What are adult mental health services doing to improve the outcomes for Black service users? A mixed method analysis of Black Psychologists' perspectives and UK mental health Trust data

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ABSTRACT

Background: Within mental health services, Black people tend to have poorer experiences of mental health services, in terms of access, treatment and outcomes. Institutional racism has been cited as one of the main causes for the differences. Over the years, several national race equality policies, initiatives and pieces of legislation have been introduced across the public sector to try and address these issues. However, since the introduction of the Equality Act (2010), it seems that race equality has effectively been taken off the national agenda, with mental health services having to develop or draw on their own resources to adequately tackle this issue.

Aims: Little is known about what Mental Health Trusts (MHTs) are doing to tackle these issues. Even less is known about any specific attempts to improve the outcomes of those who are most marginalised within and by mental health services, that is, Black people. Therefore, the current study was developed to find out what mental health services are currently doing to improve outcomes for Black service users, and to contextualise the current race equality landscape within MHTs. It was also hoped that this study would capture good practice, as well as areas where MHTs could improve.

Methods: Freedom of Information Requests (FOIRs) were sent to all the MHTs in England to find out directly, what they are currently doing to address this problem. Findings were analysed using descriptive statistics. Interviews with 10 Black Clinical Psychologists, analysed using Thematic Analysis, were also carried out to capture their perspectives on this matter, and contextualise the findings from the FOIRs.

Results: Responses to FOIRs indicated that of the 56 MHTs contacted, only two had developed a race equality strategy that attempted to address the needs of Black service users specifically. The majority of the remaining MHTs relied upon initiatives that had a broader focus, such as the Equality and Diversity System 2 (EDS2) and the Workforce Race Equality Scheme (WRES), to address disparities in outcomes for Black service users. The thematic analysis of the interviews supported these findings. Themes were reflective of the professional and ethical dilemmas participants experienced when attempting to

address disparities in outcomes in the absence of a national policy, initiative or programme. Factors that maintained racial disparities in outcomes and the burden of race were explored. Participants also provided valuable recommendations about how, in the current context, disparities in outcomes could be better addressed within MHTs.

Discussion: The impact of institutional racism, workforce race inequality, unstandardised processes for monitoring and capturing outcome and ethnicity data across the NHS and methods and systems, and the absence of a national race equality strategy on the current findings are discussed. The limitations of the study are also explored, along with recommendations about future research, including regular race disparity audits by the government.

Keywords: Racial disparities, Mental Health outcomes, Black Service users, Black Mental Health, England, National Policies

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1 INTRODUCTION

The aims of this exploratory study were to capture the current landscape of national and local initiatives, programmes, or policies that are attempting to redress racial disparities in mental health outcomes; and identify examples of good practice with respect to redressing mental health outcomes, as well as areas for development. This was operationalised through Freedom of Information (FOI) requests, sent to all Mental Health Trusts (MHTs) in England to find out what they are currently doing to improve outcomes for Black service users. Ten Black qualified Clinical Psychologists were also interviewed to share their perspectives on this issue, in relation to their respective MHTs' attempts to redress racial disparities in mental health outcomes.

1.1. Overview of Chapter

In this chapter I will orient the reader to relevant terminology used within the literature and throughout my thesis. I will then, introduce the reader to my personal, political and professional relationship to the topic, and highlight the importance of thinking about the experiences of Black people specifically. I will provide an overview of the disparities in mental health outcomes for Black people who access mental health services. I will talk about possible causes for this difference, including the higher levels of social disadvantage and trauma experienced by Black people, and will then offer a summary and critical appraisal of the historical developments in national policies and practices which have attempted to address this problem. I argue that the introduction of the Equality Act in 2010 was a movement which took "race off the agenda" and halted progress in tackling the issue of poorer mental health outcomes for Black people accessing mental health services. I will conclude by highlighting that in the absence of a national strategy, not enough is known about whether mental health services are doing to address racial disparities in mental health outcomes. Even less is known about specific attempts to improve mental health outcomes for those who are affected the most by these disparities: Black service users. I will then outline the rationale for the focus of the present study.

1.2. Terminology

Several terms, relevant to this thesis project, notably, race, culture and ethnicity are often used interchangeably (Odusanya, 2016). This can cause confusion because, besides being some similarities, there are some important distinctions between them (Odusanya, 2016). Those that are most relevant to this project have been summarised below.

1.2.1. Race
Race is a term that is used to categorise people into imagined communities which has real, material effects (Anderson, 1991, p.6) and is one of the greatest and most tragic errors of our time (Montagu, 1942). It is also a socio-political construction in which physical characteristics, such as skin colour and hair texture of oneself or one's ancestors, are used to assign people to factitious, supposedly mutually exclusive, biologically distinct, demographic categories (Helms, Jernigan & Mascher, 2005). The concept of race is synonymous with designation, lineage, a type, subspecies, status, class and a social construct (Banton, 1987). Additionally, there are racial hierarchies, which can be traced back to "the rule of colonial difference", where the colonised, were represented "as incorrigibly inferior" in comparison to their colonisers (Chatterjee, 1993; Go, 2004).

1.2.2. Black
For the reasons outlined above, "'Black' is a contested term with multiple meanings" (Paulraj, 2016, p. 2). In this project, I have used Black to refer to people of African and Caribbean heritage and expanded on this definition later in this chapter.

1.2.3. Culture
Culture can be understood as a set of norms (including language), expectations, and values shared by a community (Triandis, 1996).

1.2.4. Ethnicity

Ethnicity has been defined as: "the social group a person belongs to, and either identifies with or is identified with by others, as a result of a mix of cultural and other factors including language, diet, religion, ancestry and physical features traditionally associated with race" (Bhopal, 2014).

1.2.5. Discrimination

Discrimination is the unfavourable treatment based on the (perceived or actual) possession of a characteristic (e.g. race, gender, religion) protected under the Equality Act (2010) ((Equality and Human Rights Commission (EHRC), 2016). Discrimination leads to poorer experiences, or outcomes across all domains of functioning (e.g. employment, education, criminal justice, living standards and health care) (Pascoe & Smart, 2009).

1.2.6. Racism

Racism is a form of discrimination which is perpetuated by a system of oppression based on racial categories and domination that designate one group as superior and another group as inferior (Bulhan, 1985). It is illegal under the Equality Act (2010). This topic is explored further later in this chapter. There is also evidence to suggest that term "racism" has existed within the British lexicon since the 1930s (Chattoo & Atkin, 2012). Over time, however, the term's political significance and meaning have shifted (Chattoo & Atkin, 2012).

1.2.7. Institutional Racism

Institutional racism is a specific type of racism that takes place eat an organisational level. Macpherson (1999) defines it as:

> *"The collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture, or ethnic origin. This can be seen or detected in processes, attitudes, and behaviour that amount to discrimination through unwitting prejudice, ignorance, thoughtlessness, and racist stereotyping which disadvantages people in ethnic minority groups" (Macpherson, 1999, p.49)*

1.2.8. <u>Black and Minority Ethnicity Groups (BME)</u>

In England, the majority ethnicity group is White British (81.9% of the population) (Office for National Statistics (ONS), 2012) therefore, the remaining 18.1% of non-White British individuals are typically categorised as belonging to Minority Ethnicity groups. Individuals who ascribe (or are indeed ascribed) to Minority Ethnicity groups may experience common burdens (Feagin, 1984); learning through first-hand experience, that physical and/ or cultural differences from the majority group can engender discrimination and subordination (Feagin, 1984).

Under the 1997-2007 Labour Government, Black and Minority Ethnicity (BME) was viewed as a progressive term in both political and social spheres. It provided a voice and identity for people from Minority Ethnicity groups such as Black and Asian (Parris, 2016) and was a way to challenge racism in England. This term has been viewed as a way of "tidy[ing] away the messy jumble of real human beings who share only one characteristic – that they don't have White skin" (Phillips, Okolosie, Harker, Green, & Dabiri, 2015). Current terminology reflects the existence of socially shared rules around what it means to belong, and who belongs; what minority status is or isn't; and who has the authority to determine national and/ or global minority status (Feagin, 1984).

1.3. Reflexivity

Reflexivity is central to ethical practice (Darlaston-Jones, 2007); the "ongoing mutual shaping between researcher and research", and a way of shifting the "focus away from a view of research methods as objectified procedures to be learnt by researchers, and towards the development of researchers who craft procedures integral to the environments in which they operate, of which they are a functioning constituent" (Attia & Edge, 2017). Reflexivity requires the researcher to engage in a process of stepping back from action increase their awareness of the processes that occur between themselves and their context (Attia & Edge, 2017). Documentation of reflexivity can increase transparency around the decisions made during the research process. This in turn, can

enhance the quality of the research findings (Spencer & Ritchie, 2011). As such, I have remained reflexive and shared my thinking throughout.

1.3.1. "Outsider-Within Status"

At the age of 28, I proudly self-identify as a Black British woman of West African, (specifically, Sierra Leonean) heritage. It was not until the age of 5, however, when I moved from my birthplace in London and settled in a predominantly White British area of Essex that I realised I was Black. I had left a racially, culturally and ethnically diverse environment where everyone was both the same, and different, to one where I was different, and everyone else was the same. I became well versed with the challenges of growing up in a country that had an awkward and troubled relationship with its own history of racism (Hirsch, 2018); namely, the complex ways in which race and race issues were conceptualised and responded to on individual, interpersonal and societal levels.

My interactions with my White British peers taught me that being White was the norm; it was desirable, and acceptable, therefore, anything that deviated from this was less normal, desirable and acceptable. Being Black, meant being something fundamentally and qualitatively different than being White, and that there were physical, emotional, behavioural and intellectual markers that helped to make these distinctions in an objective way. While it was very rare that I was the recipient of racism that was intentional or overt (Ridley, 1995) in different ways, I was often reminded that my honorary membership to the local, predominantly White community was precarious. For example, comments like "I don't mean you; you're not like them, you're more like us" that followed disparaging remarks about what "all of the foreigners" had "done to our area".

Growing up in this context, I believed that being Black was something I had been afflicted with. Therefore, to be accepted and acceptable to my peers, I had to somehow mask my Blackness. In some ways, my father reinforced and extended this idea when he gave me "the talk" about the intersection between my most visible identities: my gender and race. He told me that I could achieve anything I wanted to achieve, but as a woman, more specifically as a Black

woman, he warned me that I would have to work one hundred times harder than everyone else, for half the opportunities and a quarter of the success. It was difficult for me to truly comprehend sexism and racism as the mechanisms that necessitated this additional labour from me. What was clear to me at this tender age, however, was that success, in any sense of the word, meant defying other people's expectations of what it meant to be a Black woman.

For the remainder of my childhood, my interactions with and exposure to "Black culture" and "Black peers" (of African or Caribbean descent) were relatively limited in frequency and duration. This exposure, was nonetheless invaluable in providing me with an alternative, and to an extent, more affirmative picture of Blackness. For example, through this lens, being Black was not only about having higher concentrations of melanin in your skin; it was about the specific attributes, skills and knowledges that those of African or Caribbean descent were presumed to have been automatically endowed with. As a woman, this was signified by having a voluptuous body shape; the ability to cook and dance; as well as being sufficiently familiar, and fond of "Black" culture (e.g. "Black" music, colloquialisms, movies, and fashion).

Further, if you did not possess all of these attributes, knowledges, skills, or affiliations you were liable of being stripped of your Black identity, or your "Black card", and being labelled a "coconut", "bounty", or any other object that is white on the inside and black on the outside. After being called these names by my Black peers, I learnt that there was in fact, a right way to be Black. Despite feeling ostracised by the assumptions embedded within this label, being called Black by, or at the very least having a sense of belonging and shared identity with my Black peers, was a form of highly sought after validation and respect. I was also educated about the hierarchies within and between the African and Caribbean communities, in which those with Caribbean, more specifically, Jamaican heritage and / or cultural affiliations were seen as more desirable.

It was as a result of these kinds of interactions that took place during my formative years that I began to develop my own ideas about Blackness at an

individual and interpersonal level. My consumption of mass media, on the other hand, offered me an insight into what it meant to be Black on a societal level. There was visible underrepresentation of positive Black role models, and overrepresentation of Black people being seen as living in poverty, participating violent crimes, and receiving more severe mental health diagnoses (e.g. "schizophrenia"). African and Caribbean identities were constantly subsumed under the label Black, and the general public was denied the opportunity to develop more nuanced perceptions of multicultural and multi-ethnic communities. Further, minimal coverage was given to the contextual factors that may have made for a richer understanding of the perceived psycho-socio-economic differences between different racial, ethnic and cultural groups living in England.

The thin narratives promulgated by the media that portrayed Black people as being synonymous with delinquency, danger and madness did little to attenuate remnants of the erroneous and overtly racist attitudes and practices of the pre-race relations legislature Britain. From what I (and others) saw on the news, being Black was a problem; one that was irrefutably located inside Black people. Moreover, these widely held, stereotypes of Black people that I subsequently internalised, certainly did not represent my personal experiences with or perceptions of Black people; nor did they depict the stories of strength or resilience that is also within Black communities.

It was through my exposure to a range of different ideologies that often differed from my own that I gained special perspectives and insights (Merton, 1972) about what it means to be Black in Britain. I had earned what is known as "outsider-within status" (Hill Collins, 1986, p.14; Merton, 1972). I was an outsider who had become "systematically frustrated by the social system" (Merton, 1972, p. 29) because I did not fit neatly into the prescribed norms or expectations of my geographically or racially prescribed identities. However, the combination of being a Black person in a predominantly White area initiated me into groups and discourses that would have otherwise been out of reach had I

held full insider status, for example, as a self and peer defined Black woman (Hill Collins, 1986).

My outsider-within status emphasised that Blackness is a dynamic term that means more than one thing at any one time. For me, it is the intersection between the context, perceived racial, ethnic and / or cultural identities and the socially constructed expectations associated with these contexts and identities; it is, indeed, a qualitatively different experience to being any other ethnicity; and it is one that is equated with less favourable experiences and outcomes. Throughout the write up of this project, the terms "race" and "ethnicity", have been used with the understanding that they are "social constructions, which therefore, have different individual and societal meanings depending on the context in which they are applied" (Keating, 2009, p. 43; Cooper, Beach, Johnson & Inui, 2005).

1.4.   Developing This Project

During my first year of clinical psychology training, we were taught about the composition of traditional mental health services, as well as how they operate within the National Health Service (NHS) and socio-political contexts. Our lecturers encouraged us to reflect on the impact of social inequalities on mental health, specifically in relation to who mental health services benefitted (e.g. those who "recovered" from their mental health difficulties) and for whom these services were not a good fit or had negative experiences of mental health services (e.g. those who engagement with mental health services meant higher risks of institutionalisation, poorer standards of care and even death). We were often presented with statistics, to support us in our reflections (to which I will return later in this chapter). Whether it was the overrepresentation in the "sharper end" of the mental health system, such as inpatient or social care services, or underrepresentation in primary care services, overwhelmingly, the statistics depicted a broken system in which people from BME backgrounds, specifically young Black men, were disadvantaged by the incumbent mental health systems/services, policies and practices.

1.4.1. <u>The Only Black in the Village</u>

As a Black woman operating within a predominantly White discipline, learning about on the overrepresentation created a feeling of personal resonance that I was deeply disturbed by. This was exacerbated by being the only Black Trainee Clinical Psychologist in my cohort of 32, my "outsider-within" status was, in addition to my personal context, ever present in my professional life. This forced me to ask myself some difficult questions: was working within a system that is potentially harmful to people who look like me something I was prepared to do?

There are many reasons that the issue of overrepresentation as outlined above, are important to the work of both Trainee and qualified Clinical Psychologists, as well as mental health professionals from other disciplines. For example, it forms part of our duty bound commitment to promoting social justice and upholding professional integrity (Patel, et al., 2000). There are also statutory requirements, health authority recommendations, and discipline specific recommendations (e.g. from the BPS) that obligate us to ensure that the provision of mental health services is "accessible, adequate and appropriate" to all of our clients (Patel, et al., 2000, p. 23).

In addition to these professional commitments, I felt that on a personal level, I could not ignore or avoid the picture of racial disparities in mental health outcomes for Black people painted by these statistics. However, I found the prospect of trying to overhaul this broken system incredibly daunting and wondered whether this would be a fight my cohort (with whom I was newly acquainted), and/or colleagues, both senior and junior would take on with me. Or as the only "Black [trainee] in the village" (McNeil, 2010, p. 115), would it fall onto me to be the equality and diversity "flag bearer" (Shah, 2010, p. 74)? Or worse, the angry Black psychologist (Harris-Perry, 2011; McNeil, 2010, p.46) on training and, invariably, in my career moving forward?

1.4.2. Alternative Practices

Fortunately, in addition to the teaching we received about traditional mental health services, we learnt about alternative models of care, as well as how Clinical Psychologists had developed and used them within local services (e.g. the Trailblazer Project (Byrne, et al., 2011), What's the story? Project, and My Life Project (Afuape & Hughes, 2015)). They employed creative, strengths-based, social justice and social action-oriented approaches to understanding and improving the wellbeing of those who are systematically disadvantaged within and by society (e.g. African and Caribbean men, and Young people experiencing multiple social inequalities, respectively). They were underpinned by key ideas from Liberation and Community Psychology; interrelated theoretical frameworks that recognise the role of power within socio-political contexts on wellbeing (Martín-Baró, 1994). They also position clients as experts in their own lives, and psychologists as part of the emancipatory process for, and with oppressed communities through: consciousness-raising, social orientation, consideration of and siding with the "oppressed majorities" and de-ideologising reality (Martín-Baró, 1994).

Clinical Psychologists have also been active in racial disparities in mental health since the 1980s. For example, a small group of Clinical Psychologists came together to tackle these issues within the profession (Wood & Patel, 2017): the Race and Culture special interest group (later turned faculty) within the British Psychological Society (BPS) was developed to:

> *"see clinical psychology transformed to acknowledge and examine its historical and current racism and Eurocentricity, in order to help future generations of Clinical Psychologists to be better skilled to work with a multi-ethnic population and to help realise the goal of a health service for all, and one which did not reproduce institutional racism"*
>
> (Wood & Patel, 2017 p. 3)

Their mission statement was: "To ensure that services are relevant and accessible to people from BME communities,... Psychologists... working to advance the development of inclusive and meaningful knowledge and practice

with and for ethnically diverse communities" (Tribe, 2014, p. 4); and they did this in a number of ways, most notably through the publication of the "Clinical Psychology Race and Culture Training Manual" for those delivering training on the Clinical Psychology doctoral courses (Patel et al., 2000). However, in 2014, the faculty was closed down without consultation or formal explanation by the BPS at the time, (Wood & Patel, 2017). The profession's role in addressing racial disparities arguably became less clearly defined after issues of race became subsumed under the equality and diversity agenda within the BPS (Wood & Patel, 2017). Other developments within the profession, such as the Minorities in Clinical Psychology Group, Widening Access to Clinical Psychology Scheme and more recently, the development of the "Decolonising White Psychology" workshop (Wood & Patel, 2017), indicate that psychologists are actively thinking about and attempting to tackle issues of race at workforce and service delivery levels.

