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Co-navigating care for emotional distress in South Asian men with long-term conditions: a qualitative study of patient and GP perspectives

Hassan Awan
h.awan@keele.ac.uk
Keele University
Nadia Corp
Keele University
Tom Kingstone
Keele University
Carolyn Chew-Graham
Keele University

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Abstract

Background.

Men of South Asian (SA) origin in the UK have increased rates of long-term conditions (LTCs) and mental health problems compared with the general population, yet are less likely to seek help from NHS services, and Pakistani men in particular report the lowest recovery rates in NHS Talking Therapies. Co-occurring physical and mental health problems are associated with poorer outcomes. Research examining help-seeking in SA men with LTCs experiencing emotional distress is limited. Understanding this is essential to addressing inequalities in access to, experience of, and outcomes from primary care mental health support.

Methods.

This qualitative study used online semi-structured interviews analysed through reflexive thematic analysis, underpinned by a critical realist epistemology. Participants were SA men with diabetes or coronary heart disease (n = 17) and general practitioners (GPs) working in practices serving higher density SA populations (n = 18), across three UK regions. Participants were recruited through community and faith centres, social media, and snowball sampling. Topic guides were adapted iteratively during concurrent data collection and analysis. A Patient Advisory Group of SA men were involved in all stages of the study.

Results.

Two overarching themes were developed: (1) trust and mistrust, in primary care and in culturally-based support, and (2) co-navigating care, negotiating health beliefs between GPs and patients. SA men in our study described avoiding NHS services for emotional distress because of perceived over-medicalisation, experiences of discrimination, and divergent health beliefs, turning instead to faith-based support, family, and self-management. Both patients and GPs described the need for care that engages with patients' cultural and religious health beliefs, built through relational continuity. Co-navigating care recognises that patients and GPs may bring distinct beliefs to the consultation which require mutual negotiation. Integrating findings with PAG input and prior work, we present the 3Cs framework (Contextualising distress, Conceptualising distress, Co-navigating care) for general practice consultations.

Conclusions.

SA men with LTCs in our study described limited engagement with primary care for emotional distress. The 3Cs framework may support GPs to engage through co-navigating care. Embedding community and faith organisations as core partners in primary care, consistent with the 10 Year Health Plan shifts toward community-based care and prevention, could contribute to more equitable service delivery.

Background

Addressing co-occurring physical and mental health problems is a global priority [1]; understanding the link between physical and mental health was identified as the second priority for mental health research in the 2020s [2]. Physical and mental comorbidity results in worse health outcomes including quality of life and mortality [3–5]. Ethnic minority populations experience a disproportionate burden of both long-term conditions (LTCs) and mental health problems yet face systemic barriers accessing appropriate support [6]. In the United Kingdom (UK), South Asians (SAs) are the largest minority group, comprising 9.3% of the population (5.5 million people, with the majority of origin from India, Pakistan and Bangladesh) [7], and exemplify this inequality, with substantially higher rates of long-term conditions such as diabetes [8] and coronary heart disease [9] than the general population. SA adults, particularly Pakistani men aged 35–54, experience elevated mental health problem rates compared with White British populations [6, 10], yet men from ethnic minorities are significantly less likely to seek help for mental health problems [11]. This reluctance links to perceptions of masculinity, cultural norms, and religious beliefs that shape mental health conceptualisation, and systemic barriers within healthcare [12, 13]. The consequences are stark: Pakistani men report the lowest rates of recovery (33.5%) in comparison with Irish women (50.5%) in NHS Talking Therapies [14].

In this paper, we use the term emotional distress to refer to negative emotional experiences including low mood, anxiety, worry, and feeling overwhelmed, which may or may not meet diagnostic thresholds for a mental health condition. This working definition, consistent with our earlier systematic review [15], reflects how SA participants in our programme of work have described their experiences, which often sit outside biomedical diagnostic categories.

A systematic review identified cultural stigma creating help-seeking barriers, discrimination within services, and preferences for culturally adapted interventions, alongside gender-specific factors such as 'breadwinner' roles intensifying work-related stress; perceived inadequate clinical support led SAs to turn to self-management, family, and faith [15].

Three gaps persist. First, research focuses on mental health service users with diagnosed illness [16], missing those experiencing emotional distress alongside physical LTCs who do not reach mental health services. Second, SA men with LTCs remain under-researched despite increased risk of mental health difficulties such as depression, and low NHS Talking Therapies engagement and recovery rates [14]. Third, GP perspectives on supporting this population are largely absent, despite GPs' pivotal gatekeeping role in UK primary care.

