Nagina Khan | Mental Health Research

Dr Nagina Khan is a Senior Clinical Research Fellow at the Centre for Health Services Studies, University of Kent. Her work champions lived experience, patient involvement, and socially impactful research, and she is actively involved in editorial roles with *BMJ Leader*, *BMJ Mental Health*, and other journals to help bring diverse voices into academic publishing.

Dr. Nagina Khan, PhD is a Senior Clinical Research Fellow in Primary Care at the University of Kent's Centre for Health Services Studies (CHSS), where she also serves as Director of the MSc Applied Health Research Programme. Her current research supports Integrated Care Systems (ICS) to enhance collaborative research, prioritise underserved populations, and strengthen local infrastructures for evidence-based practice and innovation. Her expertise spans mental health, social justice, and healthcare equity. She has held research roles at the University of Oxford's Department of Psychiatry and as a Project Scientist at the Centre for Addiction and Mental Health (CAMH) in Canada, where she focused on culturally appropriate mental health care for South Asian communities. She was previously a Medical Research Council (MRC) Research Training Fellow at the University of Manchester, researching complex interventions for depression, and later conducted postdoctoral work at the NIHR School for Primary Care Research on early intervention for first-episode psychosis.

She is currently an Associate Editor for BMJ Mental Health and an Editorial Fellow for BMJ Leader. She also served on the Editorial Board of BMC Medical Education. Her research interests include medical education, professionalism, social justice in healthcare, culturally appropriate care for South Asian Communities, and global mental health.

Hello, I'm Domhnall MacAuley, and welcome to this BMJ Leader Conversation, where we talk to the key opinion leaders in health and medicine around the world. Today I'm talking to Nagina Khan.

You've had the most fascinating academic career. But I want to bring it back to the very beginning, because you began as a mental health nurse. Tell us about that…

N**agina Khan:** That was an interesting time. I always wanted to be part of research that could meaningfully impact clinical practice. I was working in dementia services for older adults and became particularly interested in the needs of patients from ethnic minority backgrounds. I began questioning the accessibility and cultural relevance of formal care. That really propelled me into thinking about why some communities didn't

engage with services and how we could design care pathways that worked better for everyone.

DMacA: Tell me about this transition from service provision in mental health to those first steps in academia.

NK: The very first steps were small projects rooted in questions I encountered daily in practice. I was curious about why mental health services were perceived so critically and why they were often underutilized. That kind of marginalisation both of services and the communities they were meant to serve became a strong driver for me. Over time, I realised the importance of elevating mental health as equal to physical health, not just in discourse but in systems, funding, and education.

DMacA: You clearly were interested in that asking those questions when you were in the service job. But then you did a degree and moved on to further your career

NK: Yes, I realised that to fully explore these questions, I needed academic grounding. I was fortunate to have both clinical and educational mentors who supported me early in my journey – Mr Stepen Kelly and Mr Philip Barton-Wright https://www.airedale-trust.nhs.uk/. I completed a first-class degree in health sciences, which gave me a foundation in psychology, sociology, and healthcare. I followed that with a Master's level course to bridge clinical practice with health service research. This dual lens helped me remain close to both practice and academia without having to choose one over the other.

DMacA: You've talked about the clinical and the academic, but you had another component of your career- you were the face of an NHS recruitment campaign!

NK: Yes, that campaign was about widening participation and attracting people from diverse backgrounds into nursing. I was passionate about changing the perception of nursing within South Asian communities and beyond. There was a sense that it wasn't a prestigious or desirable path, especially for young people from ethnic minority backgrounds. I felt it was important to challenge that narrative, and the campaign gave me the opportunity to do that visibly and publicly.

This is a long time ago, I'm surprised you even know about this…

For the campaign they did a lovely poster of all healthcare professionals from different backgrounds. I met a lot of lovely people, and I think I was able to contribute to the way people saw nursing because I don't think nursing was an attractive career for individuals of an ethnic background at the time, especially South Asians.

DMacA: I'm fascinated by the combination of all these components, the academic, the clinical, and this public recruitment campaign, and you then moved on to do an MRC PhD Fellowship. Tell us about that.