It was through finding out about these ways of working and thinking that I was able to firmly reconnect the role of a Clinical Psychologist working in NHS mental health services with my personal values and my initial reasons for following this career path. The existence of these projects and initiatives demonstrated that there were people within mental health services, actively committed to improving mental health outcomes for those who were most oppressed within and by society.

1.5.   What is Meant by Mental Health Outcomes?

It is important to situate the above reflections in the broader context of the outcome monitoring culture that is prevalent within the NHS. Andrews, Peters and Teeson (1994, p. 4) define outcomes as "the effect(s) on a patient's health status attributable to an intervention by a health professional or health service". Outcomes are synonymous with the measurement of progress or change and monitoring of experiences through direct (e.g. number of admissions to an inpatient unit) or indirect means (e.g. self-report measures or standardised assessment measures) (Thornicroft & Slade, 2014). The use of outcome

measures forms part of a shift within the healthcare industry from clinical epidemiology as a specialist interest, to the use of evidence-based treatment as best practice within national health services (Coster, 2013). A growing number of Governments are relying on the use of outcome data and evidence-based treatment data bases to establish local and national health policy, and formulate cross-national recommendations for health policy and practice (Lambert, Gordon & Bogdan-Lovis, 2006).

Outcome data has been used to create a culture of transparency, accountability and consistency in the application of NHS standards to public healthcare, help consumers of public healthcare make informed choices about their care based on conclusions drawn about service quality, and to provide the rationale for decisions about future service provision and commissioning (Lambert, Gordon & Bogdan-Lovis, 2006). Further, this data can be used to develop interventions (e.g. randomised controlled trials) and in turn can inform policy and shape national guidance relating to the identification and management of different mental health presentations. However, the way outcomes are monitored and analysed varies considerably depending on service context, clinician preferences, national guidelines, and client preferences.

1.5.1. Selecting Outcome Measures

Thornicroft and Slade (2014) proposed eight questions researchers, clinicians and services should ask themselves to think more strategically about their use of outcome measures:

1.5.1.1. *Whose Outcome?*

The outcome data relating to the patient is generally considered the most important, however, the outcomes of their informal carers (e.g. family/friends), staff (e.g. their wellbeing and satisfaction) and members of the public, can reveal key information about service performance and quality.

1.5.1.2.   Which Scientific Stage?

Outcomes are said to vary according to the scientific stage of enquiry; the objectives or function of monitoring or analysing outcomes towards the beginning of therapy will be different to those at the end of therapy.

1.5.1.3.   What Outcome Domain?

There are seven main domains that outcome data can inform us about: wellbeing, cognition/emotion, behaviour, physical health, interpersonal, societal and services.

1.5.1.4.   What Level of Assessment?

There are different levels within a system that can be monitored or analysed using different outcome measures; the individual intra-psychic level (e.g. symptoms), interpersonal and immediate social environment (e.g. carers, social networks) and the broader environmental level (e.g. stigma).

1.5.1.5.   Clinical or Recovery Outcomes Focused?

Outcomes have traditionally focused on monitoring and analysing clinical data (e.g. improvement or worsening of a particular symptom), social functioning and service use (e.g. referral or admission rates). In the UK, the most commonly used measures to assess general psychological functioning include: Clinical Outcomes in Routine Evaluation – Outcome Measure, (CORE-OM) and Outcome Questionnaire-45, (OQ-45) (Lambert, et al., 1996; Barkham, Mellor-Clark, Connell, & Cahill, 2006). The Health of the Nation Outcome Scale (HoNOS) is typically used to monitor and analyse social desirability (Wing, Curtis & Beevor, 1996), and the Camberwell Assessment of Needs (CAN) or analysis of service usage data can provide an overview of service use (Phelan, et al., 1995).

Recovery focused outcomes, however, tend to draw on five key recovery processes: connectedness (social inclusion, community integration), hope and optimism, development of a positive identity, meaningfulness in life, and empowerment. The Recovery STAR is being used by many Mental Health Trusts as a tool for optimising individual recovery and gaining the information to create recovery-focused Care Plan (MacKeith & Burns, 2008). The Star Chart is

co-developed by the service user and the staff member in partnership and covers 10 life domains (MacKeith & Burns, 2008).

1.5.1.6. Whose Perspective?
To evaluate mental health outcomes, the main perspectives that are used within services are that of the patient and the clinician. However, service-related outcomes, measuring service performance (e.g. accessibility, usage, relevance) against key performance indicators are also used.

1.5.1.7. Deficits or Strengths Focused?
Outcomes used within research and practice tend to be focused on mental "illness" rather than mental "health". Therefore the assessment of how effective an intervention or service has been in improving difficulties (e.g. risk, undesirable symptoms) is more likely to be seen than the development of resilience, attainment of positive wellbeing or other similar protective factors.

1.5.1.8. Invariant or Individualised?
Standardised measures, including self-report questionnaires, are used to collect and analyse outcome data. They are used, typically, because there is a belief that by using these measures, the same outcome domain is assessed for each client, and that data collected can be understood objectively, in relation to "norms" or psychometric criteria.

1.5.2. Limitations of Outcome Data
At present, there is no uniform way of capturing and monitoring outcome data across MHTs or services, partly due to wide variations in the architecture and use of technology throughout the NHS. Outcome data collection is reliant upon human participation (e.g. staff are required to manually enter data about patients onto a system) which renders this process liable human oversights or fatigue, as well as technological flaws (Reynolds & Suzuki, 2013). Further, when looking at the relationship between direct outcome data and socially constructed and contested concepts, such as race, there are additional methodological limitations in terms of how reliably or meaningfully this, or other information, such as context, can be captured and understood (Reynolds &

Suzuki, 2013). Therefore, opportunities for the meaningful analysis of national direct outcome and ethnicity data are virtually non-existent.

Direct outcome data cannot tell us much about causation in terms of the relationship between different pieces of data (e.g. ethnicity and likelihood of referral to inpatient services), the context within which the outcomes were observed (e.g. austerity, Brexit, institutional racism etc.) or about human experiences and emotions (Gilbody, House & Sheldon, 2003). As such, the data may only be meaningful in a particular context (e.g. to answer a specific research question) and attempts to interpret the meaning behind direct outcome data would be unreliable without drawing on methods of data collection, such as interviews or self-report measures which rely on indirect observations or information (Gilbody, House & Sheldon, 2003). Despite these limitations, there can be a place for strategic monitoring and analysis within mental health services, where stark differences exist between different groups. This study will focus on mental health outcomes, as evidenced by clinical tools, more closely associated with the work of a Clinical Psychologist (e.g. CORE-OM).

1.6. What are Disparities?

In healthcare, the term "disparities" is used to refer to the unequal treatment of clients, that is not justified by their needs, underlying health conditions or treatment preferences (Smedley, Stith, & Nelson, 2003). Where racial disparities in mental health outcomes exist, the perceived racial or ethnic background of the client, is the basis for the unequal treatment of clients, and the resultant unjustified variation in psychological wellbeing (McGuire, Alegria, Cook, Wells, & Zaslavsky, 2006). There is evidence that this is an issue in mental health services that disproportionately affects Black people, as expressed by the presence of more severe symptoms of distress.

This has been highlighted within previous literature reviews investigating racial disparities in mental healthcare. For example, a review commissioned by the Sainsbury Centre for Mental Health (SCMH) (2002), explored the relationship

between mental health services and African and Caribbean communities. The review highlighted that Black people were more likely to be overrepresented in the most restrictive parts of the mental health system (e.g. inpatient / forensic services), and were less likely to access preventative, or specialist community mental health services than other ethnic groups. Key issues relating to the experiences African and Caribbean communities face during their contacts with mental health services were outlined. Recommendations for future practice were also proposed, namely a wide-ranging, multi-modal programme that improves the experiences of African and Caribbean service users. Other reviews, conducted by Rethink (2000) and Mind (1997) looking at the experiences of African and Caribbean people, had similar findings.

Keating, Robertson and Kotecha (2003), as part of an initiative to determine whether London's mental health and mental health services have improved over the last five years, conducted a review of the experiences and mental health outcomes of BME communities in London. Racial disparities were identified for BME women as well as refugees and asylum seekers in London across a number of social and mental health indices (e.g. women from BME were found to have higher rates of suicide, domestic abuse, imprisonment). A number of policy and practice recommendations were also put forward to directly address the challenges and levels of systemic disadvantage faced by these groups.

Grey, Sewell, Shapiro and Ashraf (2013) investigated the causal factors and solutions for mental health inequalities facing U.K. minority ethnic populations. They found that of all the minority groups included in the review (e.g. African, Caribbean, Irish, Roma, Gypsy, and Indian), Black groups were found to be most affected by racial disparities in mental health utilisation across a number of domains (Grey, Sewell, Shapiro, & Ashraf, 2013) Causal factors, such as the application of the western mode of psychiatry, communication barriers, racial disadvantage and discrimination, and the social inequalities, were examined (Grey, Sewell, Shapiro, & Ashraf, 2013). Recommendations for future practice based on the evaluation of previous and current solutions were also put forward

(e.g. application of social model of health, cultural competence, longer-term initiatives that focus specifically on racial disparities).

These reviews provided comprehensive overviews of the racial disparities in mental healthcare. Rates of death and suicide, levels of service user experience and satisfaction, as well as referrals to inpatient services, for example, were used as markers of disparities in mental health outcomes for Black service users. However, there are no reviews that draw upon mental health outcomes derived from clinical tools (e.g. CORE-10, HoNoS) exclusively. That is the focus of the present study, and will be examined in the following section.

1.7. Literature Review of Disparities in Mental Health Outcomes

A literature search was undertaken to examine racial disparities in mental health outcomes. Preliminary searches indicated that the nature of these disparities was shaped by environmental factors, such as the political, social and geographical contexts within which they developed. Therefore, this search was limited to racial disparities in mental health outcomes observed for people accessing public (i.e. NHS) mental health services in the UK. The focus of the literature search was the disparities faced by Black people (e.g. those of African and Caribbean descent). Although attempts to ensure that the terminology used throughout is consistent, the labels used to describe Black people varies and is a reflection of the terminology used by the authors cited in this review.

1.7.1. Literature Search Strategy

Selected databases were searched including: PsychINFO, CINAHL Plus, Academic Search Complete, and Science Direct. Reference sections of journal articles, books, Google Scholar as well as 'grey' literature of unpublished research and articles were reviewed to ensure the search was thorough. Key search terms used were derivatives of: "race", "ethnic", "disparities", "differences", "mental health", "psychological", "outcomes", "national health service" and "United Kingdom". Publication search parameters spanned from the period of 1969 to 2018 inclusive.

I read the abstracts of 853 articles. From this search, I found that in order to understand the nature and extent of racial disparities in mental health outcomes, it was also important to consider the link between racial disparities in mental health outcomes and the disparities in social and mental health indices, access to mental health services, as well as, treatment and experiences within mental health services. Twenty-three of the articles reviewed were loosely connected to the main topic of this thesis, disparities in outcomes as a result of mental health services, however, only two articles focused on symptom severity, as indicated by scores on clinical outcome measures, after receiving treatment from mental health services. The findings from this review are summarised below.

1.7.2. <u>Racial Disparities in Social and Mental Health Indices</u>

People from BME backgrounds are disproportionately affected by social inequalities (e.g. income, housing, education, social isolation, social disadvantage; (ONS, 2004; Mangalore & Knapp, 2012; Morgan, et al., 2008)). The government recently carried out a race disparity audit (Cabinet Office, 2018) as part of its "abiding mission to tackle burning injustices" within England. This audit highlighted notable disparities in outcomes across a number of social indices for people who were defined as Black African and / or Black Caribbean. They were identified as the ethnic groups who were more likely to be poor as well as in persistent poverty, falling behind in educational attainment, lower rates of home ownership, as well as higher rates of unemployment and contact with the criminal justice system. The race disparity audit (Cabinet Office, 2018) also found that Black people had the lowest ratings for life satisfaction, feeling that things they do in life are worthwhile, and overall happiness compared to other ethnic groups. Further, Black women were the most likely to have experienced a "common mental disorder" such as anxiety or depression in the last week, and Black men were the most likely to have been diagnosed with a psychotic disorder in the past year.

The Prison Reform Trust (2017) found that, additionally, Black women, who are more likely to be sole parents, are more likely than other women to be

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remanded or sentenced to custody, and face longer sentences. Edge and MacKian, (2010) also notes that African Caribbean women are at increased risk for mental health problems during the perinatal period. This has implications for their children, family networks, with issues such as stigma, cultural and language barriers, as well as possible issues around immigration control (The Prison Reform Trust, 2017). Cooper et al., 2008, corelated social inequalities and social disadvantage with lower self-esteem, and self-concept. In addition, specific forms of social disadvantage, namely racism, were cited as mediating the presence of severe distress, observed in and experienced by Black people (e.g. racialised body image disturbance, dissociative experiences, low global self-esteem, delusions and hallucinations) (De Maynard, 2009).

Strong correlations between social disadvantage, ethnicity and mental health have been noted (e.g. Modood, et al., 1997; Bhui et al., 2003; Erens, Primatesta, & Prior, 2001; Department of Health (DoH), 2003; SCMH, 2002). Ethnic differences in the complexity and severity of psychological distress (as indicated by the presence of more severe psychiatric symptoms and diagnoses (e.g. psychosis) explained as intelligible psychological reactions to the stressful and / or unpleasant life events caused by social disadvantage (e.g. Lewis, Croft-Jeffreys & David, 1990; Littlewood & Lipsedge, 1981; Littlewood & Lipsedge, 1982). Other studies identified racism, issues relating to integration, poverty, unemployment, urbanicity, isolation, financial disadvantage and a range of other measures of social disadvantage, explicable by the sociodemographic factors that affect this community, as causal factors which disproportionately affect people from BME backgrounds (Read, Johnstone & Taitimu, 2004; Sashidharan, 1993; Gilvarry et al., 1999; Sproston & Nazroo, 2002; Rabiee & Smith, 2014). Increased social isolation, and heightened vulnerability resulting from "racial minority stress", i.e. stress people experience owing to being a visible minority (Xanthos, 2008), has also been identified as an additional form of disadvantage experienced by people from BME backgrounds.

1.7.2.1. *Contributory Factors for Racial Disparities in Social and Mental Health Indices*

In England, Black people are more likely to experience extreme levels of disadvantage, across every level of community disadvantage, and are more likely to be exposed to, or engaged with, higher rates of violent crime (Laurence, 2015). The somewhat problematic media coverage has highlighted this in terms of the knife crime epidemic and how it has disproportionately affected Black communities in England (Gunter, 2017; Alexander, 2008). This in turn can lead to Black people being reduced to stereotypes which position them as "trouble makers" or at the forefront of conflict, drama, controversy, violence and deviance (Halloran, 1974; Hartmann & Husband 1974; Troyna, 1981). Coverage of how this stems from structural and social inequalities, as well as the effect of such devastating events on Black people at an individual and community level, could be a much better approach to responsible reporting that captures the reality of Black people's lives and experiences.

Experiences of trauma can also disproportionately affect people from BME backgrounds. Trauma, "an event or events that involved actual or threatened death, or serious injury, or a threat to the physical integrity of self or others (American Psychiatric Association (APA), 2013). Experiences of being in or witnessing events such as a car accident, natural disaster, torture, sexual assault, physical assault and bullying are examples of traumatic events cited within clinical guidelines and relevant literature (Allen, 1996; Briere, 2004). These events can have significant and long-lasting consequences, including high levels of psychological distress and poorer quality of life (Foa & Meadows, 1997; Helms, Nicolas & Green, 2010). A person's race may pre-dispose them to witnessing and / or experiencing different types of trauma. The strong relationship between disadvantage and violent crime is well documented (Peterson & Krivo 2005).

Absent from most conceptual and research analyses of trauma is the experience of historic disadvantage and discrimination resulting from racism as causal or aggravating factors in the development of psychological distress or

poorer quality of life for (Helms, Nicolas & Green, 2010; Wallace, Nazroo, Bécares, 2016). However, for Black people, these experiences can present real threats to personhood, sense of self and wellbeing (Bryant-Davis & Ocampo, 2005). The systematic dehumanisation of African slaves has been identified as the first significant form of trauma experienced by Black people (Alleyne, 2017). It was followed by centuries of structurally oppressive and racist practices, which resulted in what is understood as the intergenerational transmission of trauma or legacy of pain passed on from one generation to the next. The effects can still be observed within Black communities. Cognitive impairments such as loss of memory and difficulty remembering, and somatic symptoms such as headaches, body pains and aches, and trouble sleeping are reported (Bryant & Ocampo, 2005). Victims of trauma as a result of racism are likely to respond to their experiences by engaging in self-blame, or exhibit feelings of confusion, shame, and guilt (Carlson, 1997). These symptoms are further exacerbated when people's experiences of racism as traumatic are undermined or misunderstood by others; their peers or professionals (Sue, et al., 2007).

In addition to the historical and societal factors outlined above, resistance within and by the mental health system, to address the social inequalities and disadvantages outlined above, has also been offered as a causal explanation for the observed racial disparities in social and mental health needs / presentation. Williams and Lindley (1996) suggest that mental health services could take account of the impact of social inequalities, as evidenced within the literature in order to affect change for those who are systematically disadvantaged. However, mental health practitioners are indeed constrained by the lack of any concrete examples of how to address these inequalities (Williams, 1996). Further, moving towards a social model of distress would likely "undermine one of the prime social functions of the mental health services; to re-name and manage the psychological damage and distress caused by social inequalities" (Williams, 1996, p.312). The power base of mental health professionals, namely psychiatry and psychology, would also likely be undermined by attempts to attend to the social inequalities that mediate

psychological distress in people from BME backgrounds (Pilgrim & Rogers, 1993; Rose, 1986).

Language difficulties, isolation from not having the same range of extended family support and stigma is particularly detrimental for people from BME backgrounds, namely BME women who have migrated from another non-English speaking country (Templeton, Velleman, Persaud & Milner, 2003). Other factors, such as highlighted that ethnic density, that is, the concentration of people from the same ethnic group, can also affect the severity of psychological distress and wellbeing in ethnic minority groups (Bécares & Nazroo, 2013). Although high ethnic density has been linked with improved wellbeing, for Black (African and Caribbean) people, the opposite is true. It is likely that this effect is mediated by the ways in which predominantly "Black" areas are racialised by their communities, as well as the level of resources and social capital apportioned to Black people in "Black" areas (Bécares & Nazroo, 2013).