Contemporary barriers to care include language differences, culturally inappropriate assessment tools, and discrimination in healthcare encounters, compounded by healthcare systems designed around majority population needs and preferences [17, 18]. Ethnic minorities remain significantly under-represented in healthcare research (White British people are 64% more likely to participate than people from ethnic minorities [19], with Asians comprising

only 3% of public contributors [20]), perpetuating service development that does not meet diverse needs [21, 22]. Despite policy commitments such as the 10 Year Health Plan, *Fit for the Future* [23], and the Core20PLUS5 framework [24] identifying ethnic minorities as requiring focused intervention, implementation remains inadequate, with the gap between policy rhetoric and practice delivery persisting.

We focused on diabetes and coronary heart disease because both have substantially higher prevalence in SA populations, both are long-term conditions requiring lifestyle changes and medical management with overlapping risk factors, and both are primarily managed in UK primary care. Findings may have wider relevance to other LTCs with similar trajectories of primary care follow-up, but we do not claim transferability to all LTCs.

Our previous work identified the importance of contextualising distress (including social determinants) and conceptualising distress (including integrative health paradigms based on faith and culture) [25], but the specific question of how SA men with LTCs seek help for emotional distress, and what GPs identify as necessary to provide effective support, remains unexplored. This study addresses this gap by exploring both patient and GP perspectives on help-seeking and service engagement. Understanding these perspectives is essential for translating policy commitments into practice, offering practical guidance for primary care clinicians to meaningfully reduce health inequalities.

Methods

This qualitative study used semi-structured interviews to explore help-seeking for emotional distress among SA men with LTCs and among GPs providing their care. Analysis was underpinned by a critical realist epistemology, which assumes that mental health experiences are shaped by underlying social and psychological mechanisms and are interpreted through individual and broader lenses [26–28].

Setting and participants

The study took place in Staffordshire, Greater Manchester and Lancashire (UK), areas with high SA population densities [29] where the lead author had established community trust through prior health research and community engagement over several years.

SA men with LTCs. Inclusion criteria: men; aged 18 or over; self-identified SA origin; self-reported diabetes and/or coronary heart disease; able to provide informed consent. Exclusion criteria: acute mental health crisis at the time of recruitment.

GPs. Inclusion criteria: GP partners or salaried GPs currently working in practices whose registered list included a higher than national average proportion of SA patients, identified using the Public Health England Shape Atlas tool [30], which maps practice catchment demographics against Office for National Statistics ethnicity data. Exclusion criteria: locum GPs and GPs in training.

Recruitment

SA men were recruited through purposive sampling via community centres, faith centres, SA-frequented grocery stores, social media, and local radio. Purposive sampling aimed to promote inclusivity and representation of SA men from diverse backgrounds (different SA countries, faith, age, and health conditions).

Prior to the interview, potential participants received an information leaflet and consent form by email. Participants who consented were contacted via telephone or email to schedule an interview.

GPs were recruited through professional networks of the research team and direct approaches to practices identified via Shape Atlas. Invitations were sent by email with a participant information leaflet. Interested GPs were followed up to confirm eligibility and arrange an interview.

Data collection

Online one-to-one semi-structured interviews were undertaken between November 2020 and October 2021 by the lead author (a male SA academic GP). The lead author occupied an insider-outsider position, sharing cultural identity with many SA participants and professional identity with GPs. With consent, interviews were audio-recorded, anonymised and transcribed verbatim. Interviews were conducted iteratively alongside analysis, with the number and depth of interviews considered in terms of inductive data saturation [31].

Separate topic guides (Additional file 1) were developed for SA men with LTCs and GPs based on systematic review findings [15], team discussions, and Patient Advisory Group (PAG) input. Topic guides were iteratively refined. For example, early interviews discussing faith-based support led to more detailed questioning about religious practices in later interviews. The Consolidated criteria for reporting qualitative research (COREQ) were used to ensure quality of reporting (Additional file 2) [32].

Data analysis

Data were analysed using reflexive thematic analysis [33, 59], following the six phases of familiarisation, generating initial codes, developing initial themes, reviewing themes, defining and refining themes, and producing the report. Analysis was recursive rather than linear, with later phases prompting return to earlier data and codes. Sample size was considered in terms of inductive data saturation [31], given the specificity of the research question, the density of the interview material, and the analytic aim of theme development.

Patient and GP interview transcripts were coded separately in the first instance to prevent professional framings displacing patient accounts. Initial themes were developed within each dataset before being brought into dialogue at the theme review phase. Integrated themes were constructed with explicit attention to tensions and resonances between the two perspectives. For example, the theme of trust was shaped by convergence on mistrust of primary care but divergence on where trust could be invested. Where patient and GP accounts pulled in different directions, we retained both rather than resolving the tension analytically. NVivo 12 (QSR International) supported data management.