NK: That was a turning point. I was awarded an MRC Fellowship at the National Primary Care Research Centre (NPCRDC), School of Medicine, University of Manchester, and I was supervised by Professor Anne Rogers, whose work on lived experience and patient narratives had long inspired me and Professor Peter Bower who was supportive. My advisor was Professor Aneez Esmail. The NPCRDC was led my Professors Martin Roland and Martin Marshall. The PhD allowed me to delve into how individuals from diverse backgrounds used self-help strategies for depression. I was looking through multiple disciplinary lenses medical, psychological, sociological. It helped me understand not only how people accessed care but also what their journeys looked like before and after contact with services. That grounding in real-world complexity has stayed with me ever since. When I found out that Anne was going to be my supervisor, you can imagine how thrilled I was to be able to be guided by someone so important and so close to my passions in mental health research and looking at people's experiences and lived experience and coming from a different angle I had studied health sciences, which also includes psychology and sociology, so I didn't just work from a medical perspective even though I had had clinical roles and developed in them. So, it was interesting for me to be able to come and do this piece of research and be able to have the support to look through different lenses. I think that is a powerful way to develop a broader understanding of the issues and, especially if you're working with people, you need to be able to take on their different backgrounds, how people come to services, why they access to them, and what's happened prior to contact that led them there. And I think that's fascinating.

DMacA: I liked the content and the subject of your research, because it's very grounded and practical. Your postdoc work done really interested me. Tell me about that.

NK: My postdoc was at the NIHR School of Primary Care Research. And, at that time, I was working with a professor of general practice with a specialist interest in mental health late Professor Helen Lester. I worked on early intervention in psychosis, particularly focusing on young people experiencing their first episode. This was a shift from my secondary care background. We explored how community-based services could provide timely and intensive support without relying solely on hospitalisation. It was about continuity of life and relationships, especially with families, during a hugely challenging time. That work taught me the importance of designing services that don't just treat symptoms, but support lives. Working with Helen, left a huge impact, on me. We wanted to look at how this service would impact individuals who wanted to continue their lives and the whole trajectory outside hospital-based care, but then also have that that intensity when required. That was really important because it was young people having, perhaps, their first episode in psychosis, how did they deal with that, and how did everyone around them support them because, you know, families matter a lot to individual recovery.

DMacA: Together with your academic work in the UK, you have quite a lot of international experience. Tell us first about your work in Canada.

NK: Canada was an interesting time for me as I worked for a non-profit organisation called the Compass Food Bank, and it was an outreach centre as well. And my interest stemmed from working with people experiencing homelessness. It was situated in a really affluent area of Ontario just outside Toronto with pockets of poverty around it. That really interested me, and, at that time, I wanted to be able to give back to communities and people, outside of faculty domain, and formal services. It allowed me to explore how people engaged with community-based services before ever reaching formal healthcare. This work added to my understanding of culturally grounded, place-based care and reaffirmed the importance of compassion, trust, and listening. It always interested me what was happening before people came to the formal services, what was going on, and who was supporting individuals. I 'd already had contact with people in the community, as I was involved with families, and care packages, in health and social care, and medicine and I knew all of that area or domain. But I also wanted to know about what happens in not-for-profit and how people were sometimes happy to engage but then had a hard stop at a boundary where they don't want formal services.

And also looking at how we impact people's lives from different settings in the different ways (our role change) and the different approaches of how different institutions, like a non-profit, work as well.

I think that's really important, especially as you saw in my work from my PhD, looking at the lived experiences of individuals and how they use self-help, then I moved into looking at how young people access services, like early intervention service, and how that is experienced by them and by their families, and how we can input that and make improvements. And I worked at the centre for Addiction and Mental Health, looking at adapting CBT with a team over there and then culturally appropriate care working with the Centre for Addiction and Mental Health (CAMH). But I don't think that culturally appropriate care is so different from looking at place-based care for individuals, because for me I am not starting new, its building on my previous experiences across the board. I think you need to work with the community that you're situated in at that time and look at what their needs are, and you can't always do that from sitting in a hospital or an academic university building.

You won't know who's going to come through the door, if it's someone homeless, if it's someone who is not homeless – if it's someone with different set of challenges. You cannot be judgmental because you cannot judge from how someone looks. You really need to be able to speak to people, people won't tell you everything, so you need to listen, build trusting relationships, have good communication, and be compassionate and kind because any one of us can be in those positions at any time of our lives, we should never lose sight of that. My research has always been informed by what happens

outside traditional settings what happens before people come to clinics or hospitals, and how systems can better meet them where they are.

DMacA: And then I was fascinated by your work in the USA on professionalism in undergraduate medical education.