1.7.3. <u>Racial Disparities in Access to Mental Health Services</u>
In addition to experiencing higher levels of need, people from BME backgrounds are also affected by racial disparities in accessing support from mental health services. For example, Black people who accessed mental health services had more complex pathways (e.g. delayed referrals, access via the criminal justice system etc.) than their White counterparts (Bhui, Stansfield, Hull, Priebe, Mole & Feder, 2003). Morgan et al., (2002) found that this may be related to issues of detection and engagement with and by GPs. Black people who were experiencing psychological distress, were less likely to seek help from their GPs. However, when Black people did seek help, unless they were in an acute crisis, GPs were less likely to refer them to specialist mental health services (Morgan et al., 2002; Littlewood & Lipsedge, 1993; Commander, Sashidharan, Odell & Surtees, 1997; Fernando, Ndegwa, & Wilson, 1998; Smaje, 1995; Rwegellera, 1977). In addition, Black people were found to be less likely to have access to psychological interventions such as psychotherapy, psychological treatments, or counselling, and are underrepresented in primary and secondary care mental health services (SCMH, 2002).

Racial disparities in access to specialist mental health services were also reflected in the overrepresentation of people from BME backgrounds in inpatient mental health services and in the use of the Mental Health Act (MHA) (1983, 2007). For example, in their review of literature on ethnic variations in pathways to, and use of, specialist mental health services in the UK, Bhui, et al., (2003) found that Black people used inpatient mental health services to a greater extent than other racial or ethnic groups (e.g. McGovern & Cope, 1987; Birchwood, Smith, & Cochrane, 1992; Takei et al , 1998). The 2006 census of inpatient services in England and Wales also reported that higher readmission rates, greater involvement from the criminal justice system, higher rates of detention under the MHA as well as higher rates of detention in medium and high secure wards were experienced by Black people (Bhui, Ulrich, Coid, 2014; Healthcare Commission, 2007; Burnett et al., 1999). These findings highlight how Black people are more likely to access mental health services through more punitive and coercive pathways than other ethnicities in England.

1.7.3.1. Contributory Factors for Racial Disparities in Access to Mental Health Services

The stereotyping, criminalisation and medicalisation of people from BME backgrounds have been identified as some of the causal factors that contributed to observed racial disparities in access. Williams, Turpin and Hardy (2006) carried out a literature review on this topic and found that these disparities were linked to the failure by mental health services to account for the specific needs of ethnic groups, and named racial stereotyping and discrimination by healthcare staff as the underlying mechanisms for these failures (e.g. Bhui, 2003; Commission for Health Improvement, 2003; DoH, 2003; Nadirshaw, 1993). For example, African Caribbean people are less likely to be referred for psychological therapies because they have been historically viewed within mental health services as "non-psychologically minded" (Bennett & Dennis, 2000, p. 95). Francis (1989) added that the issue of race and ethnicity in mental healthcare is not just another discrete demographic factor that can be understood within a "positivistic, medical model of cause and effect". Rather, it is an issue that questions psychiatry's role and function within society; that is, a

larger social control apparatus that has much influence over the lives and experiences of Black people (Francis, 1989).

The role of fear in maintaining the observed racial disparities in access to mental health services has also been examined. For example, Keating and Robertson (2004) talked how fear, felt both by professionals and people from BME backgrounds, especially those of African or Caribbean backgrounds, has contributed to the development of a fractious relationship between BME people and mental health services. They highlighted how Black service users' main sources of fear came from previous negative encounters with mental health services, and the perception of the mental health service as replicating experiences of racism, discrimination and oppression they experienced within other institutions and wider society (Keating & Robertson, 2004). Fear has also been linked to differences in the way Black people seek help from mental health services when they are experiencing psychological distress For example, racial disparities in access to mental health services may be related to Black people's fears about the potential consequences of doing so, namely loss of status, control, independence and autonomy (White, 2006). African and Caribbean men, were found to perceive the consequences of engaging with mental health services as much more severe, based on the "real and potent" beliefs that they will instead experience discrimination or worse, that engagement with mental health services will lead to their death (Keating & Robertson, 2004; Men's Health Forum, 2006).

Black people also experienced mental health services as inhumane, unhelpful and inappropriate, and that services were not accessible, welcoming or integrated in the community (SCMH, 2002); they were, therefore, unlikely to seek help from mental health services (SCMH, 2002). This meant their pathways to receiving mental health support or interventions that were minimally intrusive and / or preventative, were virtually non-existent. As a result, Black people would only come into contact with them when it was "too late", and they required involvement from acute and inpatient settings, which typically involved more coercive and seemingly punitive treatment: intramuscular

injections and/or involuntary detention within confined and restrictive environments. Further, Black people, especially young Black men, can end up with an extremely racialised profile of their mental health (Keating, 2009). For example, by being seen as 'big, Black, bad, dangerous and mad' by mental health services likely leads Black people to conceptualise themselves as being less deserving of care that could promote their recovery and /or enhance their wellbeing (e.g. early or preventative interventions) (Keating, 2009).

There are highly publicised incidents in which Black people have died while being detained in mental health services, due to the use of excessive force by staff when using physical restraint. This resulted in a mistrust and fear that Black people exhibit towards services, and a wariness and fear of criticism, not knowing how to respond, nor how to manage "violent" Black men exhibited by staff as a "circle of fear" (SCMH, 2002; Keating & Robertson, 2004). He explained that the circle is "fuelled by prejudice, misunderstanding, misconceptions and sometimes racism" (SCMH, 2002). These circles are present in the current landscape of mental health services, where Black people continue to be underrepresented in primary care interventions and /or talking therapies, and overrepresented in the sharper ends of services.

This conceptualisation of the disparities is also consistent with the picture of Black people as well as people from BME communities being generally underserved by the UK healthcare systems as a result of their needs being inadequately addressed (Fatimilehin, 1989; Fatimilehin & Dye, 2003; Smaje, 1995). This in addition to the multiple layers of disadvantage experienced by Black people due to intersections of multiple minority statuses has implications for how data about access to, as well as outcomes from mental health treatment is captured and understood (e.g. hooks, 1981; Crenshaw 1989). For example, if the differences between in the severity of mental health presentation, were thought about in terms of differences in experiences of disadvantage and discrimination, there may be a more clearly defined role for mental health services in reducing these experiences (Rogers & Pilgrim, 1996). The provision of specialist services, responsive to the needs of Black people would also likely

improve their access to the right support at the right time, thereby reducing the severity of their presentation, and improving their mental health outcomes.

Racial disparities in mental health access and utilisation can also be thought about in relation to the lack of relevant or accessible services available to people from BME backgrounds. For example, the lack of access to bilingual healthcare professionals, language and communication barriers, stigma related to service involvement, fears that confidentiality may be compromised, and insufficient awareness of existing services and what they may have to offer have been cited as affecting BME people disproportionately (Fatimilehin & Dye, 2003; SCMH, 2002; Rabiee & Smith, 2007). Further, the nuanced ways in which people from BME backgrounds conceptualise and manage their psychological distress, especially if it is connected to collective and individual historical experiences of oppression and discrimination, may not be acknowledged within mental health services. For example, people from BME backgrounds may not recognise their distress as being related to mental health (Harrison et al., 1989), and/or may view their ability to withstand high levels of adversity as a source of pride, self-esteem and/or sense of belonging impact of longstanding oppression (e.g. Burr & Chapman, 2004; Edge & Rogers, 2005). Without sensitivity to these socio-historic contexts, and their potential impact on the wellbeing of people from BME backgrounds, the mental health services are unlikely to be of relevance to these underserved communities.

1.7.4. Racial Disparities in Mental Health Treatment
In addition to the racial disparities in social and mental health indices, and access to mental health services, disparities in the treatment Black people receive from mental health services have been repeatedly documented (SCMH, 2002; Sewell, 2012). The first example of this kind of disparity is the type of psychiatric diagnoses given to people from BME backgrounds. For example, when compared to their White British counterparts, Black people were four times more likely to be diagnosed with more severe and enduring illnesses such as "schizophrenia", and psychosis and are less likely to be diagnosed with depression or affective disorders (e.g. Harrison et al., 1989; Cooper et al. 2008; Fearon et al., 2006; Fernando, 2017). These issues disproportionately affect

young Black men (De Maynard, 2007). Moreover, the impact of these disparities are also felt by Black families and communities as a whole, which is an area that is under researched within the literature (Rogers & Pilgrim, 1996, p. 137).

The disparities in diagnoses are then implicated in the differential treatment people from BME backgrounds receive from mental health services. For example, they are more likely to be compulsorily detained and / or on a locked ward while in receipt of mental health care (Ferns, 2005; Ineichen, Harrison & Morgan, 1984; McGovern & Cope 1987). They are also more likely to be given physical treatments forcibly, such as antipsychotic or other psychotropic medications as the primary form of treatment, as well as ECT (in higher doses) and as outlined earlier, are much less likely to receive or be offered psychological or psychotherapeutic interventions (Little & Lipsedge, 1993; Ferns 2005; Fernando, 2017; DoH, 2003).

Black people are more likely to be treated using more punitive or coercive means. For example, compared to other ethnic groups, Black people are more likely to have the police involved in their hospital admission and be treated under Section 136/137 of the MHA (Turner, Ness & Imison, 1992; Rogers & Faulkner, 1987). They are also more likely to be transferred to locked wards (e.g. high and medium secure facilities) from open wards and are more likely to be subjected to forensic services (Fitzpatrick, Kumar, Nkansa-Dwamena, & Thorne, 2014; Tarbuck, Topping-Morris, & Burnard, 1999). The Mental Health Foundation (2008) also noted that Black people aren't given enough information about their rights with respect to the MHA, which undoubtedly affects their experience of, and treatment within, mental health services.

In addition, although no ethnic differences in the use of physical force (e.g. restraint) have been identified within mental health services (e.g. Care Quality Commission (CQC), 2011), Black people are negatively affected by the experience of this to a greater extent than their White counterparts (Mind, 2013). This results from the strong resonance with restraint in Black communities that exists because of the disproportionate number of Black

people treated in inpatient and secure settings, as well as the recent deaths of young Black men accessing services within statutory institutions (CQC, 2011; Mind, 2011)

Testimonies, taken from research investigating BME people's experiences of mental health services further support this stance. For example, Rabiee and Smith (2007) found that African and Caribbean service users and their carers felt that mental health services: criminalised Black people; weren't sensitive to the impact of social disadvantage on mental health and that service provision was based on medication rather than psychological support. Other negative experiences, namely: the "lack of continuity of care; the attitude of staff; being overlooked; not understood and respected; lack of equity in accessing resources, particularly in relation to talk therapy"; and the disconnect between mental health services and social models of wellbeing, have also been shared by African and African Caribbean Service users and their carers (Rabiee & Smith, 2014, p 130). There were also first-hand accounts of Black service users being beaten up by hospital staff and other patients; receiving degrading and inhumane treatment (e.g. a Black female service user's underwear was pulled down to her ankles by a male member of staff as he gave her an injection); and feeling silenced by the system (e.g. being unable to complain) (Rabiee & Smith, 2014, p 131).

Black people have also reported feeling that mental health services did not adequately help them to understand their problems, that their views or opinions were disregarded, experiencing a pervasive sense of powerlessness, having their request to see a psychologist denied, and finding that there was no redress to being given medication (Secker & Harding, 2002). Similar findings were shown in a national service user survey conducted in 2005 ("Count Me In Census", Commission for Healthcare Audit and Inspection, 2006) which highlighted that Black service users were most disadvantaged in inpatient services, experienced higher levels of dissatisfaction with their care and were more likely to receive harsher treatments such control and restraint (Mental Health Act Commission, 2006; Keating, 2009).

1.7.4.1.   Contributory Factors for Racial Disparities in Mental Health Treatment
Stereotyping, discrimination and criminalisation of Black people also has a role in the observed racial disparities in treatment. For example, the issue of pre-emptive criminalisation, that is, the use of criminal justice responses, being used in an a-priori fashion, (i.e. in anticipation of, rather than as a result of, criminal acts) (Fitzgibbon, 2004)). Pre-emptive criminalisation is also linked to the use of risk analysis or risk assessment across a wide range of public services, including mental health (Ftizgibbon, 2004). It has been described as a way of trying to determine the statistical likelihood of a crime being committed by an individual (e.g. something that may cause harm to the individual or the public) and responding to them accordingly. As such, risk has become "defining feature of service-user contact" (Turner & Colombo, 2008). Mental health professionals' erroneous perception of Black people as "dangerous", coupled with the above "risk agenda" that has dominated recent mental health policy increases the likelihood of Black people receiving of more severe psychiatric diagnoses and treatments within the sharper end of mental health services (Ferns, 2005; Keating, 2009; Lewis et al. 1990; Bhui & Bhugra, 2002).

It has also been suggested that psychiatric diagnoses are not scientific or objective, rather, they are the product of White European culture (Sashidharan, 1990). Therefore, the expression of emotional distress and experiences of non-European people are not likely to be accurately understood by mental health services and systems that rely upon these frameworks (Sashidharan, 1990). For example the undermining and misunderstanding of traumatic experiences can further traumatise Black people and prevent them from engaging with mental health services (SCMH, 2002). The mental health system (namely psychiatry and psychology), along with the criminal justice system, has played a key role in perpetuating racist stereotypes about Black people, and used it to justify the unjust treatment of people who belong to this community (Cummins, 2015; Fernando 2017). For example, psychological services have historically been inaccessible to people from BME backgrounds, however, once they do manage to access psychological services BME people are often viewed as

"culturally backward, psychologically illiterate, lacking in insight and emotionally unsophisticated" (Wood & Patel, 2017, p. 5).

The inherent power imbalances and racial biases that exist within the mental health system can also be seen as contributing to the racial disparities in treatment. For example, the power to forcibly treat, restrain and control individuals is exclusive to the discipline of Psychiatry (Keating, 2009). This power is distributed across mental health services, where mental health professionals are given the authority to (inappropriately) rename people's emotional distress using Eurocentric psychiatric tools and criteria (Rogers & Pilgrim, 2001). The current set up of mental health services continues to show disparities in the treatment offered to Black people, (e.g. coercive forms of treatment). It has therefore, been suggested that Black people are subject to structural disadvantage owing to the racial biases within the psychiatric system and related disciplines (Pilgrim, 2005). Other factors, such as lack of cultural understanding and competence in practice and language barriers have also been cited (SCMC, 2002).

Ridley (1995) also highlights the unintentional racist implications of the models, commonly used in mental healthcare, that in turn contribute to the observed racial disparities in the way Black people's needs are understood and responded to (i.e. treatment offered) by mental health services. For example, deficit models of mental health lead to people from BME backgrounds being viewed as having genetic or constitutional deficits (e.g. IQ, personality, character and behaviour) (e.g. Jensen, 1969; Rushton, 1988), as well as being culturally inferior. Similarly, the medical model of mental health, views psychological problems as being located within the individual, which invariably "overpathologises" the individual, and overlooks the effects of racism, discrimination and poverty on mental health (Ridley, 1995; Bennett & Dennis, 2000, p. 96). The socio-cultural or conformity model, can too be problematic. It relies up normative data based on a particular population is used to make sense of individual behaviours, (Ridley, 1995; Bennett & Dennis, 2000, p. 96) which

could also lead to stereotyping and a lack of curiosity about the experiences and needs of Black service users..

1.7.5. Racial Disparities in Mental Health Outcomes

The racial disparities in support needs, as well as access to and treatment within the mental health service, are also reflected in the mental health outcome literature. The quality, availability of and consistency across the literature is limited. The dearth of literature, as well as the "relative lack of commitment" has been highlighted as problematic at a national level (National Institute for Mental Health in England, 2003, p10; Fitzpatrick, et al., 2014). The notion that mental health services are racially discriminatory has been at the centre of many national policies and initiatives. Much of the evidence for racial disparities in mental health outcomes is derived from clinical observations, anecdotal accounts, and epidemiological research, some of which will be explored further later on in this chapter.

Within the available literature, racial disparities in mental health outcomes have been examined most frequently for people who have been given severe mental health diagnoses such as "schizophrenia" or psychosis. For example, Black people who are diagnosed with "schizophrenia", are more likely to have longer stays in hospital, have more long lasting symptoms of psychological distress, as well as poorer social outcomes than their White counterparts (McGovern & Cope, 1991; McGovern, Hemmings & Cope, 1994; Birchwood et al., 1992). Further, Black people diagnosed with "schizophrenia", also face higher rates of readmission, with a greater proportion of these readmissions taking place compulsorily under the MHA (McGovern & Cope, 1991; McGovern, Hemmings & Cope, 1994; Birchwood et al., 1992). Other studies have looked at the rate of self-harm in those who died by suicide within 12 months of their last clinical contact (Bhui & McKenzie, 2008); risk of death by suicide in those who had a diagnosis of "schizophrenia" and experience of social disadvantage, such as unemployment (López-Moríñigo et al., 2013) and found that in these dimensions of mental health, Black people fared worse than their White counterparts.

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A higher number of incidents involving Black men with mental health diagnoses dying while in police custody has also been found. For example Sean Rigg, a young Black man with a diagnosis of "schizophrenia" (who at the time was described as having a "breakdown") died as a result of positional asphyxia from being unsuitably and unnecessarily arrested and restrained face down in the prone position for eight minutes by the police (Hemmings, 2012). Burnett, (2014) found that of the people who have died in police custody, 52% of them were Black. Further, that approximately half of all deaths in or following police custody involve detainees with some form of mental health problem; 32% of the deaths were as a result of apparent suicide or self/harm and 13% of the deaths in custody were of people who were known to have mental health problems (Burnett, 2014). Black Caribbean young men were also found to be three times more likely than their White counterparts to have been in contact with mental health services before committing suicide, and Black African male psychiatric inpatients were twice as likely to commit suicide than their White counterparts (Bhui, McKenzie, & Rasul, 2007).

Chorlton, McKenzie, Morgan and Doody (2012) conducted a systematic literature review of outcomes of psychosis in Black Caribbean populations and other ethnic groups in the UK. One of their findings was that relevant literature was disparate, namely because those who had conducted research in this area did not adequately define what was meant by "outcome", nor was the term used consistently across different articles. Of the 2164 studies they examined, 14 were included in their review, and only one explored "overall outcome": Bhugra et al., (1997) found that Black Caribbean people had "poorer outcomes" than their White counterparts. Poorer outcomes were defined as those whose first episode of psychosis did not show remission, relapsed within follow up period or committed suicide (Sartorius, et al., 1986).

Some research that considers mental health outcomes derived from clinical outcome tools (e.g. self-report questionnaires for symptoms of depression or anxiety) following contact with other services, have been documented. NHS Digital recently published a performance report for their last quarter (quarter 3

2017-18) showing mental health outcomes from psychological therapy offered by Primary Care Mental Health services (i.e. Improving Access to Psychological Therapy) (NHS Digital, 2018). In this report, they showed that as a result of receiving therapy, 46.8% of people from BME ethnicities had moved to recovery, and the severity of their symptoms of anxiety or depression were no longer deemed to be at a clinical level. This was compared to 51.1% of their White British counterparts. Although this is not a significant difference, the data the report was based on was missing 8% of its data (i.e. ethnicity not recorded), therefore these findings need to be interpreted with caution.