The research team comprised a male SA academic GP who conducted the interviews, a female White British academic GP, a male White British social scientist, and a European evidence synthesis specialist. Monthly team meetings provided a forum for interpretive dialogue, testing readings against alternative accounts and surfacing assumptions, consistent with a critical realist frame in which multiple perspectives on data generate fuller interpretations of a stratified reality rather than verifying a single truth [34].

Positionality shaped data generation and interpretation in specific ways. Shared SA heritage between the interviewer and patient participants opened conversations about faith, family roles, and experiences of racism, and made the use of culturally familiar idioms possible, but may have foreclosed fuller explanation of concepts participants assumed were shared and may have produced some social desirability in accounts of cultural practice. With GPs, the interviewer's insider status as a GP enabled quick rapport and access to professional reasoning, while also risking collegial alignment that could soften critical reading of GP accounts. These dynamics were recorded in a reflexivity diary and discussed in team meetings, and they shaped analytic decisions about quote selection and theme development. Sampling across three geographically distinct areas provided contextual variation in primary care organisation and community composition, strengthening the analytic scope.

This analysis draws on the same dataset as our earlier study of the social determinants of distress in SA men with LTCs [25] but addresses a distinct research question focused on help-seeking and co-navigation of care. The two analyses are complementary rather than sequential; transcripts were re-read and re-coded for this paper in light of our specific research question.

Patient and public involvement and engagement

A Patient Advisory Group (PAG) of five SA men was convened through a specific Keele University initiative which supported ethnic diversity in public involvement by working with university staff and students who have trusted community relationships (community champions) to encourage members of under-served communities to contribute to research [35]. The PAG was involved throughout all stages of the research according to the UK Standards for Public Involvement [36], highlighted in Table 1. PAG contributions were co-interpretive rather than validating: members reshaped language, renamed themes, and negotiated analytic sense-making. A clear example was the group's rejection of an initial theme labelled 'navigating health beliefs', which they felt implied patients' cultural and faith beliefs were obstacles for clinicians to work around. Through iterative meetings, this was reframed as 'co-navigating care', in which both clinician and patient bring health beliefs into the consultation. This reframing forms part of the analytic decision trail for this study.

Table 1
PAG contribution.

Research area	PAG input and impact
Research question	Developed the research question and aims via a team approach; preference for research on South Asian men rather than specific countries, and for emotional distress over mental health problems
Public-facing documents	Adapted to be culturally appropriate, including simplifying wording and adding images
Recruitment	Targeted, for example Asian grocery shops, specific radio stations, community and faith centres
Analysis	Challenging and re-working themes, such as co-navigation
Dissemination	Animation video co-created; 'top tips' developed for working with patient advisory groups from under-served communities using HICCMAT (wisdom)
Future priorities	Next steps after this research discussed, including a possible intervention study and research on faith leaders' roles

Results

Seventeen SA men with LTCs and 18 GPs were interviewed. Interviews lasted around one hour. Patient participants spanned Pakistani, Bangladeshi, Indian, and Sri Lankan heritage, first and second generation migration status, and varied in faith background and intensity of religious practice, with a majority identifying as Muslim. GPs varied by ethnic background, gender, career stage, and practice type. Full participant demographics are provided in Additional file 4.

Two themes were developed: (1) trust and mistrust, in primary care and in culturally-based support, and (2) co-navigating care, negotiating health beliefs between GPs and patients. We use culturally-based support to refer to forms of help and meaning-making drawn from participants' cultural and faith resources, including faith practice, family networks, and community gatherings. Illustrative data are cited using participant identifiers (SA or GP and transcript number).

Trust and mistrust: in primary care and in culturally-based support

Participants described mistrust of healthcare and trust in culturally-based support.

Mistrust of healthcare

Mistrust of healthcare operated at multiple levels. Historical mistrust was expressed in terms of a clear link between authoritarian governance in SA countries and British military training, fostering suspicion of institutional structures.

We have been ruled in Southeast Asia by, let's say, dictators or very authoritarian people… And then when we see these military people who have ruled Pakistan for a great deal of their history, and we find that they are trained at Sandringham… (SA02)

Contemporary mistrust was expressed in terms of direct discrimination, such as a female relative being treated rudely for wearing traditional clothing.

