2025, Vol. 10, No. 1
ISSN: 2771-3520

Amplifying Culturally Responsive Mental Health Support: Insights from a Sikh and Punjabi Community Helpline in the United Kingdom

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Abstract

There is a growing need for cultural and linguistic adaptations within the United Kingdom's (UK) mental healthcare system, with a specific focus on faith-based inclusion for the South Asian communities, specifically Sikh and Punjabi populations. Current practices within the National Health Services (NHS) are not structured to deliver culturally competent care for diverse service users. Thus, this study aimed to examine how faith-based nonprofit organizations can support the Sikh and Punjabi community in navigating topics of mental healthcare and accessing supportive services, by collating feedback from callers of a telephone helpline. This helpline was staffed by seven trained volunteers providing support for users across the UK. Based on feedback gathered from seventy-five helpline users over a period of 3 years, researchers found that callers engaged more actively in personal help-seeking behaviors when they perceived providers as culturally competent. Findings suggest that statutory organizations could benefit significantly from offering culturally sensitive training to better serve diverse clientele.

Keywords: *South Asian, Punjabi, culturally responsive, faith-sensitive, mental healthcare.*

Introduction

The Punjabi community is collectivistic in nature, valuing the growth and wellness of all members through group unity, care, and nurturing (Ganeri, 2003; Chilana, 2005). Due to migration and immigration, the Punjabi community today has established itself globally, particularly in countries such as the United States of America (USA), the United Kingdom (UK), Canada, and Australia (Jakobsh, 2012; McCarthy, 2013; Singh, 2022). Making up more than half of the South Asian population in the UK, Punjabis follow diverse spiritual and religious practices. Within the UK's Punjabi community, 80% of members identify as Sikhs, while the remaining 20% follow Hinduism (including Hindu Punjabis and Hindu Dalits, who are primarily followers of Sant Ravidass and Valmik) and Christianity (Thandi, 2016; Virdee, 2022). There are 520,092 Sikhs in the UK, comprising 0.9% of the total UK population (Census, 2021).

Sikhs initially migrated to the UK in the mid-1800s as soldiers in the British Indian Army, and more Sikhs arrived in the 1980s from Uganda, East Africa (Striking Women, n.d.; Tatla, 2005). Sikhs also travelled to the UK as part of educational and diplomatic missions, with some remaining to form the first small Sikh communities. Following World War II, there was a significant increase in Sikh migration, as many Sikhs who played a role in the war remained in the UK to support the rebuilding of Britain (Tatla, 2005). Later, in the 1950s, an increased demand for labor attracted more Sikhs, particularly to the Midlands and other

industrial cities. In the 1960s, the Commonwealth Immigration Act of 1962 enabled greater freedom of movement, prompting further Sikh migration (Hepple, 1968; Thompson, 1970).

Arguably, given the collectivist nature of Punjabi and Sikh communities, individuals from these groups do not readily engage in personal help-seeking behaviors. They prioritize the wellness of their families and respective communities over themselves, while also perceiving mental health as a taboo subject (Chandra et al., 2016; Islam et al., 2017). During the COVID-19 global pandemic, racialised communities experienced increased mental health difficulties due to systemic disparities, higher mortality rates, financial difficulties, racism and discrimination, and a lack of access to previously available coping strategies and social support networks, such as faith communities and cultural spaces (Fish & Mittal, 2021). As a minority group, the Punjabi Sikh community was notably impacted during this unprecedented period, as help lines, psychological services, and related care organisations were not adequately positioned to meet the faith-based needs of the community (Agarwal, 2023; Karasz et al., 2019; Quraishi, 2023). Kaur and Basra (2022) investigated the impact of COVID-19 on the Sikh community in the UK through online focus groups. They found that Sikhs were able to form meaningful connections through their faith by engaging in *seva* [selfless service], *sangat* [community fellowship], *chardikala* spirit [an optimistic outlook], and drawing inspiration from spiritual narratives of their *Shaheeds* [martyrs] to sustain themselves during the pandemic.

To address the availability of culturally responsive mental health support in the UK, Sikh Your Mind (SYM), a Sikh-run and Sikhi-orientated grassroots charity, was founded in 2015. It was one of the first mental health organisations in the UK to support people of all faiths and backgrounds, primarily serving Sikh Punjabi populations. Although founded in 2015, SYM became an official charity in 2019 and, to the authors' knowledge, remains the only charity in the UK established by qualified mental health professionals within the Sikh community (Charity Commission, 2019). One of the co-authors (GK) is a trustee of the charity and has overseen the services and projects, including the mental health helpline available to the community. The SYM helpline, alongside other support services offered by the charity, is provided in both English and Punjabi. Punjabi is the third most spoken language in the UK (Census, 2021), with 63% of Punjabi speakers identifying as Sikh. The SYM mental health helpline is available to callers of all faith backgrounds, acknowledging that not all Punjabis identify as Sikh. However, for the purpose of this paper, we will be exploring this group specifically and in further detail, as Sikhs represent the majority of the UK Punjabi population.