Fisher et al., (2008) also showed how Early Intervention Services (EIS), developed for people experiencing psychosis, were trying to make use of routine outcome data gathered using an electronic package called MiData. While they were unable to show differences in mental health outcomes between or within groups, they demonstrated how this package could be used to collect demographic data and data from a range of assessment measures to better understand the effect of interventions provided by EIS services on the mental health outcomes of BME people. No other studies looking at racial disparities in mental health outcomes using clinical tools (e.g. data from mental health outcome measures) were found.

1.7.5.1. Contributory Factors for Racial Disparities in Mental Health Outcomes
Fitzpatrick, et al., (2014) note that there is a paucity of data showing the relationship between ethnicity and mental health owing to the lack of routine data collection and out of date studies. Other challenges, namely, the inconsistencies in the terminology or the categories used to describe people from different ethnic backgrounds across the literature and clinical settings, means that opportunities to compare data or draw meaningful conclusions are limited. These issues are present across all the types of racial disparities explored in this review, however, it is particularly evident in literature that focuses on treatment outcomes.

Nonetheless, some authors have reflected on what may be contributing to racial disparities in treatment outcomes. For example, the mental health care offered

to Black people has been described as inferior because of racism within the field of Psychiatry and Clinical Psychology (e.g. Fernando, 1988; Littlewood & Lipsedge, 1989; Fernando, 2017). Further, the profession has been "charged with:

> *"lack[ing] the ability to adequately address, offer, and provide an appropriate range of clinical and psychological services that are aptly sensitive to, attractive to, respectful of and relevant to ethnic, cultural, spiritual, and religious needs of a multi-cultural society"*

> (Williams, Turpin & Hardy, 2006 p.325)

Mental health services' reluctance to seriously address issues of structural and institutional inequality that affect Black people has also been identified as a factor that may be contributing to the observed differences (Fatimilehin, 1989; Husband, 1992; Morgan, 1998; Nadirshaw, 1992; Howitt & Owusu-Bempah, 1994). Singh (2007, p.364), supplements this line of argument by highlighting that failures, such as the disparities in mental health outcomes outlined above, are a reflection of services having "done too little, not because they have done too much".

McKenzie and Bhui, (2007, p.650) add that "these disparities reflect the way health services offer specific treatment and care pathways according to racial groups, and therefore seem to satisfy the well-established and widely known definition of institutional racism". Concerns have also been raised about the lack of national and planned strategies required for sustainable change (Fernando, 2005). Fitzpatrick, et al., (2014) added that the absence of central or binding guidance for statutory agencies around addressing disparities in mental health outcomes for Black people means that statutory agencies are not incentivised nor encouraged to form and maintain partnerships with voluntary sector and grassroots organisations. Further, re-structuring the provision of mental health services in order to redress the observed disparities would be very costly and may also be incompatible with too many vested interests (Warner 2004; Read, Johnstone & Taitimu, 2004)

1.8. Summary

In the above literature review, the nature and extent of racial disparities in mental health outcomes were examined. People from BME backgrounds, were found to be more likely to experience social disadvantage, namely racism and other forms of discrimination, than their White British counterparts. Of all the BME groups, Black people were most affected by these experiences of social disadvantage. This was associated with Black people experiencing poorer social and psychological functioning as indicated by social (e.g. higher levels of unemployment, poverty and contact with the criminal justice system), and wellbeing (e.g. higher levels of psychological distress) indices. Higher levels of distress were also linked with higher levels of need, and the role of mental health services in managing these needs by having an active role in addressing social inequalities was emphasised.

Higher levels of need were not shown to correspond with higher levels of support for Black people when they accessed mental health services. People from BME backgrounds were found to have fewer experiences of straightforward and positive pathways into mental health services, and were therefore less likely than other ethnic groups to access mental health services in a timely and productive fashion. Black people, especially young Black men, were shown to be at a greater risk of entering the mental health system through the most coercive means (e.g. compulsorily detained under the MHA), and were overrepresented in the harsher end of mental health services (e.g. inpatient mental health services or forensic mental health services). Racial stereotyping, criminalisation and medicalisation of Black people within mental health services and the impact of fear, and inadequate service provision were identified as barriers to care that maintain the observed racial disparities in access to mental health services.

Once people from BME backgrounds accessed mental health services, there was also evidence of disparities in the way they were treated within and by mental health services. The most palpable examples of this were in the higher rates of severe mental health diagnoses given to people from BME

backgrounds, with Black people being more likely to be diagnosed with "schizophrenia" and "psychosis", and receiving more physical, coercive and punitive forms of mental health treatment including being given medication forcibly, being compulsorily detained and restrained, as well as reports of physical violence from hospital staff. Racial stereotyping, underpinned by the inappropriate use of Eurocentric conceptualisations and approaches to distress within psychiatry, and the focus on risk assessment and management within mental health services were considered as contributory factors for the observed disparities.

Upon receiving treatment from mental health services, people from BME backgrounds were found to have worse outcomes than their White British counterparts. This was characterised by longer stays in hospital, more severe symptoms of psychological distress, poorer social outcomes, higher rates of readmission, as well as increased risk of self-harm and death by suicide. Black people were overrepresented in the literature relating to poorer outcomes following their contact with mental health services, however, the literature in this area was disparate and rarely relied upon outcomes as identified using clinical outcome tools or measures commonly used to identify the effectiveness of an intervention. The residual impact of social disadvantage, disparities in access and treatment is undeniable. Several authors, conceptualise the resultant disparities in mental health outcomes as a manifestation of institutional racism within mental health services, and statutory services in general, and the need for national, inter-agency strategies to redress these disparities was stressed.

1.9. Critical Reflection

One of the main concerns I encountered when carrying out this search was the paucity of literature that clearly evidenced racial disparities in mental health outcomes. There was an overreliance upon the general, anecdotal awareness that racial disparities in outcomes exist, and there were inconsistencies within the literature, specifically in relation to what was meant by outcomes and how

people from BME backgrounds were labelled (e.g. Black was synonymous with "non-European", "non-White", "immigrants", "Africans", "Afro-Caribbean", "African Caribbean"). Further, although we are in a digital age, where most mental health services are leaning towards using paperless information recording systems, the availability of population level data was also scarce. Most systems should be sufficiently technologically advanced that this data could be analysed in a meaningful way. However, the homogenisation of people form BME backgrounds is on the whole, problematic as it can create "fertile ground for racism to flourish" (Patel & Fatimilehin, 1999, p. 59). Although this is not the aim of examining disparities for specific ethnic groups (e.g. Black Africans), it is important that the complexity of this endeavour is appreciated. It may also help to explain, in part, why the literature is so disparate.

The few relevant studies that looked at larger samples were limited in their utility as they focused on prevalence of specific diagnoses, mostly of psychosis or schizophrenia, and had not attempted to examine the effectiveness of psychological interventions or mental health service provision using clinical outcome measures. Many mental health professionals and service users have questioned the reliability and validity of clinical tools such as diagnoses and outcome measures (e.g. Bentall, 1990; Bentall, 2009; Read & Dillon, 2013; Boyle & Johnstone, 2014). However, this does not mean that the phenomenon should not be examined at all. Perhaps, instead, a consensus needs to be reached on how best to capture the experiences and needs of people from BME backgrounds, so that they can be identified and monitored effectively within mental health services. The lack of consistency across the data made it challenging to examine the nature and extent of disparities in mental health outcomes more directly (e.g. ethnic differences in mental health outcomes resulting from accessing specific psychological interventions or services). It also painted a rather thin picture of people from BME backgrounds that is deficit-focused and "based on the premise that minority ethnic people have predetermined deficiencies" (e.g. Darwin, 1959; Jensen, 1969) and essentially overrides the stories of strength and resources people from BME backgrounds may hold (Patel & Fatimilehin, 1999, p. 64).

Psychological literature on the complex relationships between race, racism, and mental health is useful in reflecting on some of the mechanisms that perpetuate the observed disparities in mental health outcomes. Patel and Fatimilehin (1999, p. 70) talk about racism within the mental health system, and highlight the role of Eurocentric literature, models and practices used within mental health services in maintaining racial disparities across the board (e.g. access, treatment and mental health outcomes). This is exacerbated further by the "reluctance of mental health professional to acknowledge the varying manifestations of racism in the field, including their own racist attitudes and practices" (Patel & Fatimilehin, 1999, p.63; Sue, Ivey & Pedersen, 1996). They also suggest "that racism is implicated in much of the material, social and emotional difficulties" experienced by people from BME backgrounds (Patel & Fatimilehin, 1999, p. 63).

As such, rather than viewing them as corollary, mental health services should adopt a holistic approach to supporting people from BME backgrounds, such that the "whole of the person and their contexts are addressed so that" their issues "are taken into account and seen as legitimate areas of inquiry and action" (Patel & Fatimilehin, 1999, p. 67). They consider how empowerment, the development of holistic services, alternative (non-Eurocentric) theoretical frameworks and service provision (e.g. integrated vs separate services), could help to redress, not only the disparities in mental health outcomes, but the far-reaching consequences of racism. They also advocate that the needs and experiences of people from BME backgrounds should be considered within "the context of social consequences and the socio-political forces" which perpetuate the observed racial disparities, so as not to privatise "that which is essentially public and political" (Patel & Fatimilehin, 1999, p. 61)

Alleyne (2009) also talks about the impact of racism on the needs and experiences of people from BME backgrounds, and how these needs are often misinterpreted within mental health services. This in turn leads to the misdiagnosis and mistreatment of people from BME backgrounds, and results in

the observed disparities in mental health outcomes outlined above. Clinicians and services, therefore, are encouraged to draw upon alternative, non-Eurocentric frameworks for conceptualising people from BME backgrounds' experiences and needs, (e.g. the universal strengths / resilience model (Grotberg, 1995); the grinding down experience (Alleyne, 2004); Black identity wounding (Sarup, 1996); cultural shame (Alleyne, 2004); and the internal oppressor (Alleyne, 2004, 2005)). In doing so, they will be in a better position to provide treatments that are appropriate and responsive, which should in turn improve the experiences and mental health outcomes of people from BME backgrounds.

Although contributions from psychology and psychiatry help to highlight some of the specific roles different professional groups can take on to reduce racial disparities in mental health outcomes, the responsibility to acknowledge and redress racial disparities should be shared among everyone working within mental health services (e.g. nurses, social workers, wellbeing practitioners etc.). There are also national legislative frameworks, policies and guidelines that undoubtedly influence the way mental health services identify and respond to the observed racial disparities in mental health outcomes. Therefore, the attempts to address these disparities should be considered in relation to these broader contexts and influences. Further, there have also been several attempts to redress the observed disparities in mental health outcomes at a national level, which has undoubtedly shaped the way this issue has been conceptualised within mental health services. In the next section, I will identify some of the key legislative frameworks, policies, and guidelines that were introduced over the last few decades. This may help illustrate why the observed disparities in outcomes exist today.

1.10. Review of State-Level Attempts to Redress Racial Disparities in Mental Health Outcomes

Using several databases (including PyschINFO, SCOPUS, Cochrane, GOV.UK, Google Scholar) as well as grey literature, I searched for keywords and related

terms where possible, such as "Race equality", "inequality", "inequity" "Black", "Black and Minority Ethnicity", "BME", "policy", "guideline", "initiative", "programme", "strategy", "National Health Service", "NHS" "Britain", "United Kingdom" and "England". A snowballing method was used to locate relevant literature on reference lists. I then corroborated my findings with previous policy and practice reviews and summaries (e.g. Bhui & Olajide, 1999; Patel, et al., 2000; Keating, 2002, Rogers & Pilgrim, 2003 Inyama, 2009; Fitzpatrick et al., 2014; Craig, Atkin, Chattoo & Flynn, 2012; and Fernando, 2017).

This review consists of a synthesis of publications from a range of sources. Documents were included if they contained information or guidance that had a probable benefit or impact on Black service users. They have been arranged in chronological order to capture the socio-political and historical contexts within which they occurred. Reflections regarding how this relates to current practices and racial disparities in mental health outcomes have been included, where appropriate.

1.10.1.   A Brief look at the Historical Context

There is a specific sociohistorical context within Britain which ultimately led to the development of policies aiming to redress racial discrimination. It is beyond the scope of this project to provide a detailed account of this or other similar movements that took place outside of the UK. However, a brief summary of the events that led to the first piece of legislation relating to race has been provided below to orient the reader to the reader to the importance of earlier developments in policy and legislation with respect to the racial disparities in mental health outcomes outlined.

Public records, such as diaries, published accounts, portraits and official accounts show that people from BME backgrounds have been living in the UK since 55BC (Craig, 2012; Patel & Fatimilehin, 1999). Black people became observable in number at least 500 years ago, and by 1772, the Black population had grown rapidly as a result of the slave trade (Porter, 1991; Craig, 2012). However, after the abolition of slavery in 1833, and most notably, following the end of the Second World War, Britain continued to experience increasing levels

of immigration (Flynn & Craig, 2012). This growth occurred as people from former British colonies and Commonwealth member states were recruited to rebuild Britain and contribute to economic growth (Flynn & Craig, 2012; Brown, 1995). However, those who moved to the UK were often made to feel inferior in a number of ways, including being paid less for the same jobs as their White British counterparts, or having poorer working conditions (Levy, 2007; Brown, 2006). Increased hostility and violence from White British people towards Black people (including the Nottingham and Notting Hill Race Riots initiated by White people).

1.10.2.   <u>1960s</u>

1.10.2.1. *The Commonwealth Immigrants Act (1962, 1968) & Immigration Act (1971)*

During this time, BME people were blamed for the hostility they experienced from others, and there was also mounting evidence of a racist attitudes being held by the police towards Black people (Muir, 2005). Further, the rising racial tension between White British and BME groups was perceived to be happening as a result of increased numbers of BME people living in the UK (as opposed to high levels of racism and intolerance from White British people towards people from BME backgrounds) (Flynn & Craig, 2012). This ultimately led to calls for immigration control at a policy level, and resulted in the development of the Commonwealth Immigrants Act (1962). This piece of legislation was viewed as institutionalising racial discrimination (Sivanandan, 1982). It was the first to outline state regulation of Commonwealth immigration and entry restrictions on British Commonwealth citizens; immigration was contingent upon the possession of a work voucher (Brown, 1995).

The 1962 Act was later replaced by the 1968 Act, which was overtly racist towards people from Commonwealth member states. It aimed to stop immigration of Asian people with British passports who had been driven out of Kenya because of Africanisation policies (i.e. policies designed to increase the number of African people living in Africa) (Flynn & Craig, 2012). This, Act was eventually superseded by the Immigration Act, 1971 in which a partial "right of abode" was introduced. All restrictions on immigrants with a direct personal or

ancestral connection with Britain were subsequently lifted. Other acts and policies on immigration and related matters (e.g. refugee and asylum-seeking status) have been influenced by the "numbers game" which originated in the 1962 Act (Flynn & Craig, 2012).

1.10.2.2. The Race Relations Act (1965, 1967 & 1976)

The Race Relations Act, 1965 (c.73) was the first legislation in the United Kingdom to address racial discrimination. The Act made discrimination a civil offence on the "grounds of colour, race, or ethnic or national origins" in private businesses. This Act was introduced in England to address the issue of "casual colour prejudice" that was a part of everyday life for BME people who had migrated to England after the Second World War. However, this development took place against the backdrop of extremely restrictive immigration legislation (Flynn & Craig, 2012). Further, it was not viewed favourably by those whom it sought to protect, as discrimination on the grounds of race was not treated as a criminal offence (Patterson, 1969).

Amendments in 1967 and 1976 expanded the scope and force of the legislation, making it illegal for a person to be refused housing, employment, or public services to someone on the grounds of their colour, race, ethnic or national origins. This change in legislation resulted in the development of the Commission for Race Equality, which had a remit to promote "harmonious community relations" (Race Relations Act, 1976, c.74). It also obligated health authorities to ensure that the services they provided were not racially discriminatory, and that services were appropriate, and easily accessible to all ethnic groups (Patel, et al., 2000).

These legislative milestones, did not significantly change the "Eurocentric bias of policies and practices" (Aitken, et al., 1996). Further, these developments have been criticised for having little impact on the "material circumstances of Black peoples relative to White" (Aitken, et al., 1996). However, in some ways, the legislation created pathways for promoting anti-discrimination culture within England, and for individuals and organisations, both private and public, to be held accountable for racist practices.

1.10.3. <u>1990's</u>

1.10.3.1. The Patient's Charter (1992)

The Patient's Charter was part of a government-led movement within the UK to dramatically change the focus and activity of the NHS (Oliver, 1993). It was built upon previously issued legislation and was seen as a way of ensuring that a high standard of care was delivered across the NHS (Oliver, 1993). The needs of people from BME backgrounds were considered in standard one: "Respect for privacy, dignity and religious and cultural beliefs" (Oliver, 1993, p.85). The introduction of this standard prompted services to identify ways of concretely monitoring how closely they were working towards meeting this standard by ensuring that their staff were adequately understanding, educated and experienced to support the diverse needs of the populations they served (Oliver, 1993).

1.10.3.2. The Orville Blackwood Inquiry (1993)

In 1991, Orville Blackwood, a Black man of "African-Caribbean" descent, died following several systematic failures, which resulted in him being forcibly injected with a lethal combination of antipsychotic medications while under the care of Broadmoor Hospital. The inquiry into his death shone a light on two other Black men who were of "African-Caribbean" descent, Michael Martin, and Joseph Watts, who died under similar circumstances. The hospital was criticised for its knee jerk responses to patient misdemeanour and violence, poor quality nursing skills, lack of management guidance and the insensitivity towards patients shown by staff. However, organisational racism, both direct and subtle (e.g. negative labels and perceptions of Black patients as "big Black and dangerous" held by staff) was highlighted as playing a significant role in the deaths of these men (Prins, 1993; Crichton, 1994; Victor, 1996).

Forty-seven recommendations for preventing these incidents from reoccurring were put forward, including: revising recruitment policies to improve the representation of ethnic minorities working within the hospital at a management level, developing race awareness training programmes, involvement of an

external consultant, and a follow up inquiry to see whether reforms had been implemented (Prins, 1993; Crichton, 1994; Victor, 1996). Not all of the recommendations were taken on board by the MHT, however, it began to put a spotlight on the role of race in outcomes, where Black people, especially Black men, were most vulnerable to discrimination and negative experiences within mental health services.

1.10.3.3. The Report of the Inquiry into the Care and Treatment of Christopher Clunis (1994)

In 1992, Johnathan Zito was stabbed to death by Christopher Clunis, a Black man of Caribbean descent. This inquiry was the most high profile inquiry of its time, and received significant amounts of media coverage (Cummins, 2015). It summarised the findings of the public inquiry into this incident, in which Clunis' contact with health and social care services was described as a "catalogue of missed opportunities" (Bhui, 2002). Clunis was said to have come into contact with at least 30 named psychiatrists and there was a tendency to postpone decisions or action when difficulty was encountered, possibly, amongst other things, because he was "big and Black". Poor communication and poor service provision in the form of "service structures, individual and professional practice, and the manner in which those who receive a psychiatric diagnosis, and are from a BME background are alienated by professionals and the wider British society" were cited as the main factors that led to Zito's death (Bhui, 2002).