I went with my mum to see a white doctor. And she [my mum] was wearing her niqab [face veil], right? And he was making faces. He was behaving rudely. And when you experience that, it's very hard for you to trust them. (SA10)

Experiences such as this eroded trust not only in the individuals directly affected, but more broadly among families and communities, who would then be unable to trust the medical community.

Epistemic mistrust was expressed through misalignment of health beliefs, with SA participants seeking causal explanations of their symptoms and perceiving GPs as plastering over problems with medication without engaging with the cause.

I don't think that GPs are much help anyway. I don't think even doctors are much help. Doctors, they don't find the root cause of any illness, they just give you medication after medication. (SA03)

There was a background about ten years ago. I was off work with stress… The doctor prescribed tablets and to be honest, I didn't take the tablets. (SA02)

The divergence between biomedical framings of mental illness and patients' explanatory models was reflected in GP perspectives, which described poor adherence to medication and resistance to medical labels.

If mental illness was suggested they would often say 'no, I'm not depressed, no I don't have a mental illness' even if the explanation was to go down the route of anxiety… They would be very, very reluctant to be classed as someone who was suffering with an acute mental health issue… The management of these patients is far more difficult because the acceptance is poor. (GP04)

This may have reflected a more fundamental rejection of suggested management plans, with SA men preferring alternative conceptualisations of distress that mapped to their cultural understandings instead of diagnostic labels such as depression and anxiety. This led to SA participants not seeking help from GPs, given the importance of understanding culture in their experience of distress and the perceived lack of GP understanding.

I just feel like with talking to a GP, it's going to be so long, and they probably won't know what's going on, because there's so much cultural baggage that comes with it sometimes, it's just so hard to explain. (SA09)

Some GPs demonstrated reflective awareness of the importance of understanding the influence of culture on health, and the responsibility lying with clinicians to engage with this to care for their patients, in a system which rewards performative care and documentation above meeting patients' needs.

As community healthcare professionals, we're actually quite illiterate when it comes to looking after the health needs of our BAME [Black, Asian, and Minority Ethnic] community… If you deliver it in the right way, I think the literacy level among the Asian chap compared to the Caucasian chap is not going to be that different. (GP16)

Being able to identify with that group and understand them, and having appreciation of their wants and needs is really helpful… If you can't connect with people, if you're not culturally competent… you might as well waste your time. It's like prescribing someone Prozac who just bins it as soon as they walk out the door. (GP05)

Accounts varied within the sample. Second-generation participants more often described willingness to engage with NHS services, while first-generation participants more often spoke of prior experiences of discrimination as shaping their reluctance. Among GPs, those of SA heritage described both the possibilities and limits of cultural concordance, with one noting that shared heritage did not guarantee shared understanding of emotional distress.

Trust in culturally-based support

In contrast to mistrust of healthcare, participants described deep trust in culturally-based support which aligned with their worldviews. SA men with LTCs described trust in religion as protective when experiencing distress, through finding solace in divine wisdom, reframing distress as a test to pass rather than meaningless suffering, and providing hope that would otherwise be potentially absent. Structured prayer, regular attendance at faith centres, and community connection were described as sources of support across religions.

When I would be around any issues regarding myself personally or my family or friends, it's basically my belief that sees me through these challenges, issues and calamities that may befall us… So, specifically the belief is that when things happen, when tragedies happen and we can't really come to terms with it, then my belief is that this is in Allah's wisdom. There is a better plan beyond what we are experiencing at the moment. (SA05)

If I see English people around me, the one who goes to church, and one who regularly goes to church or with the community, the faith, or set on a faith programme, they don't have any depression. The faith gives you lots of hopes, lots of courage to deal with the problems. (SA12)

SA men described taking practical measures to improve their health while at the same time placing trust in a higher power.

There are a couple of things. One is I have to put the effort in, right, to do the best I can to look after my body which was what I was doing with exercise, sport and a healthy diet. Secondly, I have put my trust in Allah and those together helped me get through the issues. (SA05)

These two approaches were described as working hand-in-hand to reduce emotional distress and concerns about future health problems, providing a holistic approach that encompassed physical, mental and spiritual dimensions as complementary rather than compartmentalised.

Family and community support was described as one of the most beneficial aspects within SA culture. SA men emphasised a sense of belonging to a wider group providing collective support and social connections in addition to individual strength.

The family support mechanism. With the South Asian community, they'll always pull together… The sense of belonging, the sense of community cohesion is valued to members. That's why I feel proud living in the South Asian community. (SA06)

GPs acknowledged not asking patients about faith and its interplay with distress. Some GPs perceived a need for integrating services to align with holistic models of care that bring together physical, mental and spiritual health, practised through culturally-based traditional doctors and incorporating the breadth of patients' lives.