Additionally, while other Sikh helplines do exist, the authors are not aware of any published data regarding outcomes or demographics relating to satisfaction with service provision by Sikh organisations to the Sikh community. Ongoing research is necessary to evaluate the impact of initiatives such as helplines, enabling continuous improvement to ensure support is effective, inclusive, and culturally appropriate.

Gap in the Findings

Research specifically focusing on satisfaction levels among Sikhs after using Sikh-specific mental health support services is limited. The British Sikh Report (2018) highlighted that 77% of Sikhs reported finding

their lives stressful, with 10% of women and 5% of men diagnosed with mental health difficulties. The British Sikh report was established by a British barrister in 2012, aiming to annually document and highlight the needs of the Sikh population in the UK. Given that the Sikh population in the UK is substantial, the report's inclusion of responses from over 2,000 Sikhs likely represents approximately 0.4% of the UK Sikh population. These statistics, therefore, must be interpreted cautiously given the limited sample size. However, this also highlights the overall lack of sufficient data on mental health difficulties Sikhs experience in the UK. Additionally, it is noteworthy that while the sample size may not adequately represent the broader Sikh population, the sampling strategy was not clearly identified in the report.

Furthermore, there remains a lack of data reflecting the use of mental health services when Sikh communities do seek support. Although more general data on South Asian and Punjabi mental health support satisfaction may be available (Prajapati & Liebling, 2021), there continues to be a gap in satisfaction data from Sikh populations specifically regarding their use of culturally sensitive support services. For example, studies on South Asian women's experiences with mental health services in England highlighted the importance of cultural sensitivity, noting that a lack thereof can negatively impact engagement with services (Phillips & Andriopoulou, 2022; Roberts et al., 2016).

In response to this gap, community organisations (i.e., Sikh charities including Sikh Helpline, Sikh Awareness Society, Taraki, The Heera Foundation, etc.) throughout the UK have begun working towards increasing dialogue and activism around mental healthcare accessibility for Sikhs. However, despite this growth in representation in the UK, there remains limited or no quantitative data on satisfaction rates within the Sikh community; rather, the feedback available tends to be more qualitative and relates more to general involvement. Thus, the lack of research into South Asian, Punjabi, and specifically Sikh satisfaction with generic mental health services persists, especially concerning satisfaction with Sikh-specific mental health support.

Theoretical Framework

The field of mental health typically views individuals from historically marginalized backgrounds through a Western lens, often omitting their heritage, culture, and ideologies within service delivery models. To accurately capture the nuanced experiences of culturally and linguistically diverse populations, specifically Punjabis and Sikhs in this study, it is essential to consider how immigration, acculturation, and adaptation have occurred in the UK. These processes further shape help-seeking behaviors and client perspectives within the UK context. In this regard, intersectionality (Crenshaw, 1989) exemplifies the multifaceted nature of minorities' experiences in mental healthcare and communal spaces.

Intersectionality. Kimberlé Williams Crenshaw (1989) popularized the term 'intersectionality' to highlight the unique experiences of discrimination and oppression individuals face across their intersecting identities, particularly when navigating societal spaces and services, including mental health services. The concept of intersectionality draws from the foundational work from Black feminist thought (Gines, 2011), Critical Race Theory (Bell, 1995; Delgado & Stefancic, 2023; Khan, 2016), and the activism of women of color (Dill & Kohlman, 2012), who laid the groundwork for understanding the complexities of overlapping

systems of inequality (Carastathis, 2016). Crenshaw's contributions have been instrumental in applying intersectionality to various societal contexts, such as mental health provision. Intersectionality highlights that, when developing a holistic understanding of an individual within mental healthcare, providers must consider all facets that can marginalize a person, including social constructs of gender, race, class, sexual orientation, physical ability, and more.

This qualitative review is grounded in the theory of intersectionality to integrate the duality of immigrant identities within culturally and racially diverse communities as they navigate social support systems. Intersectionality is significant because it addresses interwoven social categorizations (e.g., race, class, and gender) as they apply to a given individual or group. These categorizations actively create overlapping and interdependent systems of discrimination or disadvantage, evident in the outreach and hesitancy experienced when accessing mental healthcare services (Al-Faham et al., 2019; Hayanga et al., 2021; Runyan, 2018; Savaş et al., 2021).

Cultural Competency. Supplementary to intersectionality, cultural competency provides a framework for both understanding and interacting effectively with individuals from culturally and linguistically diverse backgrounds. This framework aims to deliver equitable and inclusive services, particularly within fields such as healthcare, education, and social services (Truong et al., 2014). Moreover, cultural competency emphasizes that mental healthcare providers must acquire the knowledge, skills, attitudes, and behaviors necessary to work respectfully with minority populations (i.e., Sikhs) and effectively handle cross-cultural situations (Hernandez et al., 2009).