Several recommendations were put forward, including the introduction of a "supervised discharge order" legislation, which would enable a patient to be compulsorily recalled to hospital on the grounds of non-compliance with discharge plans or if there are signs of deterioration to their mental state upon being discharged. Improvements in the aftercare provisions for those who are detained under the MHA (1983) were proposed, including the provision of trained keyworkers, more streamlined transferral of care between services, and better monitoring of aftercare (Cold, 1994). However, the report did not discuss issues of race in much detail, citing that there were no examples of racial prejudice or discrimination becoming apparent to through the inquiry. This was viewed as downplaying the role of the individual, cultural, and ethnic heritage of

Clunis in his opportunities to receive adequate mental health care from the NHS (Cummins, 2015).

1.10.3.4. *Mental Health Task Force: London Project and Regional Race Programmes (1994)*

A need for the development of national consultative procedures and programmes with representatives of Black and/or ethnic minority groups was identified (Burman, 1996). In 1994, Secretary of State for Health set up a mental health task force to ensure adequate provision was made to replace services that were being closed down (Wattis & Thompson, 1995). They reported some dissatisfaction with services, as well as highlighting good practice (SCMH, 2002). The Department of Health (DoH) worked alongside the task force to make several recommendations, including strengthening the mechanisms for communication and cooperation with key agencies and local authorities, as well as making services responsive to people from different ethnic and cultural backgrounds.

1.10.3.5. *Black Mental Health: A Dialogue for Change (1994)*

In 1994, the government produced a document highlighting the need for action to tackle the issue of injustice affecting Black and Asian people who access mental health services (Fernando, 2010). Integration of voluntary and statutory sectors was advocated as a new way of providing services that were appropriate and valuable in the management of mental "illness' among BME service users (Keating, 2002). Despite the innovative approach to addressing disparities in treatment and outcomes for BME people, not enough was done to create any meaningful change (Fernando, 2010).

1.10.3.6. *The NHS Ethnic Health Unit (1994)*

The NHS set up a national unit run by a small team (five staff), that was tasked with collaborating with "bodies committed to improving the health of BME people both within and outside the NHS" (Chan, 1994). During its three-year life-span, the Ethnic Health Unit focused on encouraging partnerships between BME people and NHS bodies, raising awareness of the issues experienced by BME and promoting good practice in service delivery for BME people. It gave grants to help NHS MHTs and authorities improve their services, through

supporting research. Although this initiative took important steps towards putting the issue of race inequality on the NHS" agenda, it closed down with the task "only just begun" (Bhopal, 2014). This was seen to signal the government's active commitment to issues of race within the NHS (Burman, 1996).

1.10.3.7. NHS Executive Letter (1994)

The NHS Executive for hospital inpatients and day cases published a letter requiring that all service providers collect data on service users' ethnicity. This was part of a government strategy to try and improve the health of the population as a whole, and to "narrow the health gap" as a way of assessing which groups were using particular services, and whether these groups' needs were being adequately considered (Keating, Robertson & Kotecha, 2003). This was then mandated in 1995. It was hoped that this would help the NHS to provide services that did not discriminate against people on the grounds of their race or ethnicity (Gill, Kai, Bhopal & Wild, 2007). However, this initiative was viewed as half-hearted and poorly coordinated, which meant that there were poor uptake rates (62.9% of data was missing, invalid, incomplete etc.). The data collected, therefore, was not of a high standard and was not particularly meaningful or useful for (Fernando, 2010).

1.10.3.8. The Human Rights Act (1998)

England was one of the first member states of the European Union to ratify the European Convention of the Human Rights (ECHR) in 1951 (Donald, Gordon & Leach, 2012). This convention outlined several universal and fundamental human rights that were considered common to all people. However, it was not until 2000 that they were integrated into and became legally enforceable in England, in the form of the Human Rights Act (1998). Notable articles within this Act include Article 2, which requires public authorities to take reasonable steps to protect individual's right to life; Article 3, which prohibits inhumane or degrading treatment; and Article 5, which entitles individuals to move around as they wish and not be locked in a room or building; and article 14 which states that enjoyments of these rights and freedoms should be enjoyed without discrimination on any ground (including language, religion, political or other

opinion, national or social origin, association with a national minority, property, birth or other status).

Violations of these articles can occur as a result of an act or omission by a public authority, which could result in the victim seeking legal action. This is particularly relevant to the treatment of and outcomes for BME people, as there is evidence that their rights are more likely to be violated within mental health services than their White counterparts. Mental health services must therefore demonstrate their commitment to complying with these articles, and be held to account when they are violated.

1.10.3.9. The Macpherson Report (1999)

On 22 April 1993, Stephen Lawrence was stabbed to death at a bus stop in South London in an unprovoked, racist attack. The police were criticised for the way they conducted the investigation and, to this day, no one was convicted for the crime. The Macpherson Report, found that the police investigation into Stephen's murder was "marred by a combination of professional incompetence, institutional racism and a failure of leadership by senior officers."

The report demonstrated how, in addition to more explicit forms of racism and discrimination, the absence of thought and action can have damaging consequences, and maintain race disparities across the Metropolitan Police Service, and police services elsewhere (Macpherson, 1999). Although mental health services nor the NHS directly addressed in the report or the recommendations, in addition to the inquiries and initiatives highlighted above, the media attention this case received helped to raise awareness of these issues within different organisational contexts. Further, as highlighted previously, the link between the criminal justice system and mental health services is particularly relevant to and contentious for people from BME backgrounds. Therefore changes to the attitudes or processes within the police service also have implications on the attitudes, processes and practices adopted within mental health services.

1.10.3.10.Mental Health National Service Framework (1999)

Mental Health National Service Framework (MHSNF) recognised that services were not adequately meeting the needs of BME service users, and that communities lacked confidence in mental health services. However, by drawing on examples of best practice from mental health services across England, as well as the research evidence base, this framework was developed to address the wide range of issues affecting people who access mental health services. There was a clear push for all mental health services to promote mental health for all in a consistent fashion.

However, ensuring social inclusion for, and combatting discrimination against individuals and groups was prioritised within this framework. Further, the needs of adults from disadvantaged groups, such as BME communities were emphasised. Recommendations for improving access to services, making services more culturally sensitive, and including people from BME backgrounds were noted (e.g. providing more accessible information about services, setting up crisis services as an alternative to inpatient admissions under the MHA, and drawing on BME people's experiences of services to monitor performance).

1.10.4.   2000's

1.10.4.1. The NHS Plan (2000)

In 2000, the government decided to "make an historic commitment" by increasing the funding of the NHS over a four-year period. In addition to this financial investment, there was a focus making the most out of current resources, to modernise the NHS and meet public expectations and demand. The plan highlighted an awareness of the disparities in health care experienced by BME groups and sought to redress this by tackling "the inverse care law", where communities in greatest need are least likely to receive the health services that they require. Although guidelines about how this would be achieved lacked clarity, plans to provide a free and nationally available translation and interpretation service were outlined. Treating everyone with respect, and improving quality to reduce inequalities, was however, emphasised throughout the plan.

1.10.4.2. Race Relations (Amendment) Act (2000)

In 2000, the Race Relations Act was amended so that it could be applied to police and other public authorities. Under the Race Relations (Amendment) Act (2000), all organisations were required to have a Race Equality Scheme that set out how they plan to address cultural diversity and ethnic equality within services, including service planning, delivery and training. It focused on accountability and visibility to ethnic and culture al issues at Board level and MHTs were required to publish and be assessed on their performance. Terms such as positive action and positive discrimination were used to help with issues of BME underrepresentation in organisations. Whereas terms such as indirect discrimination and victimisation were used to highlight the many ways in which BME people encountered maltreatment from others.

1.10.4.3. Race for Health Programme (2002)

The Race for Health programme was set up to create fairer Primary Care Trusts (PCTs) for Black and Minority Ethnic communities (Randhawa, 2007). It supported a network of up to nineteen PCTs around the country. The programme worked with BME communities to "to improve health, modernise services, increase choice and create greater diversity within the National Health Service (NHS) workforce" (Race for Health, 2007). It supported PCTs to deliver "measurable improvements in the health outcomes of BME people". They drew on examples of culturally sensitive mental health support available in the community and emphasised the importance of partnership working.

Independent Inquiry into the Death of David Bennett (2003)

In 1998, David Bennett died during his admission at a medium secure psychiatric unit in Norwich. An independent inquiry revealed that he was not provided with appropriate or professional care because of his ethnic origin (Sallah, Sashidharan, Stone, Struthers, & Blofeld, 2003). Instead, he experienced institutional racism in the form of inadequate psychiatric diagnosis, harsher and more coercive treatment, and poorer engagement with his carers and family members (Macpherson, 1999). The report had asked for a 'ministerial acknowledgement of institutional racism in the mental health

service', but this verdict was rejected at a government level. Mr Bennett's case was one of many (e.g. Michael Martin and Orville Blackwood). The inquiry into his death was, however, influential in shaping subsequent policies and guidelines that aimed to address the disparities in the treatment of, and outcomes for Minority Ethnicity service users (Ftizpatrick et al., 2014).

1.10.4.4. Inside Outside (2003)

The Inside Outside (2003) report, produced by the National Institute for Mental Health in England, "mark[ed] the beginning of an historic dialogue" on tackling ethnic inequalities within mental health services. It was posited as the beginnings of a national policy aimed at reducing and eliminating ethnic inequalities in health service experience and outcome; a first since the inception of the NHS (Sashidharan. 2003). It recognised that institutional racism exists in the NHS and recommended policy in the areas of combining workforce development, governance and research governance (Fitzpatrick et al., 2014). It was the first national report which focussed specifically on the delivery of services within the context of the NHS, as opposed to its broader, more generic predecessors: The document makes the case for reform, action and investment both inside mental health services and outside at the community or the population level (Sashidharan. 2003).

This was an important shift from the more traditional individualising and de-politicised approach. Although issues of race inequality had been raised for decades prior to the publication of this document, the inside outside report outlined clear standards for practice and monitoring performance, many of which are still relevant today. The introduction of an Equality Framework, where audits tracing ethnic variations would serve as a key performance indicator for BME access and experience of mental health services.

1.10.4.5. Delivering Race Equality: An Action Plan for Reform Inside and Outside Services (2005)

The government combined its official response to the death of David Bennett with a five-year action plan for reducing inequalities for BME people accessing mental health services. This formed what is known as the Delivering Race

Equality (DRE). It lasted for 5 years, and during this time, its main aims were to create more culturally appropriate and responsive services, enhance community engagement, and better information sharing practices to enhance transparency and trust. It formed part of a programme of action which aimed to bring about equality in health and social care services. The programme sought to support the implementation of a 10-point race equality action plan and to enable NHS MHTs to fulfil their obligations under the Race Relations Act (2000). A BME mental health programme tasked with overseeing the action plan board was set up at the DoH. They were directly accountable to Ministers and were informed by the work of the BME national steering group. The initiative was informed by the inside out report (2002) in two ways: staff receiving mandatory training in cultural awareness and second that there should be emphasis on ensuring that the workforce is diverse, reflecting the population it serves.

The clinical governance and organisation of this programme was complex (Fitzpatrick et al., 2014). It was managed by eight regional development centres that were tasked with orchestrating a whole system approach to care and practice through the deployment of Community Development workers (CDWs), implementation sites and Clinical Trailblazers. The programme was supported by service users and their relatives were recruited to act as DRE ambassadors, and its outcomes were monitored via the "Count me in Census". Subsequent evaluations of this programme highlighted numerous organisational and political obstacles that prevented meaningful change from happening at both service and societal levels (Wilson, 2009). For example, "the inadequacy of a coordinated, systemic response" was cited as one of the main reasons that this programme did not realise its potential (Fitzpatrick et al., 2014, p. 12). In spite of the attempts to improve outcomes for BME people, disparities were highlighted in the Count me in Census, suggesting that Black and minority ethnic service users were still getting a raw deal from the NHS (Allen, 2007). Some gains were achieved, however. The DRE programme started to create a culture of accountability by encouraging MHTs to record and analyse patient data and outcomes by ethnicity, to improve the relevance and appropriateness of services (Care Quality Commission (CQC), 2011). The head of mental health

charity, Rethink, even recommended "P-45" targets, which can mean people lose jobs If targets are not met" as a way of holding people and services accountable for disparities (CQC, 2011).

1.10.4.6. The Human Rights in Healthcare Frameworks (2007/2008)

The DoH advocated for the application of a human rights approach to healthcare within the NHS (DoH, 2007, 2008). The core human rights values were summarised as fairness, respect, equality, dignity and autonomy (FREDA) central to people's lived experiences (DoH, 2008, p. 11) in a framework document for NHS practitioners and services. This approach was said to help "improve experience and outcomes for patients"; "support the delivery of wider priorities" and improve "compliance with the Human Rights Act and reduces complaints/litigation". They suggested that human rights lay at the heart of policy and planning, in order to develop a culture of accountability, empowerment, participation and involvement, and non-discrimination and attention to vulnerable groups within the NHS. Examples of how to embed this within clinical practice and policy were also outlined. Under the value of equality and "the right not to be discriminated against in the enjoyment of other human rights", they suggested that there should be a ""commitment to improving mental health services for people from black and minority ethnic groups" across the NHS (DoH, 2008, p. 11). However, no concrete examples of what this might look like with respect to talking racial disparities in healthcare were mentioned.

1.10.5.   2010's

1.10.5.1. The Equality Act (2010)

In 2010, the Equality Act (2010) replaced the Race Relations Act, 2000, and other related anti-discrimination legislation. It legally protects people from discrimination on the grounds of nine protected characteristics (e.g. gender, race, sexual orientation, physical ability), in the workplace and in society and makes the law easier to understand and abide by. This change in legislation coincided with the formation of the Conservative and Liberal Democrat coalition and has been linked with the de-prioritisation of BME inequalities in mental health. A marked reduction in the national commitment to tackling this issue was highlighted by stakeholders, who expressed concern that there was no

current interest in BME mental health, and that race had been explicitly taken off the agenda (Fitzpatrick et al., 2014).

The only substantive acknowledgement of disparities for BME groups was highlighted in the "No health without mental health" policy, a "cross-government and all age strategy" for all mental health services (Fitzpatrick, et al., 2014). In it, the Increasing Access to Psychological Therapies (IAPT) services were being developed to improve choice of mental health providers that "ensure equal accessibility for all groups, including Black and Minority Ethnic communities" (Fitzpatrick, et al., 2014; HM Government, 2011). The Equality Act (2010) marked the beginning of issues of race becoming subsumed under a national Equality and Diversity remit. The following year, the Public Sector Equality Duty (2011) was developed. This duty required public bodies, including NHS mental health services to eliminate unlawful discrimination, advance equality of opportunity, as well as encourage good relations between people who had characteristics that were protected under the Equality Act and those who did not (Citizen's Advice Bureau, 2018).

1.10.5.2. The Equality and Delivery System (EDS) (2011)
The NHS developed the Equality Delivery System (EDS) to help their services comply with this duty, as well as NHS Outcomes Framework and the NHS Constitution, and Essential standards of Quality and Safety (NHS England, 2012). It was commissioned by the NHS Equality and Diversity Council, and it aimed to take inspiration from existing work and good practice. NHS MHTs were provided with templates, resources and recommendations for good practice (e.g. monitoring outcomes) across different equality performance indicators. The core human rights values (FREDA) were also incorporated into this system.

The goals of EDS were to "ensure better outcomes for all", provide "improved patient access and experience", create context within which staff felt "empowered, engaged and well-supported" and that there were opportunities for "inclusive leadership at all levels". An independent review of the EDS highlighted several concerns about the practicalities of implementing the

system. The collection and sharing good practice was challenging for many MHTs (Shared Intelligence, 2012). Issues regarding staff resources and competing priorities placed an enormous amount of pressure on organisations (Shared Intelligence, 2012). The review recommended that the system was streamlined to address these concerns (Shared Intelligence, 2012). No specific recommendations or outcomes were highlighted for BME service users/groups.

1.10.5.3. Equality and Diversity System 2 (EDS2) (2013)

The EDS was refreshed and streamlined in 2013 and was replaced by the Equality and Diversity System 2 (EDS2). The main purpose of the EDS2 was, and remains, to help local NHS organisations review and improve their performance for people with characteristics protected by the Equality Act 2010 and Public Sector Equality Duty. It is aligned to NHS England's commitment to an inclusive NHS that is fair and accessible to all. Reports generated as part of the EDS and EDS2 showed a lack of consistency between MHTs in terms of how they presented, evaluated and responded to their performance across different domains. This development in the equality and diversity remit was a further step away from specific racial initiatives, policies and programmes, in an attempt to provide more inclusive and accessible services for all. However, data from the latest Race Disparity Audit (Cabinet Office, 2018), are indicative that BME people are not yet benefiting from mental health services on a level that is comparative to their White counterparts.

1.10.5.4. Workforce Race Equality Standard WRES (2014)

In 2014, the Workforce Race Equality Standard (WRES) was established to ensure employees from BME backgrounds have equal access to career opportunities and receive fair treatment in the NHS. It was developed in response to key stakeholder research which highlighted that "less favourable treatment of BME staff through poorer experience or opportunities, has significant impact on the efficient and effective running of the NHS and adversely impacts the quality of care received by all patients" (Naqvi, Razaq,& Piper, 2016). Recommendations, therefore, were based on the notion that a workforce in which people feel motivated, included and valued workforce in the

delivery of high quality patient care, leads to increased patient satisfaction and better patient safety.

WRES was mandated in 2015 and requires health services to publish data relating to the treatment and experience of BME staff compared to White staff, to help NHS organisations to make necessary and relevant changes to improve their performance in this respect. The latest WRES report, published in 2017, shows that although there have been some improvements across key performance indicators, such as representation within senior roles and on MHT Boards. However, there are still many areas for development. BME staff are more likely to experience harassment, bullying or abuse from their colleagues, and are more likely to enter the formal disciplinary process than their White counterparts (NHS Equality and Diversity Council, 2017).

1.10.5.5. Next Steps on the Five Year Forward for Mental Health (2016)
In 2015, NHS England, an organisation that leads, funds and commissions, as well as sets out the priorities and direction for all NHS services in England (Mental Health Task Force, 2016), set up The Mental Health Task Force. It was comprised of health and social care leaders, professional bodies, charities and experts by experience, and was asked to develop a five year strategy for mental health in England. In 2016, they produced the Five Year Forward for Mental Health Report. In it, the experience of marginalised groups, including people from BME groups was acknowledged, and several recommendations; a clear commitment to monitoring the use of the MHA, with a focus on BME groups, and better consideration of the intersection between BME people's multiple minority identities were put forward. A follow up report produced in 2017 highlighted some of the steps that had been taken to improve outcomes for BME service users (NHS, 2017), including working specifically with Black men to understand their views on what they need from mental health secure care and forensic community services, as well as the introduction of a new mental health Quality Premium, which encourages Commissioners to focus on outcomes for people from Black and Minority Ethnic group.