If we go to those sort of orientalist places, the word for doctor is all-encompassing. It covers the whole breadth of wellbeing. There isn't this artificial divide. And nor should that divide exist based on where that care is received… I think the whole-person approach, if we're talking about an American term, the Americans talk about integrative medicine. (GP02)

Co-navigating care: negotiating health beliefs between GPs and patients

Both SA men and GPs recognised that effective care required more than cultural awareness; it required active negotiation across differing health perspectives and practices. 'Co-navigating care' reflects this mutual work of bridging paradigms, achieved through developing trusting relationships, community-centred approaches, and professional development.

Not all participants described the same route to trust. Men with more intensive religious practice were more likely to speak of faith leaders as pre-primary care support, whereas less religiously observant men emphasised family and community without specific reference to faith institutions.

Developing trusting relationships over time

GPs described how SA men with LTCs would have multiple contacts with primary care due to having complex LTCs, creating opportunities for trust-building and to ask about emotional wellbeing. Proactive care with scheduled follow-up was described as demonstrating to patients that they were cared for.

A good GP is probably someone who listens to them first, understands or asks them what type of help they need… and who is persistent in following them up regularly. I don't think you can be a good GP on the first visit, but I think a good GP for them is someone who they eventually feel they do care… I think that will start to develop some trust. (GP17)

SA participants described how continuity and consulting the same GP led to developing trusting relationships, which was a prerequisite to disclosing emotional distress.

It's not something that happens overnight. You don't just suddenly start offloading to your GP, without any kind of trust-building time… It's very important. You need stability. You need a stable figure, who you can turn to whenever you want to. (SA10)

GPs described awareness of their own biases and beliefs as central to good care, noting that these biases could be more pronounced when consulting with SA men. They described active awareness as a way of mitigating the effect of these biases on the consultation.

You might only have one chance to get it right with them, because they attend so rarely. And I think it comes down to the basics of any GP work and primary care work. It's just listening. Our job is to listen. And it's not to go in with our own biases, cognitive biases, or assumptions, driving things. (GP07)

This was felt to be very important when consulting with SA men with LTCs, as a single negative consultation could stop SA men from returning, given the previous experiences of discrimination described above.

Healthcare relationships were described as going beyond individual-level (doctor-patient) to a more collective approach (doctor-family), particularly with older first-generation SA men with LTCs.

99% of the time another family member would consult me, the wife, the children, and inform about the stress in the household taking place. And it would be extremely unlikely for that individual, for the first generation, over 65, South Asian gentlemen to inform me directly themselves that there was a stressor in their household. (GP04)

GPs found that a family-approach was vital, particularly when addressing emotional distress, and SA men often relied on family members to communicate their struggles and gained support from a collective family and community relationship.

The more involvement you can get from families and other support networks that an individual has, the more likely they are to be able to understand their condition but also be compliant with any advice and management you give them. (GP14)

Community-centred care

SA men described willingness to utilise services for emotional distress when these aligned with their paradigms of faith and health.

I think anything like that would be good, obviously for people who can't do those sorts of stuff like CBT, and mindfulness and don't feel comfortable doing stuff, like some of the new age therapy. So, yes, if there was a community-based or spiritually-based or whatever, definitely. (SA02)

From some patients' perspectives, NHS Talking Therapies were positioned as the unfamiliar alternative, with treatments such as cognitive behavioural therapy and mindfulness described with unease as 'new age therapies' outside their worldview. Faith-based and community-based support, by contrast, was described as familiar and trusted.

Services were felt to be best placed within communities, with involvement from faith leaders, both in community awareness-building and in supporting community members in 'pre-primary care' as a legitimate first-line source of support that could facilitate help-seeking and possibly prevent escalation to crisis.

And I think to try normalise this conversation within this community… we have to start across the generations and we have to start early. This needs to be, when somebody is troubled and they're going to see their Imam for what may be… culturally competent talking therapy… it needs to be pre-primary care. (GP02)

I think they [faith leaders] can play a vital role in changing attitudes in speaking up about these issues in Khutbas [sermons], on Friday Khutba, starting courses for people about Islam and mental health. (SA10)

This challenges the positioning of community support as supplementary to medical services. Reaching out to communities, and co-producing interventions based in the community, was felt by GPs and SA men to be essential to care and to developing trust.