There is a growing need for cultural and linguistic adaptations within mental health care generally, particularly concerning faith-based inclusion (Ahluwalia & Alimchandani, 2013). Mental healthcare must be adapted to accurately reflect the daily lives of the communities it serves (Singh, 2007). Individuals from culturally and linguistically diverse communities often do not receive mental healthcare that is culturally competent (Knifton, 2012). Cultural competency is important in mental healthcare as it enhances a provider's ability to interact effectively with clients from diverse backgrounds by incorporating their unique beliefs, behaviors, and needs into diagnosis and treatment plans. A lack of cultural competence in mental healthcare can lead to long-term consequences, including misunderstandings, discrimination, underdiagnosis, and ineffective or inappropriate treatments (Fountain House, 2022). Mental healthcare services, therefore, need to understand the dynamics of specific communities, including the Punjabi and Sikh communities, to adequately converse with, serve, and support their clients (Cleland et al., 2016; Bahra et al., 2023).

Theoretical Application

Together, Intersectionality and Cultural Competency work to decolonize the lens historically used to evaluate spirituality and faith-based practices, research, and services within Western contexts. Traditionally, these areas have been analyzed through secular ideologies rooted in oppression or the dominant narratives (Bhogal, 2014; Omer, 2020). This paper emphasizes Eastern perspectives of

spirituality, interconnectedness, and community, aligning with decolonial approaches to mental health services (Long, 2024). By highlighting the strength of cultural and linguistic diversity within the cultural competency framework across clients and service providers, and respecting the multiplicity of identities articulated within intersectionality theory, this study seeks to address the existing gap in the literature regarding satisfaction data specific to the Sikh community.

Purpose and Rationale

In this study, we examined the satisfaction outcomes of a culturally sensitive mental health telephone helpline organized in the UK by the charity Sikh Your Mind (SYM). By focusing on the Punjabi and Sikh community, we aimed to amplify their voices and highlight their experiences following the use of the telephone helpline. We chose this focus because research on satisfaction surveys has indicated that the most effective methods of satisfaction data collection occur over a period of time, utilizing a combination of open-ended questions and guided short responses (Adler et al., 2020). However, research conducted with minority populations has typically not captured the nuances of cultural and linguistic diversity within satisfaction data (Adams et al., 2023; Hwen et al., 2020). Satisfaction data can assist providers in understanding context, experiences, and lived anecdotes that are not readily accessible within community-based settings (Ilioudi et al., 2013; Junewicz & Youngner, 2015).

Service-user satisfaction with care provided is a helpful measure for obtaining feedback, and evaluating service quality (Al-Abri & Al- Balushi, 2015). However, selection bias must also be considered regarding who is more likely to complete questionnaires compared to non-respondents (Compton, Glass & Fowler, 2019). High-quality data is essential for identifying the specific needs of minority groups and informing interventions required to address inequalities (Kings Fund, 2023). Lyratzapolous et al. (2012) noted that ethnic minority communities often report lower patient satisfaction compared to majority communities. Participants may not respond to satisfaction surveys due to various unforeseen barriers, including accessibility issues, language differences, and physical or mental limitations (Gayet-Ageron et al., 2011; Pinder et al., 2016). These barriers to participation further suggest that current satisfaction surveys are not adequately designed to meet the culturally sensitive needs of minority communities (SAMHSA, 2016).

Research Question

The purpose of this paper was to explore the experiences of Punjabi and Sikh users of a culturally sensitive telephone helpline following their use of the service. Through the use of satisfaction surveys to capture participant narratives, this reflexive thematic analysis study addressed the following question:

> How does SYM (Sikh Your Mind) meet the needs of the Sikh and Punjabi community through its telephone helpline service?

Regarding Language on Cultural and Linguistic Diversity

In this manuscript, multiple phrases are used to refer to the Punjabi and Sikh communities. Firstly, in the literature reviewed, Punjabis were described as "people of color" (Fish & Mittal, 2021), emphasizing their belonging within culturally and linguistically diverse groups. Additionally, the term "minorities" (Agarwal, 2023; Karasz et al., 2019; Quraishi, 2023) was used to highlight how Punjabis and Sikhs fall racially and historically minoritized groups. We made the decision to retain all instances, descriptors, and terms utilized to describe Punjabis and Sikhs within the reviewed literature to highlight both the prevalence of the communities throughout the findings, as well as the range of the racial, ethnic, and faith perspectives presented. Collectively, this language captures how these communities, specifically Sikhs, experience racial discrimination and prejudice, particularly in contexts of systemic inequality and racism. This terminology serves as a foundation for understanding why culturally sensitive Sikh-specific support is essential, and how SYM intends to address the existing gap in the literature.

Methodology

Sikh Your Mind (SYM) established a volunteer-run telephone helpline in November 2020, which was available to the Punjabi and Sikh community every evening for two hours, Monday to Sunday, and continues to run to this day. The focus of this paper is the data collected over three years, from November 2020 to November 2023. SYM initially recruited seven volunteers located across the UK, from Bradford to Slough. Telephone call handlers worked remotely, each assigned to operate the helpline one evening per week. All volunteers completed an enhanced Disclosure and Barring Service (DBS) check to confirm their suitability for working with vulnerable populations. Volunteers held qualifications ranging from lived experiences (n = 2), cognitive behavioral therapy (n = 1), assistant psychology (n = 2), clinical psychology (n = 1), and mental health law (n = 1). Volunteer demographics included seven individuals from the Sikh faith, two males and five females, with ages ranging from 22 to 38 years. Demographic information of the volunteer staff was recorded to ensure representation, accessibility, and relatability for helpline users.