1.10.5.6. House of Lords Debate (2017)

A recent debate in the House of Lords sought to uncover government's progress towards improving mental health services for people from BME communities. It highlighted several important issues. Firstly, the debate drew on the findings from the recent Race Disparity Audit (Cabinet Office, 2018), as well as relevant literature, where these issues are well documented, to shine a light on the disparities for BME people, especially those from Black African-Caribbean backgrounds. The overrepresentation of BME people detained under the MHA, and underrepresentation of BME people within primary care mental health services was discussed. Additionally, the underrepresentation of BME people within the workforce and the associated effects were noted. The issue that there has been "no real specific, targeted and strong national framework for improving mental health care for Black and ethnic minority communities since 2010" and that mental health services "lack a sense of strategic direction for reducing the inequalities for BME" people were highlighted as contributory factors for the ongoing disparities. The current situation was described as "unacceptable" and it was acknowledged that "the NHS has a long way to go before we can say that it has really tackled those issues".

The government provided some examples of what it is currently doing to improve mental health outcomes for BME people. Notable actions include, the commissioning of an independent review of the MHA, acceptance of the recommendations of the independent Mental Health Taskforce report, the Five Year Forward View for Mental Health and funding local projects (e.g. 300 Voices Project in Birmingham). NHS England, was cited as having carried out some important work to address this issue:

- NHS England has set an expectation for local services to improve representation and recovery rates for BME groups in IAPT services;
- It has set up a project to address the overrepresentation of Black individuals in mental health settings, which resulted in a mental health community forensic model with a pilot planned in 2018;
- It has funded the National Collaborating Centre for Mental Health to develop guidance to support commissioners and providers in addressing health inequalities;

- NHS England will publish new pathways for crisis and acute care, building on input from experts-by-experience from ethnic-minority backgrounds;
- It is requesting from NHS Digital and other partners that all relevant data reports are broken down by protected characteristics to allow the systematic identification of areas for improvement and monitoring of progress.

In December 2018, the CQC will be disseminating a publication to highlight good practice in reducing the need for restrictive interventions. The debate highlighted that race equality is being held in mind within the government and national bodies. However, there is still a lot more to do if the racial disparities in mental health outcomes are to be addressed in a time-sensitive and meaningful manner.

1.11. Summary

The developments in policy, legislation and practices outlined above are interlinked. They show how socio-political contexts and attitudes can greatly influence the way mental health services operate; namely the extent to which racial disparities in mental health outcomes are conceptualised and addressed. Before the introduction of the Race Relations Acts, people from BME backgrounds who experienced racial discrimination were reliant upon systems and services that were overtly racist. There were seemingly no consequences for such practices. Further, racial discrimination was endorsed at a national level with the introduction of legislation that systematically disadvantaged people from commonwealth member states who wanted to live and work in the UK.

The Race Relations Acts were significant in transforming the way racism was conceptualised and dealt with in the UK, providing a framework of the professional and legal obligations and repercussions associated with overtly racist practices and incidents. However, the impact of Eurocentric biases within

national policies and practices likely limited the reach and impact of these Acts; the high profile inquiries of Black men who were in contact with statutory services are evidence that more needed to be done to abolish racism within public services (and society). There were lessons learnt and recommendations put forward to try and minimise the reoccurrence of such tragic events. However, they did not lead to the transformation in policy and practice required to achieve this goal.

The need for a more strategic approach to redressing racial disparities in mental healthcare was recognised by national bodies, such as the DoH, which enabled the development and implementation of various race equality initiatives and policies within the NHS. The consideration and incorporation of European legislation (e.g. Human Rights Convention) into public sector services also indicated the need as well as an openness to addressing racial disparities across all sectors. However, the number of deaths of young Black men who were in contact with statutory services did not lament, sparking concerns that more needed to be done to eradicate institutional racism and ensure that services were sensitive to the needs of people from BME backgrounds.

The development of the (first and only) national race equality strategy (DRE) in response to the death of David Bennett seemed like a promising way of naming racism within the NHS, namely within mental health services. It also offered a framework of accountability and action as a way of addressing racial disparities in mental health care. The level of resource invested in this project was indicative that tackling racial disparities was a priority for the then-government. However, there were a number of organisational and political obstacles that limited the overall success of this initiative. Despite its downfall, the DRE programme should be credited with stimulating discussions about the role of data collection, monitoring and analysis in the identification and reduction of racial disparities in mental health outcomes.

The introduction of the Equality Act, and the resultant focus on "stand[ing] up for the many, not the few, breaking down the barriers that hold people back,

allowing everyone to fulfil their potential" (Blair, 2005) indicated that tackling racial disparities was no longer at the top of the agenda. Rather, it had become subsumed with more general anti-discrimination policies and practices. These policies, in the NHS translated into the EDS2 system which advocates that services should be accessible for all. However, people from BME backgrounds have not necessarily benefitted from this change, as they are still disadvantaged with respect to mental health outcomes, relative to their White counterparts.

The WRES, through its commitment to improving representation, inclusion and motivation, may indirectly positively affect the outcomes of BME people who access services. It seems that the NHS is aware of the inequalities faced by Black people who access its service, offering overview of the specific challenges experienced by African and Caribbean people in article published on its national choices website in 2017. However, current policies and practice lack the specific focus on race needed to overhaul the oppressive systems and structures which contribute to the continued racial disparities in mental health outcomes for BME service users.

Recent political debates highlight that the concern about the extent of racial disparities across social and mental health indices is ever-present. While it is necessary to acknowledge the work that has been done and continues to be done within this area, there is still a long way to go in order to combat the observed racial disparities and put race firmly back at the top of the agenda.

1.12. Rationale, Aims and Research Questions

1.12.1.   <u>Rationale</u>

The development of this project was ultimately underpinned by the insights and relative power afforded to me as a result of my "outsider-within" status. As a Black woman, I was personally concerned that persistent, widespread and seemingly well-documented racial disparities in mental health outcomes were affected Black people so profoundly. Although the teaching I had received at university had highlighted some efforts to address this issue, evidence of any

current or sense of any real urgency or motivation to change the current picture, or ongoing clear, joined-up national strategies and incentives was lacking. As a trainee Clinical Psychologist, I viewed the current picture through the lens of the legal and professional obligations of this discipline, as stated at the beginning of this chapter.

By reviewing the relevant literature, I was able to get a clearer picture of the nature and extent of these disparities, and have captured some examples of previous attempts, as well as future plans to redress these disparities at local and national levels. However, I noticed that many of the studies I reviewed focused on small local populations or services, and that inconsistencies in the terminology used to describe race, ethnicity and outcomes, which made it difficult to synthesise the literature in the most consistent and meaningful way.

My experience of conducting the searches gave me the impression that the interest and / or resources to carry out research on racial disparities in mental health outcomes at a national level are lacking. Further, that in the absence of a national race equality policy or initiative, it was not clear what mental health services were currently doing to redress these well-documented disparities. I nonetheless examined some of the factors that have likely contributed to the observed disparities, and identified institutional racism, stemming from Eurocentric conceptualisations of distress, as the main factor. In addition, I emphasised the need to view these disparities through the lens of anti-discrimination policies and legislations. I also expressed my belief that those working within statutory services should be committed to identifying and combatting institutional racism within their services and clinical practice.

Although much has been written about racial disparities in mental health care (e.g. access, treatment and to a lesser extent, treatment outcomes), I found that the majority of contributions to this literature came from the disciplines of psychiatry or public health. Despite the relative absence of the Clinical Psychologists' voice(s) within the literature, my awareness of some of the projects developed by our discipline made me consider that Clinical

Psychologists could have a lot to contribute to the discussion. The historical and contextual framework within the field Clinical Psychology was developed means that "Whiteness" has become situated in the normative and unchallenged position within the profession as much as within wider society (Odusanya, 2017). Further, although there are studies which explore the experiences of BME Clinical Psychologists, of trainee and qualified status (e.g. Shah, 2010; Samuel, 2016; Odusanya, 2017), to date, there are none which capture or are related to Black Clinical Psychologists' perspectives on racial disparities in mental health outcomes.

1.12.2.   Aims

It was hoped, therefore, that by exploring the issue of racial disparities in mental health outcomes further the findings from this project would:

Aim One: capture the current landscape of national and local initiatives, programmes, or policies that are attempting to redress racial disparities in mental health outcomes;

Aim Two: identify examples of good practice with respect to redressing mental health outcomes, as well as areas for development.

Aim Three: stimulate conversations about redressing racial disparities in mental health, as well as how to achieve this, by focusing on the mental health outcomes of Black service users

1.12.3.   Research Questions

To address the gaps in the literature outlined above, this study therefore, aimed to explore:

Research Question One: What are MHTs in England doing to improve mental health outcomes for Black service users?

Research Question Two: As mental health professionals who hold "outsider-within" status, what do Black Clinical Psychologists have to say about MHTs' current attempts to improve mental health outcomes for Black service users?

The methodology, methods and procedures used to address these research questions have been outlined in the following chapter.

2. METHODOLOGY, METHODS AND PROCEDURES

2.1. Overview of Chapter

In this chapter, I will outline the methodology used to approach the research question outlined in the introduction. I will first discuss my ontological and epistemological assumptions that underpin this project, and explore how they have informed the data collection and analysis methods employed. I will then summarise the study design, as well as the procedures and methods of analysis used within this study.

2.2. Ethics

Ethical approval for all aspects of this study was sought and received from the University of East London prior to conducting this study (see Appendix A for ethical approval). Ethical considerations were guided by professional codes of ethics and guidance on research (BPS, 2014).

2.3. Reflexivity

My philosophical orientation, experiences of and position within society, and my ethical commitments, have informed the way in which I have approached this project, with respect to area of focus, the research questions and the methodology used. The details of which, have been outlined below.

2.4. Ontological and Epistemological Considerations

The methodology is the strategy or plan of action that informs the researcher's choice and application of research method(s) (Scotland, 2012). It is concerned with "why, what, from where, when and how data is collected and analysed" (Scotland, 2012, p.9) and is underpinned by the researcher's ontological and epistemological assumptions (Crotty, 1998; Guba & Lincon, 1994). The

researcher's ontological assumptions are related to what the researcher believes constitutes reality (Scotland, 2012; Crotty, 1998). Epistemological assumptions, on the other hand, are concerned with the researcher's beliefs about "how knowledge is created, acquired and communicated" (Scotland, 2012, p.9).

A critical realist approach to research was adopted for this project. This is because critical realists are interested in understanding the mechanisms and processes that produce different social phenomena in the real world (Maxwell, 2012). I am interested in racial disparities in mental health outcomes, and in order to identify (and attempt to dismantle) the mechanisms that underpin them, there are certain ontological and epistemological assumptions I need to hold. For example, to conceptualise the project in the first instance, I relied upon the critical realist assumption of ontological realism (Maxwell, 2012, p.8); that is, the assumption that a real world that exists, independently of my own perceptions, theories and constructions (Maxwell, 2012, p.8). I acknowledged that regardless of my perceptions (or anyone else's perceptions) of "race", "ethnicity", there are disparities in the mental health outcomes of those who label themselves (or are indeed labelled), as Black. This assumption also holds that it is possible to capture data that can evidence these disparities concretely: regardless of the different perceptions of "mental health outcomes" that exist, disparities are likely to be found for Black people who access mental health services.

In deciding how to identify these disparities and mechanisms, I drew upon the critical realist epistemological assumptions of constructivism and realism (Maxwell, 2012, p.8); that is, the assumption that a person's standpoint or perspective influences the way a problem is conceptualised or constructed (Maxwell, 2012, p.8). Therefore, in order to make sense of the nature of racial disparities in mental health outcomes, it was important to draw on multiple perspectives/sources of data: Freedom of Information Requests (FOIRS) asking about current practices and policies directly, and interviews with Black Clinical Psychologists about their perspectives on the matter. In this way, I was able to capture a more complex picture highlighting: whether MHTs have

conceptualised this as a problem (e.g. have they identified or acknowledged it within their services?); the mechanisms that underpin their conceptualisation of mental health disparities in outcomes (e.g. is there an emphasis on race equality within the MHTs or an absence of it?); how this then shapes the steps taken within the MHTs to address this issue, and the resultant outcomes (e.g. are they actively trying to redress racial disparities in mental health outcomes? And has this been successful?). Collecting data from at different levels of the organisational hierarchy can also provide an insight into the potential similarities or discrepancies between an MHTs intention (e.g. to reduce racial disparities in mental health outcomes) and what is felt by staff (e.g. adequacy of resources and provisions to achieve this). A richer understanding of the factors that might contribute to the observed similarities and differences is also possible when more than one perspective is drawn upon (Patton, 1990).

2.5.   Design

This study employed a convergent mixed method design. This involved obtaining "different but complementary data on the same topic" to answer the research question (Morse, 1991). It is the most common and well-known approach to mixing methods and is considered a legitimate, standalone research design (Creswell, Clark, Gutmann, & Hanson, 2003; Creswell, 2002). Patton, (1990) highlights that this type of design enables the researcher to bring together the differing strengths and non-overlapping weaknesses of quantitative methods (e.g. large sample size, trends, generalisation), with those of qualitative methods (Creswell, 2003). Using more than one form of data can enrich the results in ways that one form of data does not allow (Brewer & Hunter, 1989; Tashakkori & Teddlie, 1998); mixed method designs enable researchers to compare and contrast quantitative statistical results with qualitative findings, to validate or expand quantitative results with qualitative data (Creswell, 2003). The quantitative aspect of this study was the operationalised using FOIRs, and the qualitative aspect involved semi-structured interviews. See Figure 1, below, for a visual representation of how these parts were implemented, and analysed.

Figure 1. Concurrent Triangulation Design
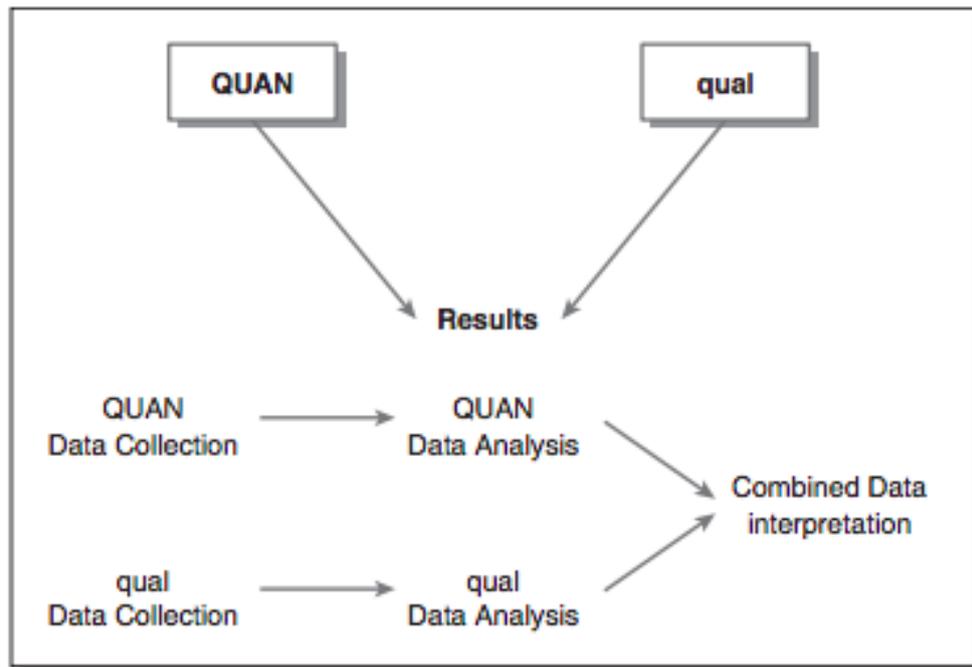
This is known as a concurrent triangulation design where qualitative and quantitative data collection methods are implemented during the same time frame and with equal weight (Creswell, et al., 2003). The researcher then synthesises the data collected from these methods during the analysis phase, to better understand the research problem (Creswell, et al., 2003).

2.6. Methods

Methods are "the techniques or procedures used to gather and collect data related to some research question or hypothesis" (Crotty, 1998). The first part of this study was concerned with perspective of MHTs, with respect to their current attempts to improve mental health outcomes for Black service users. Research question one, therefore, was "What are MHTs in England doing to improve mental health outcomes for Black service users? " Freedom of Information Requests (FOIRs) were sent to 56 MHTs to obtain this information from them

directly. The second part of this study was concerned with Black Clinical Psychologists' thoughts on MHTs attempts to improve mental health outcomes for Black service users. The second research question, therefore, was "As mental health professionals who hold "outsider-within" status, what do Black Clinical Psychologists have to say about their MHTs' current attempts to improve mental health outcomes for Black service users?". Semi-structured interviews were used to capture their perspectives. A more detailed overview of these research methods, as well as the rationale for their use within this project is presented below.

2.6.1. Part One: Freedom of Information Requests

Freedom of information requests (FOIR) are underpinned by the Freedom of Information Act (FOIA) (2000) which enables "any person" to be informed in writing as to whether a public authority holds the information specified in a request for information (Bell & Bessant, 2009; Carey & Turle, 2008). If the public authority possesses the information requested, the FOIA obligates the public authority to share that information with the person. However, if the public authority does not hold the information requested, or if the request exceeds 18 hours to collate, which is equivalent to £450 cost (calculated at a rate of £25/hour) the person is entitled to a notice of denial or exemption (Savage & Hyde, 2014). Recipients of an FOIR are normally required to respond within 21 working days, and should notify the requestor of receipt and/or any reason they are unable to fulfil the request, because of the time and cost limitations stipulated above.

2.6.1.1. Rationale

FOIRs have become an increasingly popular and powerful data collection tool within social research, including studies of mental health service provision (Geekie, Read, Renton, & Harrop, 2017; Read, Harrop, Geekie & Renton, 2017). They can provide significant amounts of meaningful data that would not normally be accessible. As such, in the absence of large amounts of resources or financial investments, FOIRs can enable more researchers to undertake projects that have previously been the domain of large funded projects (Savage & Hyde, 2014). This, in turn can then empower researchers to analyse and

report their findings, as well as make meaningful contributions within their respective fields (Savage & Hyde, 2014). The use of FOIRs may therefore lead "to greater plurality in the production and use of research knowledge" (Gough, 2007). This method of data collection affords researchers the flexibility to develop and use FOIRs in a way that is consistent with their aims and epistemological as well as ontological assumptions (Savage & Hyde, 2014).

There are 56 MHTs in England; to find out about what all of them are doing to improve outcomes for Black service users by using "traditional means" such as surveys or semi-structured interviews would have been prohibitive in terms of resources and time allotted to this project (Savage & Hyde, 2014). FOIRs appeared to be a good "mechanism for accessing information already held by the public sector" from people "who have the resources to assemble information beyond that available to researchers" . Therefore, using FOIRs was necessary to ensure the project remained feasible (Savage & Hyde, 2014).