I think reach out to community centres like mosques, places of worship, and raise awareness of the services. And have more consultation within the community people, and understand some of the issues. (SA06)

The simplest approach is going out to those areas where they congregate the most. You have to stop leaving healthcare in the GP surgery… we need to co-produce our approach to this with the communities, rather than against the communities. (GP07)

GPs described how community-centred services should be an integral part of care given the diverse UK population, rather than a two-tier provision where ethnic minorities rely on charitable support while mainstream services remain inadequately equipped to support them.

Why is it that I'm having to refer my patients to [charitable organisation]? Why can I not directly refer them into the mental health service knowing full well that the mental health service is fully equipped for this population of people? That itself just says a lot about where the NHS is at the moment. The gap between where it is and where it needs to be… I think the NHS is for the people. It belongs to the people, and that's everybody. The typical British person is no longer White English middle class, but it includes these people as well. And we have a duty to look after them just as we do for everybody else. (GP05)

GPs emphasised the importance of organisational change, highlighting the need for diversity in healthcare leadership to better serve diverse populations.

Boards, more than organisations, set the culture of the NHS itself… It determines where the money is spent… the moment the board is representative of the people it serves and the front line, then that organisation becomes a lot more effective. Sadly, at the moment, within [city name], our boards are not reflective of the people we serve and it's not reflective of the frontline staff. Consequently, the kind of decisions that they're making, they just don't fit the needs of the people. (GP05)

Professional development

SA participants described the need for bidirectional learning for health professionals to learn about cultures and faith, and for faith leaders to learn about emotional distress.

So, basically, it's not just a one-way street. The psychologist, psychiatrist, doctor, whatever, has to learn about Islam… about Jinn [spirits], black magic, and evil eye and all these… But equally, more spiritual leaders, like imams and community leaders, it's important that they also learn about the other potential causes of mental illness like trauma, chemical imbalance and genetics, so that through them the community heart is really changed, through faith and religion. (SA10)

GPs described a need for medical education to be appropriate to understand and manage people with emotional distress in different cultures and with different faiths, and for minority health to be a subject topic.

If we go right back to that first year medical student, and I'm sure this is right across the training disciplines, when I'm learning to take a medical history, the expected convention is not conducive to emotional enquiry in any shape or form. (GP02)

I think there needs to be a speciality of ethnic minority health… I think we need to educate at all levels. I think the Royal College of GPs, as a trainer, doesn't give an adequate nod to the issues of ethnic minorities. (GP10)

The 3Cs framework

The 3Cs framework (Fig. 1) was developed through integration of three sources of evidence. First, the empirical themes of trust and co-navigating care from this study. Second, co-production with the PAG, whose iterative meetings reshaped the language and structure of the framework, including the reframing of 'navigating health beliefs' as 'co-navigating care'. Third, synthesis with our earlier work on emotional distress in SA communities [15, 25], which contributed the Contextualising distress and Conceptualising distress dimensions. The framework is therefore an applied tool informed by empirical findings, co-production, and prior analysis, rather than a pure inductive output of a single dataset.

Patient advisory group feedback

The PAG's role in developing these themes is described in Methods. Beyond theme development, the PAG co-produced an animation video for SA men with LTCs (https://www.youtube.com/watch?v=pSuTAf_JU1I), which has been shared on a number of community and health forums and added to undergraduate medical curriculum. The PAG co-developed top tips for working with patient advisory groups from under-served communities, using the HICCMAT acronym (meaning wisdom in some SA languages), through iterative meetings in which members drew from their lived experiences to identify and prioritise key principles for meaningful involvement (Additional file 3). These outputs illustrate how sustained public involvement can produce resources that extend the reach of academic research into community and educational settings.

Discussion

This study provides novel insights into how SA men with LTCs navigate emotional distress in primary care, revealing key themes of trust and co-navigating care. Building on our systematic review's identification of perceived inadequate clinical support and reliance on culturally-based support systems [15], and our previous analysis identifying social determinants of distress in this population [25], the current findings describe the mechanisms of help-seeking and service engagement.

Our previous work revealed *what* contributes to distress; this study reveals *how* SA men with LTCs respond to distress, their help-seeking behaviour, reasons for avoiding NHS services, and preferences for community-centred services.

Theoretical contributions

'Co-navigating care' emerged as crucial for understanding how GPs and SA patients can work together effectively. This extends beyond traditional person-centred care [37] by explicitly recognising that both clinicians and patients bring their own health beliefs and cultural paradigms to consultations. While previous research has shown that diagnoses are collaboratively negotiated based on GP and patient health belief models [38], our findings suggest this negotiation begins earlier and extends throughout the therapeutic relationship. Emphasis on co-navigation rather than simply cultural competency represents a shift from viewing different health beliefs as barriers to seeing them as essential components of effective care delivery [39, 40].