Prior to operating the telephone helpline, volunteers received training covering: a) the purpose and values of SYM, b) effective communication skills, c) risk and safety issues, and d) role-play scenarios. Training sessions also equipped volunteers with the resources necessary to navigate data collection procedures, and emphasized the importance of self-care and seeking support after calls. Additionally, the training clarified the process for distributing the satisfaction questionnaire to helpline callers via an online text messaging system.

SYM distributed a satisfaction survey to provide individuals with an opportunity to share their experiences after accessing services provided by the organization. Over the course of three years, 98 helpline users participated in this survey, from a total of 571 callers. Of these respondents, 75 (76.5%) specifically provided feedback about the helpline service, while the remaining 23 respondents commented on other SYM services, such as workshops facilitated by the team, due to the survey being distributed across multiple forums to collect outcome data. The satisfaction survey was distributed electronically via Google Forms,

and helpline users could access this form from anywhere in the world, provided they had a stable internet connection. All responses to the questionnaire were anonymous. The survey consisted of 24 questions in total: 13 open-ended and 11 closed-ended questions (see Table 1).

Table 1

SYM Satisfaction Survey Questionnaire

Questions
1. How did you hear about us? (Social media, poster, Gurdwara, University, School, Work, Other - please specify)
2. Do you follow us on social media?
3. If not, please explain why.
4. If you answered yes to Question 2, how helpful do you find the content on our social media platforms?
5. Please detail reasons for your response to question 4.
6. What contact did you have from SYM? (Attended a workshop/presentation facilitated by them, Telephone support, Face to face support, Live chat support, Social media support, Other - please specify)
7. What was the main purpose of your contact with SYM? Please share briefly.
8. How satisfied were you with the support you received from SYM? (1: Very Satisfied - 5: Very Dissatisfied)
9. Please detail reasons for your response to question 8.
10. How likely are you to recommend SYM to your friends, peers or family?
11. Please detail reasons for your response to question 10.
12. Prior to contacting SYM, have you been in contact with any other services regarding your mental health?
13. If yes, please provide details of the services you have been in contact with.
14. After your contact with SYM, have you been advised to contact any other services for support?

15. If yes, please provide details of the services you have been advised to contact.
16. Is there any support or advice you did not receive from SYM but feel you would have benefited from?
17. If yes, please provide details of the support or advice you feel you would have found helpful.
18. SYM's core values include compassion, empowerment, equality, hope and togetherness. We strive to ensure that our approach and organization reflects these in all that we do. Please can you outline any of these values you think we have shown in our contact with you.
19. Is there any other general feedback you have about SYM?
20. If you answered yes to question 19, please provide further details below.
21. How likely are you to access support from SYM again in the future?
22. Please explain the reason for your answer to question 21.

Note. Questions represented in the table have been adapted from their original form to reflect the flow of information that users saw. There were 24 questions in total, 2 questions were merged into table items 1 and 6.

Survey questions were modeled after existing satisfaction surveys to include open-ended questions to allow helpline users to explain the reasoning behind their response. To ensure the satisfaction survey was culturally sustained, we did not directly adapt an existing survey, as research suggests that existing instruments do not adequately address the needs and accessibility considerations of minority communities (SAMHSA, 2016). SYM volunteers designed the satisfaction questionnaire based on their personal and professional experiences with the community. The survey questions aimed to step outside medical models of data collection, embracing more naturalistic, qualitative discourse (Palinkas, 2014; Thapar & Rutter, 2019; Verster et al., 2019).

Analysis

Researchers utilized reflexive thematic analysis to evaluate the responses from helpline users that participated in this study. Among qualitative methodologies, thematic analysis was selected because, in mental health and psychological research, it amplifies the voices of individuals from minority communities by representing their lived experiences from a strengths-based perspective (Braun & Clarke, 2023; Lainson et al., 2019). The researcher (MM) reviewed the descriptive anecdotes provided by the helpline users in the satisfaction survey, applying both inductive and constructionist approaches to theme formation. A constructionist approach was used to explore the lived realities disclosed within the data, while an inductive approach was employed to identify emerging themes within the responses (Braun & Clarke, 2022).

To generate themes, researchers implemented Braun and Clarke's (2006) six-phase guide systematically analyzing the data from the helpline users. The first step involved familiarization with the data (n = 75 respondents) and creating a response table to organize the nature of the concerns reported by users accessing the helpline service (see Table 2). The second step involved generating initial codes from the data using Table 1 as the foundation, which captured both social validity and cultural considerations among the helpline users. The third step involved searching for themes and constructing a thematic map (Bruan & Clarke, 2006, from which five themes emerged: a) depression/anxiety, b) relationships and safety, c) mental health support and referrals, d) spiritual and religious connectivity, and e) general help and advice.