One of the issues I highlighted in the previous chapter was the lack of current literature relating to racial disparities in mental health outcomes. This highlighted to me that in order to identify and dismantle the mechanisms that underpin the observed disparities, evidence of the disparities, as well as attempts to redress them, must be captured. This in turn can be used to help develop and justify potential solutions or recommendations for future practice. The use of FOIRs, is therefore consistent with a Critical Realist approach to research, because the data gathered can provide the researcher with evidence of the existence and nature of reality (e.g. racial disparities in mental health outcomes). FOIRs are suitable for collecting this type of information on a large scale (e.g. outcome data across the entire country) which could help to provide evidence of the mechanisms that underpin observed racial disparities at local and national levels. This type of evidence could also be attractive to policy makers and researchers interested population level disparities, as well as mental health professionals attempting to address these issues within their own services.

2.6.1.2. Developing the FOIR Template

All methodological approaches have both strengths and limitations worthy of consideration before being used in a research project. Reservations about the use of FOIRs as a research tool were noted. For example, "by invoking the Freedom of Information Act, a researcher can divert the equivalent of a consultant's yearly salary to support their project, bypassing the normal governance mechanisms for research funding" (Breathnach, Riley & Planche, 2011). Wilson (2011), gave voice to the concern shared by several researchers, that data obtained by FOIRs is "decontextualized, will not necessarily be that helpful to the information requester, and that the data may be subject to misuse or misinterpretation". I did not wish to participate in a process that inadvertently placed additional or unnecessary financial burdens on the NHS. I wanted to ensure that any information yielded from the FOIRs was helpful and contextualised.

I, therefore, developed questions, in consultation with my research supervisors, which aimed not only to highlight what MHTs are currently doing, but the mechanisms which support (e.g. examples of good practice) or hinder (e.g. areas for development) their attempts to improve outcomes for Black service users. I adhered to the guidance on how to submit a FOIR, to try and streamline the administrative aspects of the process, thereby maximising the total time MHTs could spend on my request and minimise time wasted (e.g. Bourke, Worthy & Hazell, 2012). Studies that have employed FOIR as their methodology have benefited from making the questions as simple and short as possible, to enhance the response rate (e.g. Geekie, et al., 2017; Read et al., 2017).

2.6.1.3. Analysis

Analysis using quantitative methods has enabled the researchers looking at policies to summarise and present the large volumes of data yielded from FOIRs in an accessible format (e.g. Brooker, Sirdifield, Ramsbotham, Lord & Denny, 2017; Martin & Rawala, 2017; Geekie, et al., 2017; Read, et al., 2017). I used descriptive statistics and analysed this inconjunction with the data gathered from the second part of this study.

2.6.2. Part Two: Interviews

Interviews are conversations which are designed to capture the interviewee's perspective or life-world view on a given topic (Kvale, 1996). The most commonly used method of data collection within social research (Edwards, Mahoney & Vincent, 2014). There are three main types of interview (Alshenqeeti, 2014): structured, unstructured and semi-structured. Semi-structured interviews were used for this part of the study.

2.6.2.1. Rationale

A key strength of using interviews to collect data is they offer researchers an opportunity to uncover information that is "probably not accessible using techniques such as questionnaires and observations" (Blaxter, Hughes, & Tight., 2006). Semi-structured interviews enable the researcher to remain close to their main areas of interest (e.g. by using an interview checklist), while also probing and asking follow up questions in order to expand the interviewee's responses (Rubin & Rubin, 2005). Using semi-structured interviews, therefore, can increase the depth with which researchers understand their interviewees' perspective (Rubin & Rubin, 2005). Due to the sensitive and complex nature of the research topic, data collection methods where it is not possible to ask follow up questions, such as surveys or questionnaires, would not have been able to capture the depth of the participants' perspectives. Therefore, I used semi-structured interviews in the hope that this would be a more effective way of highlighting the mechanisms that underpin the observed racial disparities in mental health outcomes; areas of good practice towards addressing these disparities within MHTs; areas for development and potential solutions.

Schostak (2006, p.1), however, notes that interviews are not a "simple tool with which to mine information", rather, they are places "where views may clash, deceive, seduce, enchant". The information gathered from an interview will also be shaped by the researcher's questions, the type of interviewed, the interview topic(s), and the participant's expectations of and assumptions of the researcher (Hammersley & Gomm, 2008), due to the limited time allotted for the process, as well as the sensitivity of the questions asked, interviews are considered an intrusion into the participant's private lives (Cohen, Manion, &

Morrison, 2007). This may, in turn, have implications for the information that is shared by the participant, as well as their emotional wellbeing during and / or after the process. Interviews, therefore, are open to several types of bias, which means that conducting and analysing interviews that are reliable, valid, and ethically sound can be "deceptively difficult", especially when the researcher wishes to generalise their findings or draw comparisons between different sets of data (Hermanowicz, 2002; Brewerton and Millward, 2001).

Researchers can do a number of things to minimise the impact of these factors on the quality of the information obtained using interviews (Sargeant, 2012). For example, by standardising their procedures, researchers can improve the reliability, and generalisability of their findings (Sargeant, 2012). Selecting participants who can best inform the research questions and enhance understanding of the phenomenon under study in a way that is consistent with the theoretical perspectives and evidence informing the study can also improve the validity of the information obtained through interviews (Sargeant, 2012). Further, to ensure that this data collection and analysis method is sufficiently robust and defensible, the number of people interviewed should be "sufficiently large and varied, to elucidate the aims of the study" (Kuzel,1999; Marshall, 1996; Patton, 2015; Malterud, 2001). It has been suggested that this can be achieved by interviewing eight to twelve people (Guest, Bunce & Johnson, 2006).

2.6.2.2.   *Developing the Interview Schedule*
The purpose of the interviews was to find out what Black Clinical Psychologists had to say about their MHT's current attempts to redress racial disparities in mental health outcomes, as this perspective is absent within the research literature. Given the underrepresentation of Black people within the field of Clinical Psychology, it was also important that the interview questions were able to elucidate the participants' experiences of and relationship to holding "outsider-within status". It was hoped that this, in turn, would situate the participants' responses within the wider context of the workforce race inequalities that not only affect staff well-being, but contribute to the observed racial disparities in mental health outcomes.

Therefore, the interview schedule was designed, in collaboration with my research supervisors, to incorporate questions that focused on what was currently being done within the participant's MHT to redress racial disparities in mental health outcomes, and what the participants thought about their MHT's attempts to redress these disparities. A combination of direct and indirect questions were used to encourage participants to provide both specific, concrete responses, as well as ones that were more open, and therefore possibly more meaningful to the participants (e.g. Kvale, 1996; McCracken, 1988). The questions were also designed to capture the participants' attitudes towards racial disparities in mental health outcomes within their MHTs by drawing on their own experiences as Black mental health professionals. The questions also left room for the exploration of the participants' beliefs about the aetiology of and potential solutions for the observed disparities within their MHTs.

2.6.2.3.   Analysis

Thematic analysis is a method, commonly used in research that has an applied focus, for "identifying, analysing, organising, describing and reporting themes found in a dataset" (Braun & Clark, 2006). It is a flexible approach, that, when conducted rigorously, can produce findings that are insightful and trustworthy (Braun & Clark, 2006). Furthermore, it is an effective method that is often used to examine different participants' perspectives (Braun & Clarke; King, 2004). Another form of qualitative analysis, such as interpretative phenomenological analysis (IPA), may have been useful if the focus of this project was different. For example, if I had wanted to examine the personal lived experiences of Black Clinical Psychologists working in the NHS, and interpret the sense they made of their experiences, this would have been a suitable method (Pietkiewicz & Smith, 2012). However, my primary goal of interviewing Clinical Psychologists was not to make interpretations of what they said; it was to capture what participants had to say about the nature of racial disparities in mental health outcomes and raise their voices, therefore, this

There are limitations to using a thematic analysis from a critical realist perspective. For example, my constructions of the themes, will be dependent on my own perspective and standpoint, and this may differ from the participants. There may also be differences between participants with respect to their own standpoints and perspectives. Therefore it was important for me to ensure that I did not assume because I had something in common with the participants (e.g. Black racial/ethnic identity), that we shared the same understanding of / relationship to our identities, nor the topic of racial disparities in mental health outcomes. As such, in addition to asking follow up questions to get more detailed responses from participants, I included in the analysis rich and thick verbatim descriptions of the participants accounts and drew conclusions cautiously (Ho, 2006; Alshenqeeti, 2014). This was done to minimise the impact of my own bias on the findings thereby increasing the reliability and validity of the themes (Ho, 2006; Alshenqeeti, 2014).

2.7. Procedures

The following section has been separated into two parts, expanding on the diagram above, and outlining the procedures followed when I conducted the FOIRs and interviews, respectively.

2.7.1. Part One: FOIRs (Quantitative Method)

2.7.1.1. Data Collection and Recruitment

For the first part of this study, FOIRs were sent to all 56 National Health Service (NHS) MHTs in England, in October 2017. The FOIR used in this study asked the MHTs to provide information about their current practices and policies relating to the provision of care for Black service users accessing adult secondary and tertiary mental health services (see Appendix B). After the initial FOIR response deadline of 21 working days had elapsed, a follow up email (see Appendix C).

2.7.1.2. Respondents

The respondents in this study were the professionals responsible for handling FOI requests, typically an FOI officer, within each of the NHS MHTs in England.

2.7.1.3. Data Collection Procedure and Informed Consent

The email addresses of the FOI officers, teams and mailboxes within each of the MHTs were obtained using a combination of publicly available secondary data sources (e.g. the internet) and a list of addresses provided by the author of a recent study of MHTs (Read et al., 2017).

2.7.1.4. Data Analysis Procedure

I compiled and coded the data obtained through the FOIRS using Microsoft Excel. Where no totals were given by the respondent, I calculated and transformed some data by hand and/or using different commands in excel. I used percentages, means, and ranges to summarise the responses received.

2.7.2. Part Two: Semi-structured Interviews (Qualitative Method)

2.7.2.1. Recruitment Strategy

I recruited participants by contacting Black Clinical Psychologists I have met previously, inviting potential participants via social media platforms, including England Clinical Psychology Facebook Group, Twitter, Instagram and LinkedIn, and recruitment through referrals, snowballing, and word of mouth. See Appendix D for recruitment poster.

2.7.2.2. Inclusion and Exclusion Criteria

Participants were qualified Clinical Psychologists currently working within an NHS Adult Mental Health Service, and identify their ethnicity as Black, and were of African or Caribbean heritage.

2.7.2.3. Participant Sample

Ten participants took part in the study. The participants consisted of two male and eight female Clinical Psychologists, and were aged between 26 and 45. Three identified their race/ethnicity as Black British Caribbean, three as Black British African; three as Black African and one as Black Caribbean. Participants worked in different types of Adult Mental Health services across England and had been qualified between 6 months and 19 years.

2.7.2.4. Data Collection Procedure

An interview schedule (see Appendix E) was developed based on guidance from Lewis-Beck, Bryman and Liao (2004). The schedule included prompting questions to allow a thorough exploration of participants' perspectives and understanding, and it was used flexibly to enable discussion when unanticipated findings emerged from the interview.

2.7.2.5. Pilot Interview

A pilot interview was completed with a Black Trainee Clinical Psychologist, to establish whether the interview questions were clear and appropriate, and whether there were areas of enquiry pertinent to the aim of the study that had not been covered. A trainee Clinical Psychologist was preferred to a qualified psychologist, to maximise the very small pool of potential participants. Some minor changes were made to the interview schedule, however, on the whole, the questions were deemed appropriate.

2.7.2.6. Interview Procedure

Participants were informed that the interviews would be audio recorded, consent was sought prior to starting the interview, and participants confirmed their understanding of their right to withdraw at any point during the study. Participants were given an opportunity to ask any questions or seek clarification before, during and after the study.

Face to face interviews took place in research rooms at UEL, and clinical rooms within the NHS. I interviewed two participants over the phone, and one via Skype. Interviews lasted between 30 minutes and 120 minutes, with an average duration of 40 minutes. The interviews were recorded using a digital recording device and then transcribed verbatim.

2.7.2.7. Informed Consent

Participants were provided with both an electronic and hard copy of the participant information sheet (Appendix F), outlining the aim and purpose of the research and what participation would involve prior to the interview. Participants

were given the opportunity to ask questions prior to, during and after the interview. They were informed that they could withdraw, without any penalty, from the study at any stage without having to give a reason. Participants confirmed their consent to participate by signing the consent form (Appendix G).

2.7.2.8. Demographics Questionnaire
Participants were asked to complete a demographics questionnaire (see Appendix H), which asked for their gender, age, ethnicity, number of years they have been qualified, the type of service they work in and the geographic location of their service.

2.7.2.9. Confidentiality and Anonymity
The limits of confidentiality, with respect to safeguarding and risk concerns, were made clear before each interview. Participants were aware that interviews would be audio recorded and then transcribed verbatim, by me or by an online transcription service. All data was anonymised. Participants were informed that transcripts might be read by supervisors and examiners, and that anonymised extracts would be included within the final write-up of the research and future publications. Identifying data such as consent forms were kept securely and separately from all other material related to this study in accordance with the Data Protection Act (1998). All electronic data was held on a password-protected computer within password-protected files. Participants were informed that following examination and award of the doctorate, the audio-recordings would be destroyed and that anonymised transcripts would be held securely for five years post submission.

2.7.2.10. Managing Potential Distress
I was mindful that discussing personal perspectives on and relationships to racial disparities in mental health outcomes, likely brought to the surface difficult feelings for the participants. At the end of each interview, participants were given the opportunity to discuss any issues arising from the interview and were provided the contact details of sources of information and support (Appendix I).

2.7.2.11. Data Analysis Procedure

The audio recordings were transcribed verbatim using an online transcription service (Appendix J). The data was then examined following Braun and Clarke's (2006) guidelines for Thematic Analysis. A combination of both inductive (bottom up) and deductive (top-down) strategies were employed. The process has been outlined below.

2.7.2.11.1. Phase 1: Familiarisation with the Data.

The interviews were transcribed so that all verbal utterances were captured verbatim using an online service to familiarise myself with the data and ensure that there weren't any inaccuracies in the text. I listened to the interviews, while reading and editing the transcripts. I read and re-listened to the interviews at least four times and made some notes on potential codes and patterns, before formally commencing the coding process.

2.7.2.11.2. Phase 2: Generating initial Codes.

Using NVivo, I worked systematically through the data, and coded it into the most basic segments, focusing on what I found relevant to the research questions. I kept some of the surrounding text around the codes, and defined each of the codes so as not to lose the meaning of the codes. I coded for as many potential themes and patterns as possible, sometimes coding the same excerpts in 5 or 6 different ways (see Appendices K & L for an example of this).

2.7.2.11.3. Phase 3: Searching for Themes.

Once all the data was coded and collated, I re-focused the analysis at the broader level of themes. To do this, I sorted the different codes into potential themes and sub-themes, and then arranged the relevant coded data extracts within these potential themes. I mapped this out on paper to support my thinking. These maps have been included in the results section.

2.7.2.11.4. Phase 4: Reviewing Themes.

After developing a set of themes, I assessed their internal homogeneity and external heterogeneity (Patton, 1990). To do this, I re-read all the coded extracts within the themes and sub-themes to see whether they formed a

coherent pattern. Tweaks were made where necessary, to the definitions of the themes, and the coded data included within them. I then re-read the entire data-set, to code for any data that may have not have been included during earlier stages, and refined my thematic map.

2.7.2.11.5.   *Phase 5: Defining and Naming Themes.*

Once I had a better idea of the themes and how they fit in with each other, as well as the overall story of the data, I turned my attention to refining and defining the themes. I did this by analysing and organising the data within the themes, to create accounts of the data that were internally consistent and coherent. The validity of the themes was addressed by sharing a sample of data extracts and their themes with my research supervisor. We reviewed how relevant the extracts were, as well as how clear and meaningful the definitions of the themes were.

2.7.2.11.6.   *Phase 6: Writing the Report.*

The final stage of the analysis consisted of writing up the report (see Results Chapter). I ensured that sufficient evidence of the themes within the data was provided by choosing extracts that were vivid and/ or captured the essence of the theme.

3. RESULTS

3.1. Overview of Chapter

This study has two main parts. The first section is related to research question one : "What are MHTs in England doing to improve mental health outcomes for Black service users?". This section reports the findings from the FOIRs sent to all 56 MHTs in England. The second section is related to research question two: "As mental health professionals who hold "outsider-within" status, what do Black Clinical Psychologists have to say about their MHTs' current attempts to improve mental health outcomes for Black service users?". This section reports the thematic analysis of the interviews I conducted with 10 Black Clinical Psychologists. The findings will be discussed in more detail in the following chapter.

3.2. Section One: FOIRs Analysis Using Descriptive Statistics

In this section, research question one, which was concerned with what MHTs are currently doing to improve mental health outcomes for Black service users was analysed using descriptive statistics. MHT compliance rates, the current landscape of race equality policies, initiatives or programmes, and mechanisms for monitoring outcomes are have presented in tables, followed by brief explanatory summaries.

3.2.1. Compliance and Engagement

Table 1 provides a breakdown of the MHTs engagement with the FOIR process. Of the 56 MHTs were sent an FOIR, 48 responded. Therefore, the response rate was 86%.

Table 1.Table 2. Landscape of current Race Equality Policies, Initiatives or Programmes FOI Compliance and Engagement Rates

	Number of MHTs	Rate
MHTs that were sent an FOI request	56	
MHTs that responded	48	86%
MHTs that provided answers to all questions	35	62.5%
Asked for an extension	3	6%
Asked for further clarification	8	17%

Of the 48 MHTs that responded, 13 raised "reasonable request" concerns, whereby they exercised their right to withhold or truncate responses to the request, if it exceeded 18 hours of time or £450 to collate. Therefore, the fully completed response rate, whereby information was provided for all of the questions sent in the FOIR, was 62.5%. Question 4 asked MHTs to provide service user outcome data for January – December 2016, broken down by ethnicity and service. Of all the reasonable requests concerns, this question was seen as creating the most work / being the most unreasonable for MHTs to fulfil.

3.2.2. Current Race Equality Landscape
Table 2 shows that of the 48 MHTs that responded to the FOI, two of them had specific initiatives and/ or policies that focused on race equality at both workforce and service delivery levels.

Table 2. Landscape of current Race Equality Policies, Initiatives or Programmes

	Number of MHTs	Rate*	Adjusted rate
MHTs that have a race equality strategy	2	4%	-
MHTs using EDS2	37	77%	84%**

	Number of MHTs	Rate*	
MHTs using WRES	40	83%	88%***
MHTs using both EDS2 and WRES	34	71%	

* based on 48 MHTs that responded
** based on the MHTs that had a service delivery equality and diversity initiative
*** based on the MHTs that had a workforce equality and diversity initiative

3.2.3. Monitoring Information

Table 3 shows the proportion of trusts that monitor ethnicity data. The average number of ethnicity categories used by the MHTs that provided ethnicity data for 2016 was 23, with a range of three to 85. There was an average of 13% unknown or missing data, ranging from 1% - 32%.