Our findings extend current thinking on cultural safety for SA patients. A systematic review and meta-ethnography of SA service users [16] identified three dominant themes: distance from services perceived as outside cultural norms, dilemmas of trust, and threats to cultural identity in encounters lacking collaborative or culturally sensitive care. Cultural safety has been proposed as the way forward, requiring healthcare professionals to examine the impact of their own culture on service delivery [41]. Our findings suggest that cultural safety needs to be operationalised through a dynamic, dialogic process, in which both GP and patient bring health beliefs into explicit negotiation, which we describe as co-navigating care.

Our findings on trust extend previous research on mistrust of healthcare services among ethnic minorities [42]. While historical persecution has been emphasised as a source of mistrust in some communities [43], participants in our study pointed to multiple contemporary factors, including perceived discrimination and over-medicalisation of distress, contributing to disengagement from primary care, consistent with recursivity [44]. Some accounts were consistent with the concept of institutional betrayal, where historical and ongoing discrimination generates warranted scepticism of institutions [45]. Taken together, participants' accounts of colonial history, contemporary discrimination, and systemic over-medicalisation suggest that the mistrust they described functioned as a reasoned response to perceived structural inequity, rather than an individual psychological disposition.

Relationship-based care and policy implementation

Both SA men and GPs described the benefits of relational continuity. Relationship-based care, defined by the RCGP as *"care in which the processes and outcomes of care are enhanced by a high-quality relationship between doctor and patient,"* [46] (p4), differs from continuity of care, which pays more attention to the continuous and coordinated delivery of healthcare over time, with relationship-based continuity focusing on the quality of the relationships. The evidence base for relationship-based care is strong: mortality is reduced [47], including within primary care [48], concordance increases [49], and emergency hospital use and admissions are decreased [50]. Where mistrust of clinicians is present, as described by participants in our study, relationship-based care may facilitate trust through co-navigation over time. Conversely, continuity of care is lower in some SA communities, for example Bangladeshi and Pakistani communities, than the White population in the UK [51]. The RCGP prioritises relationship-based care in delivering healthcare that is *"fit for the future"* [52]. For SA men with LTCs in our study, not consulting when distressed and reporting mistrust when they did consult were common. Co-navigating care may offer one route to support relationship-based care with these patients [46].

Our findings speak directly to the 10 Year Health Plan, Fit for the Future [23], particularly its shifts from hospital to community and from sickness to prevention. Participants' preferences for community-based and faith-based support, alongside calls to embed these as integral to NHS provision rather than as supplementary charities, align with the neighbourhood health service model that places general practice at the centre of community-based care. The shift from sickness to prevention resonates with participants' emphasis on pre-primary care support from faith and community organisations, offering early help before distress escalates. The 3Cs framework offers operational guidance for primary care implementation that aligns with both shifts.

Community-centred approaches

Participants in our study described turning to community-centred support, consistent with previous research on the importance of religion, faith leaders, and a bio-psycho-social-spiritual approach in supporting mental health [53, 54]. This aligns with evidence that culturally adapted mental health interventions incorporating religious teachings are more effective [54] and preferred by patients [55].

Faith centres and community organisations emerged as particularly significant, with participants describing a need for services engaged with, and embedded within, communities. This builds cultural health capital: the knowledge and skills, shaped by culture and social background, that result in more optimal healthcare relationships [56]. Cultural health capital extends beyond language and health literacy to appreciate people's cultures and attitudes to optimise health [56]. The study's findings point toward the need for an integrative approach to healthcare that bridges conventional medical services with community-centred services, and can be an approach to considering systemic factors as well as individual encounters with healthcare professionals. This approach aligns with recommendations from the 2020 Commission for Equality in Mental Health, which emphasises the importance of creating mental health support within communities [57]. However, it is not enough for services to be community-based, that is, located within communities; they must be community-centred, that is, operating within community paradigms of health.

COVID-19 context

Interviews were conducted between November 2020 and October 2021, during the COVID-19 pandemic. The pandemic affected UK primary care through the rapid shift to remote consultation, reduced routine appointments, and altered patterns of help-seeking, and had a disproportionate impact on SA communities. Recent work shows ethnic minority communities experienced compounded barriers to mental health support during and after the pandemic, including increased reliance on community rather than formal services [60]. Some accounts in our study may reflect pandemic-specific conditions, particularly the shift to digital consultation and the prominence of community and faith networks. The core themes of trust and co-navigation were reported by participants as predating the pandemic, but their expression and prominence may have been shaped by the pandemic context.