The fourth and fifth steps involved reviewing, conceptualizing, and naming the themes using Watson & Webster's (2002) concept matrix. During these steps, a constructionist approach was again applied to explore the lived realities disclosed within the anecdotal feedback, and an inductive approach was employed to further clarify emerging themes (Braun & Clarke, 2022; see Table 2). When creating the themes, findings were interpreted through the theoretical framework of intersectionality (Crenshaw, 1989).

To ensure the validity of the identified themes, the authors discussed each theme and its structure collaboratively through the six-step analytical process. This approach facilitated consensus regarding the presentation of the five themes alongside the satisfaction reports. Researchers acknowledged that though some themes may overlap, as responses may include multiple topics, issues of faith and safety were specifically emphasized by users. Themes were therefore formed based on the most prominent concerns disclosed by individuals using the telephone helpline.

Results

In total, responses from 98 satisfaction surveys were collected and included in this study, noting 571 callers accessed the helpline altogether. Helpline users accessed the SYM helpline for an average of 10 minutes to one hour per call with one of the trained SYM volunteers.

User Outreach. Helpline user outreach among minority communities is not always easy, given the barriers to accessibility that exist within mental health services. To address this area, SYM asked helpline users how they heard about the helpline and the organization at large. Responses included social media (n = 46), university (n = 2), gurdwara (n = 2), other (n = 22), and no response (n = 4). Furthermore, all helpline users who followed SYM on social media and virtual communications found the content to be helpful. Table 2 below reports the reasons helpline users reached out for support through the SYM helpline.

Table 2

Helpline Users' Reasons for Outreach

Theme	*n*	Participant Quote
Depression/Anxiety: Understanding the nature of mental health concerns	14	"I have depersonalization & depression & anxiety" "[I have] Anxiety and troubled mental health" "Feeling anxious and worried. I wanted to speak to a professional and gain a different perspective. I was hesitant to approach SYM at first as I had never done anything like this before but I'm glad I did as I found it very beneficial."
Relationships and Safety: Providing action steps and response for helpline users in need	18	"[I was the] Victim of hate crime" "[Seeking] Emotional support for my elderly, disabled depressed mother-in-law" "Crisis at home with one of my children"
Mental Health Support and Referrals: Bridging accessibility gaps through connection	29	"I wanted to find couples counselling therapists near me that would be able to understand my cultural background" "I just had a few things on my chest which I haven't been comfortable with telling friends and family. Speaking over the phone to a complete stranger helped me be as open as I can without being judge(d) and it lifted my spirits up and felt like it took so much weight of my shoulders." "I needed counselling support to help me deal with my emotions."
Spiritual and Religious Connectivity: Providing spaces for inclusion	7	"To hold a workshop in our local Gurudwara for the Sangat." "Create mental health wellbeing awareness, release taboos and encourage positive outlook by deriving inspiration from our Gurus and Gurbani [of Sikhi]" "Support and guidance for my mum- mental health vs religious beliefs"
General Help and Advice: Serving as an ally	21	"Someone to open up to" "Guidance/support on my current situation as I felt stuck." "To talk about my concerns and let it out"

Note. 13 helpline users did not provide a reason for contacting the helpline.

Table 2 highlights the themes observed from the qualitative responses that helpline users provided regarding their reasons for contacting the service. Helpline users disclosed that, as individuals living in the UK, they faced a variety of adverse life events and experiences that caused concern within their daily lives. These concerns included, but were not limited to, hate crimes, domestic violence, mental illnesses, mental health struggles, religious curiosity, spiritual connectivity desires, and the urge to advocate for and support their families. Table 2 highlights sample quotes from helpline users who expressed their concerns. Many helpline users fell under multiple categories, as they reached out for themselves, their families, and expressed concerns about safety.

Satisfaction Rates. In total, 92 users rated their experience with the helpline, while 6 users declined to disclose their ratings. When asked to justify their ratings, 50 users provided additional comments, and 42 chose not to expand further Satisfaction with the helpline service was rated on a Likert scale from one to five, where one represented "very satisfied" and five represented "very dissatisfied." Table 3 below shows the participant satisfaction ratings:

Table 3

SYM Helpline: User Satisfaction Ratings

Rating Level	Result (*n*)
Very Satisfied	56% (52)
Moderately Satisfied	17% (16)
Neutral Satisfaction	11% (11)
Moderately Dissatisfied	6% (6)
Very Dissatisfied	7% (7)

Table 3 indicates that the majority of SYM helpline users were satisfied with the support they received (73%, n = 68). In contrast, 11% of users (n = 11) reported neutral satisfaction, and 13% (n = 13) reported dissatisfaction with the services. Users who were satisfied indicated they appreciated the professionalism of the helpline, the kindness of call handlers, the rapport built during the calls, the advice provided, having a listening ear, practical and culturally responsive feedback, and the person-first approach offered by SYM, which offered a nonjudgemental space and acknowledged the systemic barriers in accessing support. Feedback also highlighted users benefited from the spiritual and religious awareness of the call handlers. Responses also captured the users' gratitude for receiving services tailored to their lives, which were not

readily available through traditional healthcare services within the UK. Telephone users expressed their satisfaction through responses to question 10 (see Table 1), with statements such as:

- *"Made it clear and made me aware it's actually not me, it's the society. It was probably the most help I've ever had when speaking to someone regarding my mental health and insecurities. [The helpline worker] was so helpful and she made me feel very comfortable which helped me share my problems with her and not bottle things inside of me helping me become more motivated."*

Additionally, some callers discussed how they were able to navigate complex emotions with support from the SYM volunteer:

- *"My phone call with SYM was very beneficial as it allowed me to pause and really evaluate why I was feeling anxious and worried. I also liked how we incorporated my belief in faith and the importance of mental health and self-care into the conversation."*

Helpline users reported feeling that they had a safe space to openly share information, encouraged by the rapport, kindness, and feeling of safety created by the volunteers.

On the other hand, helpline users who reported neutral or dissatisfied experiences mentioned that they did not receive answers, suggestions, or feedback in a timely manner, the service was not what they had expected, they wanted more follow-up after the call to validate their vulnerable disclosures, or they needed more in-person engagement and resources. Anecdotal responses captured the dissatisfaction when the service did not meet initial user expectations. Responses to question 10 (see Table 1) highlighted this dissatisfaction, with users stating:

- *"Not the support I was looking for myself."*
- *"Too early to say as it was only one phone call conversation so far, but I would like to try more discussions. Not sure if this is the right direction for me or I may be wasting your efforts."*

One user specifically expressed dissatisfaction with the outsourced support they received during their helpline interaction, stating:

- *"Maybe more human interaction rather than links to web sources."*

Overall, helpline users (*n* = 91) were asked if they would recommend the helpline to their friends and family, using a multiple-choice response ranging from "very likely" to "very unlikely," 94% of users indicated they would recommend the helpline, while 6% indicated they would not.

Mental Health Resource Accessibility. Support and services are important in addressing helpline users' needs. Further information from the satisfaction questionnaire indicated that 63% of users reported utilizing mental health resources prior to accessing the SYM helpline. Of these, the majority (66%) accessed support from generic mental health organizations (e.g. Samaritans and Child and Adolescent Mental Health

Services) as well as organizations specifically catering to the Punjabi community in the UK. Most telephone helpline users (69%) contacted SYM through social media platforms, primarily Instagram and Facebook. After accessing the helpline, 46% of survey respondents were signposted to other (often local) services for additional support. Users provided positive feedback on the follow-up from SYM volunteer staff, with one user noting:

- *"Getting back to me even if I had to wait due to being busy with other clients- great team."*

SYM volunteers were able to create a safe space for callers as described by a helpline user who reported:

- *"[Helpline Staff] made me feel really comfortable about opening up, I felt part of something. It was really good."*

However, not all helpline users were satisfied with their experience. Some expressed dissatisfaction and uncertainty about the helpline, as illustrated by one user's feedback:

- *"I believe the organisation's core value of hope really resonated for me as they offered to provide talking therapy for me; however, I am still waiting to be allocated with an advisor yet."*

This anecdotal feedback captures the progress helplines are making toward addressing the needs of culturally diverse communities, particularly Sikhs, and also provides insights for improvements in future studies.

Discussion

This study focused on understanding the impact of a culturally sensitive telephone helpline in the UK, based on satisfaction survey results completed following service use. The narratives shared by individuals revealed a myriad of challenges and adversities encountered in their daily lives, including issues related to depression and anxiety, relationships and safety, mental health support and referrals, spiritual and religious connectivity, and general help and advice. These themes highlight the diverse experiences within the Punjabi and Sikh communities, examined through the lens of intersectionality (Crenshaw, 1989). The multiple identities carried by immigrants in the UK illustrate the need for faith-based mental healthcare services that holistically integrate all aspects of a client's identity. Segregating client identities in therapy risks perpetuating biases associated with diagnostic labels (Bansal et al., 2022). Thus, it is critical to account for all facets of client identities to ensure comprehensive support plans. This suggests an increased need for mental healthcare service providers to receive training to recognize the complexities involved in patient outreach, interaction, and interventions that address clients' faith, cultures, languages, and heritage (Castillo et al., 2019; Cuthbertson, 2023).

Historically, the narrative of South Asian families looking after one another is widely accepted, promoting the belief that these communities are inherently self-sufficient. However, this assumption requires further consideration, as these communities also need external support despite their collectivist cultures (Karasz

et al., 2020). The data collected in this study illustrates varied concerns and motivations for seeking assistance outside the familial unit. A significant number of helpline users fell into multiple categories, reflecting their complex needs as they sought support for themselves, their families, and safety-related concerns. These findings underscore the need for culturally sensitive mental healthcare services tailored specifically for diverse communities, including Sikh and Punjabi populations.