NK: Absolutely, it was an interesting idea at the time during the Covid pandemic. Yes, I collaborated remotely with Touro University in Las Vegas during the pandemic Dean Wolfgang Gilliar. We looked at how to embed research literacy and critical thinking into the early stages of medical education. And it was an interesting project to bring research in an early stage to medical school because, at the time, we didn't have a lot of curricula that focused on emerging research and reading research from an independent perspective. Working with students was refreshing they're at a formative stage and open to thinking differently. We introduced ideas around professionalism, research engagement, and social accountability. Prior to that, I've always worked with healthcare professionals and it's different to work with medical students at that level and to introduce topics that might not have been introduced to them early on, and to have a different way of working than with those of a clinical doctor background. It's more multi-disciplinary. I wanted students to feel empowered not only to understand research but to act on it and bring about change, which isn't often their experience. It's another way of planting seeds for more inclusive, reflective, and socially responsible care. And I think we can learn from each other in having a multidisciplinary lens, working together to look at research. It was a good time to learn about students and how we can feed that back and create a curriculum. And, allowing them that opportunity for leadership, mentoring them, looking at ways for reflection on how they can grow and develop as well as the project, having opportunities to present poster presentations for dissemination, making it real and not an internal university project.

DMacA: In bringing all these different themes together, you wrote a piece recently, where you quoted Aristotle saying that that the purpose of knowledge is action and not just knowledge. Your message was, it's not just enough to know things about culture and inequality, we need to do something…

NK: Whether through student mentorship, research design, or editorial work, I try to champion inclusion, collaboration, and kindness. Yes exactly, I think we all need to take a stand. Knowledge without action is inert. A lot of my work has been rooted in inequality and social justice, and I think that its everyone's business. Much of my career has been about embedding social justice in real-world settings not as a theory, but as a practice. We need to look at that aspect and be active as well. I believe in mentoring, in servant leadership, and in creating spaces where people from all walks of life can lead. That also fits in with my work with the students in calling for action, looking at professionalism, vocalizing that understanding from their point of view, and integrating it into the curriculum. And, looking at culturally appropriate care and how we can bring

lived experience voices into interventions and ultimately mental health services, opening up access pathways for individuals that feel marginalized from services.

And that has led me to believe that goal is important. It's led me to places where I've been part of the action and not just sitting thinking theoretically about what my role is, and how I can do my work and how people can develop. And for mentoring, it's also been important for me to be able to allow people to grow and let them know that there's no one way of doing things, because I think faculty thinking and being in a traditional pathway in healthcare and academia is very different to someone like myself, who's taken a step out to look beyond the building and the bricks and mortars to what's going on outside.

I haven't done that just because we've had a funding change or a policy change. That's been embedded in my work from the beginning of my career. And, when I talk about it, it's been my reality rather than reading it in a paper or thinking that this is going to look good on my CV. And I think this links in to when people talk about authenticity. Sometimes people ask me, what's your leadership style? And I think it's really servant leadership and collaborative because we have to get our hands dirty. And we live in a world where there is a lot of inequality and people have experienced hard lives, so we need some compassion. And we can't get that just from reading about compassion, it has to be an action as well. These aren't soft add-ons, they're essential tools for system change. And they must be lived, not just cited.

DMacA: Finally, let's bring us right up to date, tell us about your current work.

NK: I'm currently working as a Senior Clinical Research Fellow, the centre for Health Services Studies (University of Kent) with the Professor of Health Policy, Professor Stephen Peckham, Director of Applied Research Collaboration Kent, Surrey and Sussex (ARC KSS), and my role is supporting integrated care systems in Kent and Medway. And that's really interesting for me because this now brings me through the full circle of life to where I am now working with communities, embedding research in primary care to improve service delivery, prioritize research in underserved populations, and then addressing health inequalities. My work now involves supporting the Integrated Care System in Kent and Medway. I lead research focused on underserved communities, embedding research into primary care, and addressing health inequalities. It feels like a full-circle moment working at the community interface, championing lived experience, and ensuring research doesn't just sit in journals, but leads to transformation**.** The methods that I use now are really around championing public and patient involvement. And this is a really a sweet spot to be in. It's only taken me my whole career path to get to where I am right now, working in an area where I can give a voice to this work in ways that embed those methodologies and help to bring those methodologies into publication. This is why I also like working in an editorial role with various journals. I contribute to editorial roles at *BMJ Leader*, *BMJ Mental Health* ,

and *BMC Medical Education*, advocating for more inclusive and creative approaches to publication. It's about building bridges from community voices to academic platforms. We're now opening up and looking at ways to include individuals with lived experience on the board, having people write about different schemes, programs, interventions using more creative methods that, ordinarily, journals don't really know how to review and get to publication. Making that happen has been quite important because I think it's empowering. Its actioning work that wouldn't get published in the past.

DMacA: Thank you very much for sharing so much of your life, your early career, the integration of the practical and theoretical, and finally bringing real world voices into publication. Thank you very much indeed.