Strengths and limitations

Strengths of this study include adherence to reflexive thematic analysis across datasets generated from interviews with two participant groups, sustained and meaningful Patient Advisory Group involvement (including reshaping of the central analytic concept), and multi-perspectival analysis of patient and GP accounts across three geographical areas. Patient participants came from the four largest SA heritage groups in the UK; GPs worked across varied practice types. This paper addresses a different research question from our earlier analysis of the same interview dataset [25], which examined social determinants of distress. Using a single dataset to address complementary research questions is consistent with qualitative research practice and can deepen understanding of complex phenomena [58].

Most patient participants were Muslim. While findings on faith as a source of trust and support are likely relevant to other SA faith communities, the specific expressions (including experiences of Islamophobia, engagement with Imams, and beliefs about Jinn, black magic, and the evil eye) are situated in Muslim experience. Themes related to family, community, and mistrust of primary care may transfer more readily to Hindu, Sikh, Christian, and non-religious SA men, but this requires empirical exploration. We did not systematically collect LTC duration or disease severity data; different illness stages may influence emotional distress and help-seeking differently. Interested participants were sent the information leaflet by email, which had the potential to marginalise those not digitally proficient, although family members did support some participants in this case. While the study focused on GPs and patients, future research could benefit from including other primary care professionals and community health workers.

Clinical implications

The 3Cs framework provides a practical structure for GPs consulting with SA men experiencing emotional distress. Contextualising distress involves understanding how intersecting social determinants (such as ethnicity, poverty, prejudice, and 'breadwinner' roles) may influence their experience of distress. Conceptualising distress requires GPs to actively listen to patients' explanatory models, asking about the role of culture and religion, while being aware of their own health beliefs and biases. Co-navigating care integrates different health paradigms by combining conventional approaches with culturally appropriate support, such as linking with local faith leaders, incorporating community-centred therapies, and supporting family-based approaches.

Healthcare organisations should move beyond cultural competency training to develop systems that enable cultural safety and co-navigation, including partnerships with community and faith organisations, co-creation of community-centred services, and leadership representation that reflects the communities served. Practices should reach out to community and faith centres to co-deliver events on mental health and wellbeing, supporting delivery of care within communities. The NHS 10 Year Health Plan, Fit for the Future [23], provides a policy framework for such changes. Implementation requires training clinicians in cultural safety, health inequalities, and integrative care approaches, alongside up-skilling community and faith leaders in mental health, and establishing formal, funded pathways for collaboration with faith and community organisations rather than relying on voluntary sector goodwill.

Conclusions

This study suggests that primary care mental health services fail to effectively support SA men with LTCs due to inadequate recognition of cultural health paradigms. Co-navigating care offers a solution by actively negotiating between biomedical and culturally-embedded health beliefs, requiring clinicians to move beyond cultural competency toward cultural safety. The 3Cs framework provides immediate practical guidance for GP consultations and highlights the need for systemic transformation. Healthcare systems should embed community and faith organisations as core partners in service delivery to address health inequalities. Future research should focus on implementing and evaluating interventions based on these principles, including formal integration models between primary care and community organisations.

Declarations

Ethics approval

Keele University Faculty of Medicine and Health Sciences Research Ethics Committee (MH-200132); UK Health Research Authority and Health and Care Research Wales (IRAS 293272).

Consent for publication

Participants provided written informed consent for the use of anonymised quotes from their interviews in academic publications.

Competing interests

The authors declare that they have no competing interests.

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Author Contribution

HA conceived the study, led recruitment and data collection, conducted all interviews, led analysis and interpretation, and drafted the manuscript. NC contributed to study design, evidence synthesis, analytic interpretation, and manuscript development. TK contributed to study design, analysis, interpretation, supervision, and manuscript development. CCG contributed to study design, analysis, interpretation, supervision, and manuscript development. All authors read and approved the final manuscript.

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Data Availability

The qualitative datasets (interview transcripts) generated and analysed during the current study are not publicly available to protect participant confidentiality; the study population comprises small, identifiable communities. De-identified excerpts supporting the findings are included in this published article. Further data may be available from the corresponding author on reasonable request, subject to ethical approval.

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Figures



Figure 1

The 3Cs framework for GP consultations with SA men with LTCs experiencing emotional distress.

Supplementary Files

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- Supplementaryfile1Topicguides.docx
- Supplementaryfile2Participantcharacteristics.docx
- SupplementalFile3WorkingwithpatientadvisorygroupsfromunderservedcommunitieswithHICCMATwisdom.png
- SupplementaryFile4ISSMCOREQChecklist.pdf