When evaluating the reasons for using the helpline, most users required support related to their relationships (familial and romantic; see Table 2). This finding aligns with existing literature, suggesting that these communities experience various systemic and cultural barriers such as fear and mistrust, which hinder open discussions about relationship difficulties (Hulley et al, 2022).

The telephone-based helpline likely provided an environment of safety and reassurance that in-person services were not able to offer. While direct evidence comparing openness in telephone support versus in-person consultations is limited, factors such as anonymity, reduced stigma, increased emotional expression, and culturally sensitive interactions afforded by telephone helplines may make them a preferred method for accessing support among marginalized communities (Kitchingman et al., 2024).

Additionally, 69% of the helpline users learned about SYM through social media platforms (see Table 4). Social media usage among racially marginalized communities has been shown to promote social well-being, positive mental health, and increased positive ratings of self-rated health outcomes (Bekalu et al., 2019). Nonprofit organizations have successfully leveraged social media to raise awareness among minoritized communities, build comprehensive networks, and disseminate important information (Simon, 2024). However, social media engagement also has the potential to negatively impact the mental health of individuals within minoritized communities (Stanton et al., 2017). To mitigate these potential drawbacks, SYM worked to ensure anonymity, inclusivity, and open accessibility to resources, helpline services, and information for all users.

Another strength of the helpline was the integration of *Gurbani* [the holy Sikh scriptures] and Sikhi [spiritual and religious teachings of Sikhism] during telephone interactions. Users reported feeling connected, recognized, and included through the service delivery provided by SYM, an experience not easily available elsewhere due to the limited presence of culturally sensitive providers. Research suggests that utilizing Sikhi and Gurbani in therapeutic settings enhances the sense of belonging, serenity, and safety among Punjabi Sikh clients (Bhangu, 2021; Miller, 2005). The consideration of Sikhi in clinical settings for diverse clients aligned with the faith has led to increased success rates in healing, retention, and client satisfaction (Malhi et al., 2014).

Furthermore, it is noteworthy that just under one-third of the respondents had accessed other services prior to contacting the helpline. Existing research has shown that mental healthcare services that are sensitive to clients' cultural, faith, and spiritual identities produce more effective healthcare outcomes in the long term (Whitley, 2012). Although many helpline users had previously utilized local and nationwide services specific to the Punjabi community in the UK, these services may not have incorporated spiritual

perspectives, which have shown significant positive impacts (Schultz et al.,2014). Cultural support in mental healthcare services involves the integration of culturally relevant practices, beliefs, and values into treatment approaches, ensuring that services provided to clients are respectful, effective, and aligned with the unique needs of the community (Adamson et al., 2011; Kirmayer & Jarvis, 2019). In contrast, spiritual support in mental healthcare explicitly recognizes and incorporates the spiritual beliefs and practices of clients as essential components of their overall well-being and healing process (Forrester-Jones et al., 2018; Hefti, 2011). Given the intricacies involved in delivering services to racially minoritized communities, the findings underscore the importance of recognizing these differences.

SYM offers a unique service in that individuals from the community can directly access support from qualified mental health professionals. This is particularly relevant given existing difficulties, such as long waiting lists, associated with accessing psychological support through statutory services. To the authors' knowledge, most nonprofit organizations in the UK do not have psychological professionals on their teams while also including faith as a core organizational value. Current research comparing statutory programmes (e.g., the National Health Service) with voluntary organizations (such as SYM) suggests that nonprofit volunteer organizations effectively meet community-based needs at an applied level that is not always possible at the statutory level (Stanisch, 2019; Zamora et al., 2019). This evidence highlights that nonprofit volunteer organizations like SYM are well-positioned to address specific, grassroots-level community needs in a hands-on, flexible, and responsive manner. They often fill gaps that government programs or statutory services cannot effectively address. Unlike statutory organizations, which operate under legal and bureaucratic constraints, nonprofits can adapt to providing personalized support and directly engage with diverse populations (Zamora et al., 2019). In parallel, it is important to note that under half of the helpline users were also signposted to local statutory services following their calls. This finding underscores the limited awareness among individuals about available resources within the National Health Service. Further details on where individuals were signposted following their helpline use will be published in a separate paper.

Limitations

SYM is a volunteer-led charity predominantly relying on community donations, and there are several limitations to consider regarding the satisfaction data shared in this paper. The questionnaire was provided to helpline users in English, despite callers having the option to contact the helpline in either English or Punjabi. Additionally, the survey was only available in a written format requiring users to complete their responses online, presenting a barrier for many. When considering future research, it would be beneficial to collaborate directly with service users to develop user-friendly survey questions, translated materials, and offer multiple options for survey completion to increase accessibility.

Nature of nonprofits. Helpline data collection within charitable organizations is not always streamlined to meet all needs of clients due to inherent infrastructure limitations. Table 3 highlights the common concerns reported by helpline users, including issues around response timeliness, mismatched expectations, unexpected types of support, and inadequate follow-up. These challenges reflect the nature of nonprofit

organizations, which are typically understaffed and rely on volunteers who dedicate time from their own schedules to run the service (Cuthberston, 2023). Thus, the consistency of follow-up and feedback often depends on volunteer availability. Furthermore, users who sought more communal and in-person services were disappointed to be redirected to web-based resources or signposted to other services. It is also important to acknowledge that some responses to the satisfaction survey were brief, making it difficult at times to interpret the meaning of users' feedback.

