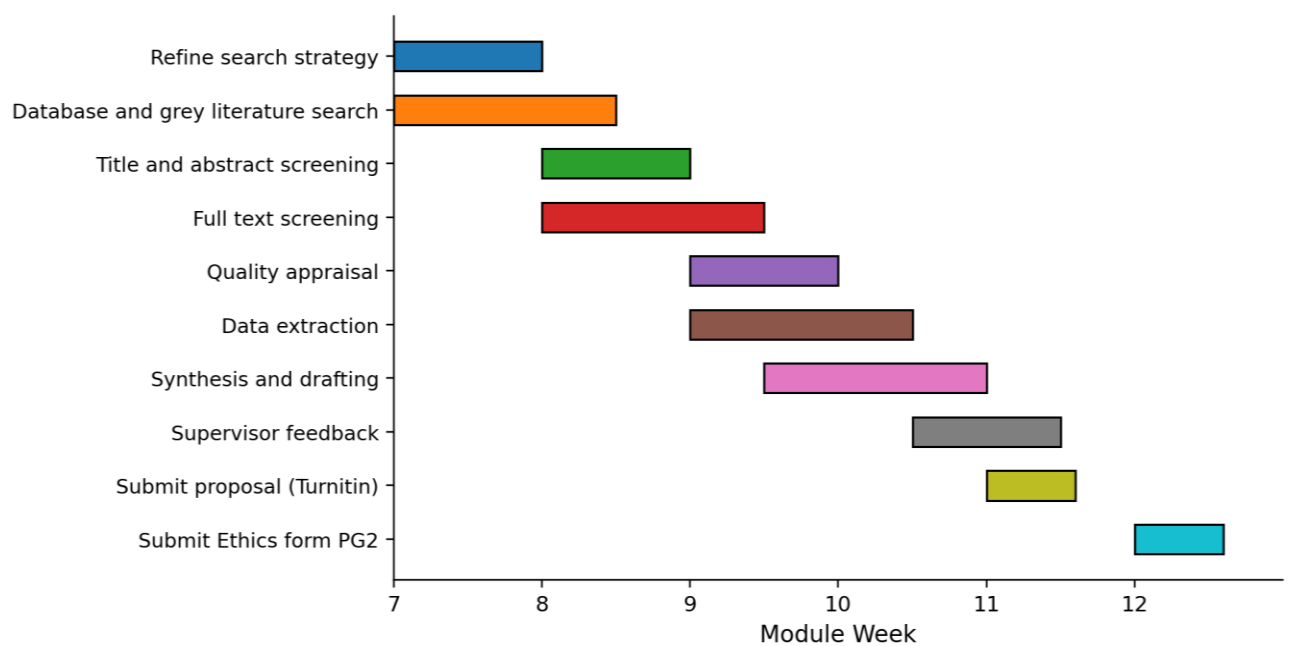


Figure 4. Visual timeline of the work plan, Weeks 7 to 12.

### 13. Summary of Key Evidence

Table 3 summarises the main studies underpinning this proposal, showing how each links to the barriers, facilitators or methodology discussed above.

| Study                                 | Design                                           | Key finding                                                                                       |
|---------------------------------------|--------------------------------------------------|---------------------------------------------------------------------------------------------------|
| Prajapati and Liebling, 2022          | Meta-ethnography of 15 UK studies                | Identified three themes, distance from services, dilemma of trust and threat to cultural identity |
| Husain et al., 2024                   | Multicentre randomised controlled trial          | Culturally adapted group therapy improved recovery from postnatal depression                      |
| Bhui et al., 2003                     | Systematic review of NHS pathways                | South Asian patients less likely to be referred to specialist mental health care                  |
| Howe and Sangar, 2021                 | Qualitative study with British South Asian girls | Shame and honour shape decisions to seek or avoid help                                            |
| Jain et al., 2025                     | Systematic review across high income countries   | Religious and moral explanatory models remain common for common mental disorders                  |
| Masood et al., 2015                   | Nested qualitative study                         | Transport, childcare and familiar settings supported engagement with therapy                      |
| NHS Race and Health Observatory, 2023 | National ten year data review                    | South Asian and Bangladeshi groups show lower referral and recovery rates                         |

Table 3. Summary of key evidence informing this proposal.

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