Lack of Culturally Responsive Mental Health Care. Often, the support that helpline users were signposted to was not tailored to any one community. However, it was hoped that the referrals provided some relevant support to the individual calling. This limitation was evident in the findings of the helpline data as users expressed their distress to call handlers about not receiving culturally specific support. This reflects a broader systemic issue within the healthcare system, where services often fail to consider the unique cultural and religious backgrounds of individuals seeking support (Hodge, 2017; Hsu et al., 2014). Current mental health services often lack space for linguistic and cultural adaptations and seldom factor in religious or spiritual perspectives into existing service care models (Ali, 2018; Bansal et al., 2022). The absence of cultural and faith-responsive care not only hinders effective treatment outcomes but also perpetuates mental disparities among minority communities (Hatala & Roger, 2021).

Flaws in mental healthcare service delivery represent a systemic issue spanning service providers across the UK (Carbonell et al., 2020). The data derived from this research can inform future practice and survey design, as it captures first-hand accounts from clients utilizing the help hotline. These accounts highlighted the limitation that neither the satisfaction questionnaire nor the service delivery models were not adapted in real time based on user feedback. Going forward, researchers and service providers can use these insights to explore and implement live-time adaptations that reflect the perspectives, emotions, and experiences of clients accessing the hotline. Potential improvements may include offering in-person workshops, video call-based support, and informational webinars on topics of interest to helpline users.

Small Sample Size. Historically, satisfaction data has been difficult to collect and validate due to small sample sizes (Carr-Hill, 1992). These limitations often stem from a number of factors that include but are not limited to accessibility, participant interest, and length or format of the questionnaires themselves. In our study, a key limitation was that both the helpline and satisfaction survey were provided exclusively in English. Not all users were able to access these materials due to the need for translation and culturally appropriate adaptations that the team was not able to generate. Future studies would benefit from considering the nature of satisfaction data and addressing this disparity through the use of translation services, culturally adapted questionnaires, and multiple response formats for helpline users (i.e., video recordings, interviews).

Additionally, SYM relied on secondary data collected from its own organizational helpline rather than incorporating or comparing satisfaction outcomes from other helplines. This was due to various reasons, including differing objectives between services and the use of incompatible data collection methodologies, making it difficult to derive meaningful comparisons. Using SYM's internal data allowed for a more focused

approach when analyzing outcomes and implementing meaningful service changes based on findings. It is, however, important to note that response rate was 13.14%, which aligns with typical helpline response rates of approximately 5 - 15% (Brown et al., 2010).

Lack of Demographic Information. Given the nature of secondary data analysis, SYM did not have access to demographic data from helpline users, as this information was not collected in the satisfaction survey. SYM prioritized preserving the anonymity of the helpline users to ensure they felt safe and comfortable disclosing their perspectives in. While this approach supported confidentiality, it limited opportunities to analyze how different demographic factors may have influenced user experiences. Future studies would benefit from collecting demographic information of helpline users to forge a more nuanced understanding of helpline services and user satisfaction.

Future directions

Continuous engagement and support for Punjabi and Sikh communities in mental health within the United Kingdom is paramount for several reasons. Like many culturally and linguistically diverse populations, this community faces unique challenges that impact their mental well-being, including but not limited to cultural stigma surrounding mental health (Baral et al., 2022), language barriers (Prajapati & Liebling, 2021), and a lack of culturally competent mental health services (Prajapati & Liebling, 2021; Weich et al., 2004). By offering ongoing engagement and support tailored to the specific needs of this community, mental health outcomes can be significantly improved (Castillo et al., 2019).

SYM is actively fostering this conversation within mental health supports by collecting further qualitative data to support the development of culturally sensitive interventions and research initiatives, ultimately strengthening the representation and dissemination of best practices for this community.

Looking ahead, increased funding is essential to sustain and expand culturally sensitive mental health support, bridging pathways between nonprofit and statutory services. While nonprofit organizations like SYM are independently working to bridge gaps in mental health support, their efforts are often constrained by limited time, resources, and availability. Additional funding would provide structure, training, and ensure broader coverage. Currently, SYM has been involved in a number of initiatives, including the development of an informational leaflet on suicide prevention from a faith-based perspective for use by frontline professionals (Faith Action, n.d.), participation in public health initiatives in England focused on mental health topics (Good-Thinking, 2023), and contributing to doctoral training programs that address the role of faith and spirituality in therapeutic settings within higher education.

Finally, these research and practice implications highlight the need for continued education and training programs for clinicians, encouraging them to consider the needs of diverse populations and the importance of asking about spirituality, faith, and religion as areas often overlooked within Western models of support. Using these findings can propel a movement toward more inclusive mental health provisions and improved resource accessibility across the UK for both clients and providers.

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