Table 3. Monitoring ethnicity

	Number of MHTs	Rate*	Range
MHTs monitoring ethnicity of service users	47	98%	-
MHTs provided ethnicity data for 2016	36	75%	-

Table 4, shows that only 25% of the 48 MHTs could provide evidence of linking ethnicity and outcome data. However, only 5 MHTs could categorise outcome data and ethnicity data by service. This accounts for 10% of all the MHTs that responded to the FOIRs, 31% of all he MHTs that routinely measure outcome data, and 80% of all the MHTs that routinely monitor outcome data and linked this with patient ethnicity.

Table 4. Monitoring Indirect Outcomes

	Number of MHTs	Rate*	Adjusted rate
MHTs that routinely measure outcomes	38	79%	-
MHTs that provided outcome data for 2016	15	31%	40%**

MHTs that provided outcome and ethnicity data	12	25%	31%** 80%***
MHTs that provided outcome and ethnicity data broken down by service	5	10%	13%** 41%****

* based on 48 MHTs that responded
** based on 38 MHTs that routinely measure outcomes
*** based on 15 that provided outcome data
**** based on 12 MHTs that provided ethnicity data

3.2.4. Monitoring Direct Outcomes

Table 5 illustrates 97% the Trusts that provided data on their use of the MHA could link this data with ethnicity data. This accounts for 71% of all the MHTs that responded to the FOIRs. However, only seven could categorise the mental health data and ethnicity data by service, which accounts for 15% of all the MHTs that responded to FOIRs, and 20% of all MHTs that provided data on their use of the MHA.

Table 5. Summary of the MHTs Direct Outcome Monitoring

	Number of MHTs	**Rate***	**Adjusted rate**
MHTs that provided MHA data for 2016	35	73%	-
MHTs that provided MHA data with ethnicity data	34	71%	97%**
MHTs that provided MHA data with ethnicity data broken down by service	7	15%	20%**

* based on 48 MHTs that responded
** based on 35 MHTs that provided MHA data

Table 6 shows which outcome measures were being used, with the HoNOS being by far the most prevalent.

Table 6. Summary of the Outcome Measures Used Within MHTs

Outcome measure	Number of MHTs	Usage rate*
Health of the Nation Scale (HoNOS) 12 items measuring behaviour, impairment, symptoms and social functioning (Wing, Curtis & Beevor, 1996).	32	84%
Short Warwick Edinburgh Mental Wellbeing Scale (SWEMWBS) 7 item measurement of mental wellbeing (NHS Health Scotland, University of Warwick and University of Edinburgh, 2006)	5	13%
Clinical Outcomes in Routine Evaluation (CORE) 34 item measurement of subjective wellbeing, problems/symptoms, life functioning and risk/harm (Evans, et al., 2000).	5	13%
Patient Health Questionnaire-9 (PHQ-9) 9 item measurement of subjective symptoms of depression (Kroenke, Spitzer & Williams, 2011)	6	16%
Generalised Anxiety Disorder-7 (GAD-7) 7 item measurement of subjective symptoms of generalised anxiety (Spitzer, Kroenke, Williams & Lowe, 2006)	5	13%
Recovery STAR 10 item measurement of recovery in different domains of functioning (Mental Health Providers Forum, 2008)	5	13%
Warwick Edinburgh Mental Wellbeing Scale (WEMWBS) 14 item measurement of mental wellbeing (Tenant et al., 2007)	4	11%

* based on 48 MHTs that responded

Of the 32 MHTs that used HoNOS as a routine outcome measure, 9 (28%) could link this data to service user ethnicity, and 5 (15%)* could link the outcome with service user ethnicity and the service they were seen in.

3.3. Section Two: Thematic Analysis of Interviews

In this section, question two, which was concerned with what Black Clinical Psychologists had to say about their MHTs' attempts to redress racial disparities was analysed using Braun and Clarke's (2006) guidelines for thematic analysis. Using thematic maps (see Figures 2, 3 and 4), six main themes, each with between two and five subthemes were identified. The themes are listed in Table 7, along with the number of participants whose responses were coded into those themes and subthemes.
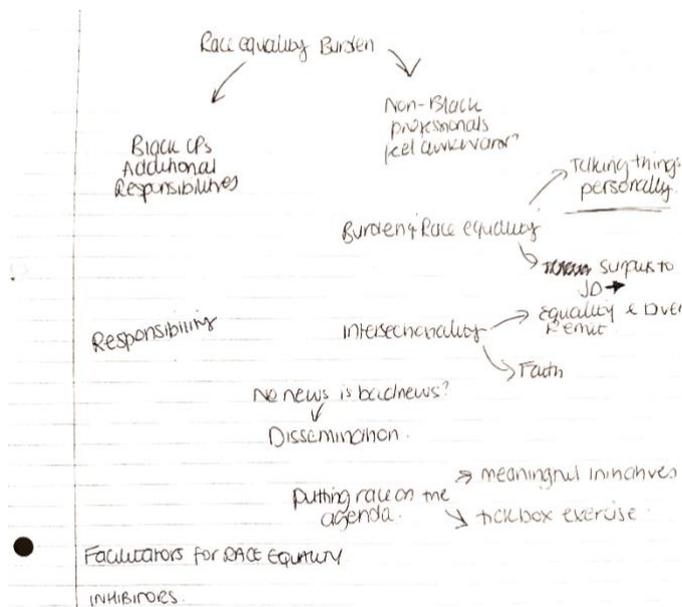
Figure 2. Developing Themes Using Thematic Map Example 1

After going through the transcripts a few times, I started to notice many of the participants had spoken about feeling as though, compared to their White colleagues, they had additional responsibilities to talk about and challenge race issues within the workplace. I had also observed that participants were mentioning other forms of diversity that they often felt would be spoken about more easily within mental health services.
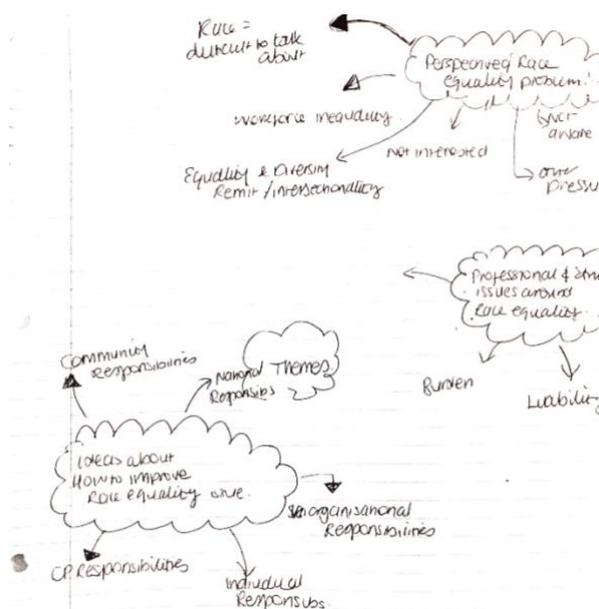
Figure 3. Developing Themes Using Thematic Map Example 2

Here, I started to think about the different ways in which participants had spoken about the "race equality problem" in their MHTs, "the professional and ethical issues" that arose when trying to address race issues or racial disparities in mental health outcomes, as well as the "ways to improve or address the race equality problem".

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Figure 4. Refining Themes Using a Thematic Map
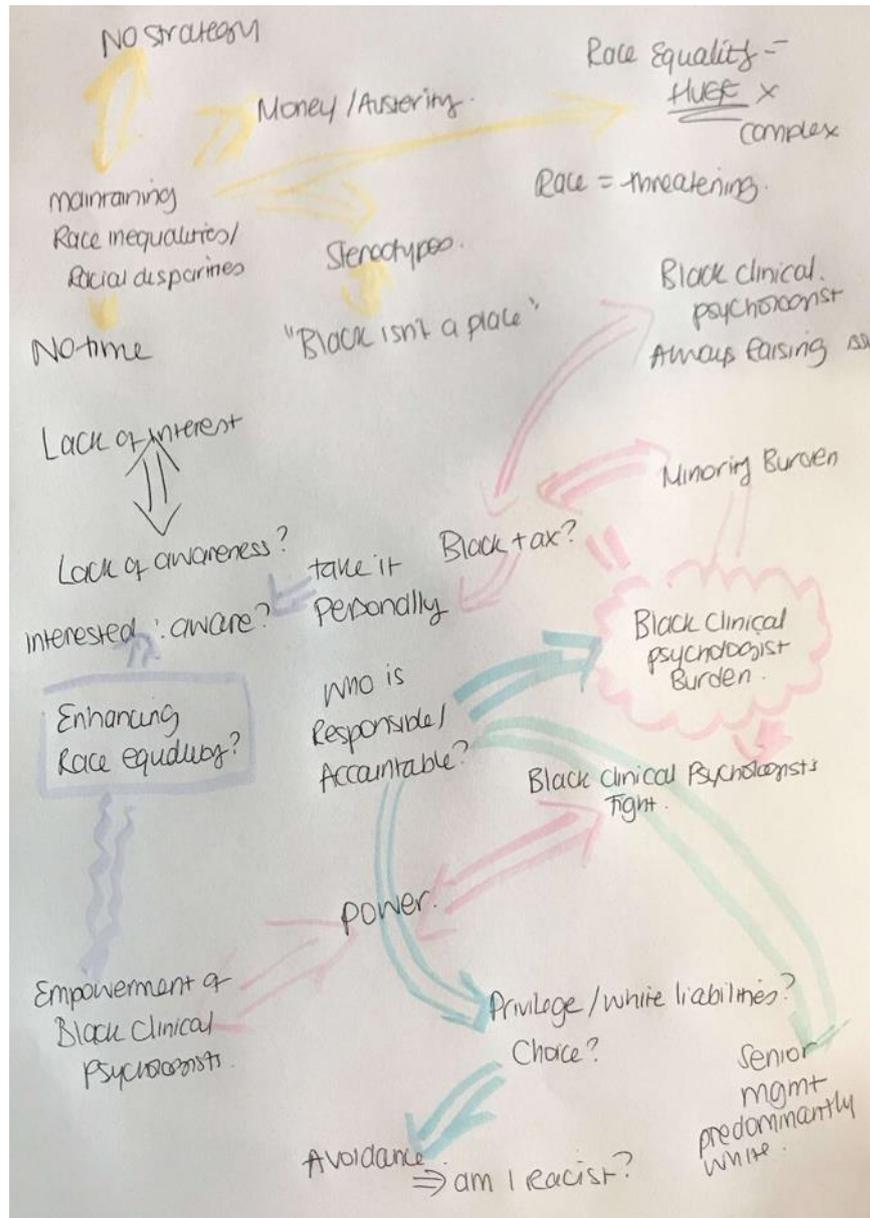
At this point, I was more familiar with the different potential themes and was trying to collapse them by making links with themes that were overlapping or similar in some way. I was also trying to think about how to present the themes in a way that would make sense and be engaging to the reader while also remaining close to what the participants said, in a meaningful and sensitive way. The final themes were developed after the broader themes were collapsed and reviewed with my research supervisor.

Table 7. Themes and subthemes

Themes	Subthemes
What MHTs and Services Are Currently Doing (9)	BME Workforce Delivery Initiatives (8)
	BME Service Delivery Initiatives (7)
	Black Service User Initiatives (3)
Factors That Maintain Racial Disparities in Mental Health Outcomes (9)	Workforce Race Inequality (7)
	Lack Of Accountability (7)
	Limited Resources (4)
Factors That Reduce Racial Disparities in Mental Health Outcomes (10)	Being Responsible For Race Equality (10)
	Taking Racial Disparities Personally (4)
The Burden Of Race (10)	Minority Burden (7)
	The Equality and Diversity Agenda (6)

I captured the essence of the themes, as well as the overall story of all the data gathered in the interviews by providing a brief definition of the theme, and relevant examples of excerpts from the interviews. Short commentaries have been included. However, a more thorough exploration of the themes can be found in the following chapter as part of the discussion of the findings.

3.3.1. Theme One: What MHTs and Services Are Currently Doing

This theme was concerned with the concrete descriptions and examples of what, in the absence of a national policy, programme or initiative, the participants' MHTs and services are doing at a local level to address racial disparities in mental health outcomes for Black service users. One participant did not provide any examples of policies or practices within their trust or service, citing that addressing racial disparities in mental health outcomes was not high on their service or MHT agenda.

"…it doesn't feel as entrenched in processes and procedures …"

Participant 5

The remaining nine participants shared examples which have been divided into the following sub-themes: BME Workforce delivery initiatives, BME service delivery initiatives and specific initiatives for Black service users.

3.3.1.1. Sub-Theme One: BME Workforce Delivery Initiatives

This sub-theme was concerned with the initiatives that had been set up to address racial disparities in mental health outcomes for BME people by focusing on the underrepresentation of BME people working within the NHS. Most of the workforce initiatives were networks or forums or committees designed for BME staff to come together so they can think about the underrepresentation of BME staff within their services. They were referred to as a place from which BME staff could seek support from their peers. Other initiatives, such as mentoring, cultural competence workshops, and linking up with community organisations was mentioned. Eight participants provided examples of the initiatives with which they were familiar; some have been outlined below.

"There is a kind of BME network, which thinks about the diversity of the staff team and thinking about inequalities in senior management and things like that….

….There's a diversity forum that you can go to if you're interested"

Participant 2

"We got an email sent around I think someone in the communications department, or sent on behalf of someone in the trust saying there's a new initiative where people from BME backgrounds can get like a mentor by someone in like a senior role."

Participant 4

"I guess some MHTs might call them "Black and Minority Ethnic support forms" or "spaces for people from BME communities to come and share stories, share experiences.""

<div align="right">Participant 8</div>

"I know that [the equality manager] is linking up with a kind of third sector organisation that is specifically geared towards, it could be any groups. And he's offering, in collaboration with these community development workers, offering a cultural competency workshop for clinicians, essentially."

<div align="right">Participant 10</div>

3.3.1.2.   Sub-theme Two: BME Service Delivery Initiatives

This sub-theme was concerned with the developments within participants' MHTs or services that focused on improving outcomes for BME people through service delivery initiatives or programmes. Improving access and engagement through specific roles, responsibilities, services and events / engagement with the local community were given as examples. Eight participants provided insights into the work that was being carried out within their services or MHTs. Some examples are presented below.

"We have a service that specifically kind of aimed at trying to engage local communities and make psychology and psychological therapies more acceptable and accessible…

… some of the things we've tried to do is go to local community events, raise awareness about our service"

<div align="right">Participant 4</div>

"There's been a lot of funding received to improve outcomes for Black communities in [area anonymised] specifically, and they've got these new hopes in this organisation called [organisation anonymised], and because they've got this funding to do this piece of work, it's now involving this Trust, and so there are quite a lot of different meetings around that. They've basically got a list of failings, and they have to work

<div align="right">99</div>

*out how they're going to address each one of those, based on some of
the deaths that have occurred within this Trust"*

Participant 9

*"We're encouraged to look at the demographic caseload. And have a
comparison to compare that to the borough…
….We don't know our own specific data. It's kind of been amalgamated
into another service as well. But that's something that the trust is asking
us to think about quite a bit."*

Participant 10

Sub-theme Three: Black Service User Initiatives

This sub-theme was concerned with initiatives that had a more explicit link with
the experiences and outcomes for Black service users specifically. Three
participants spoke about such initiatives in their service or MHT.

*"There have been a couple of papers thinking about Black men's
experience with psychology in our team, which have been published and
looked at and used kind of Tree of Life as a way to explore that and think
about psychology and their experiences."*

Participant 1

*"So we've got a couple of things that we're working on, or projects if you
like. A representative on our team, which is currently myself, sits on a
board. A working board that's specifically around the mental health needs
of people from BME groups in our borough. Because of that way of us
are working, the fact that we take on these projects and we try to do
something within the community, I guess that aids us in better in doing
things for the benefit of Black service users…."*

Participant 10

*"We kind of do use a lot of Tree of Life work, which has its roots in kind of
African kind of culture. So that can be quite helpful in thinking about*

identity and kind of what the person's hopes and dreams are for the future"

<div align="right">Participant 8</div>

3.3.2. <u>Theme Two: Factors that Maintain Racial Disparities in Mental Health Outcomes</u>

The second theme identified was the factors that maintain racial disparities. One participant reported mostly positive experiences within their MHT, and did not explicitly name any factors that were particularly inhibitory for improving outcomes for BME service users. The remaining nine participants highlighted some professional issues that impacted on how feasible it was to adequately address disparities in mental health outcomes for Black service users, for example, the discomfort experienced by non-BME staff when race is put on the agenda:

"My team leader would say "I just don't know what we're going to do about it." Is what she would say, and then she'd sort of suggest whether or not we need to get the diversity people in to do a training. She would say stuff like that, but she wouldn't be, I think she'd just go red, and get stressed."

<div align="right">Participant 9</div>

I don't think people feel really comfortable talking about these sorts of issues. And when you ask people the reasons are for why, I think people just don't feel they know how to do it the right way. But then I always think, "Is there a right way to do these things?"

<div align="right">Participant 4</div>

Workforce race inequality, limited resources in the context of austerity, and a lack of accountability within roles and organisational structures were raised by most participants. They have been divided into sub-themes, outlined below.

3.3.2.1.   Sub-theme One: Race Inequality Within the Workforce

This sub-theme was concerned with the underrepresentation of BME staff within mental health services as a barrier to speaking or thinking about, as well as addressing racial disparities in mental health outcomes. This issue was identified by seven participants.

"Actually, how do we think about it, what does it say to our clients, when the faces that they met at admin are Black but the clinicians are White. And how it means to be with other people who are like them. So do we have more groups that are focused round some of these identity issues as opposed to diagnosis…

…And I think the difficulty has been split off into this diversity race issue, got your own policy, which is great, but then if it doesn't affect you, do you need to look at it? do you need to read it?"

"…there is something about how it's a very sensitive topic. I think people are worried about being seen as racist, when we all have levels of racism within us, but how do you talk about it in a way that's not persecutory. And, sometimes, that feels like the work, before you can actually have a discussion"

Participant 3

"Clinical psychology is not very diverse in the first place, so it's not always the case that you'd have other colleagues who can identify in terms of cultural level and then it becomes almost, sometimes, quite silencing…

.. But there's a challenge in the workforce being diverse without necessarily being diverse, and this is often a struggle. You know, you could have quite a lot of BAME nurses, or junior doctors, and you feel like you have a quite diverse workforce, but actually, are their ideas, voices, as heard?"

Participant 6

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"I guess when we start to think about language like the person being "preoccupied with their race," which is something I've heard before, is quite an interesting position particularly if those comments are being made from people who are not necessarily from that community, who may be from a very different community where those issues may not present in the same way that they do for the service user. Because "preoccupation with race," to me, indicates some kind of disruptive cognitive process almost. I'm not really sure it's a simple ... I think that if we're not careful, we can be simplifying or they seem to be quite reductionist of people's experiences related to race"

<div align="right">Participant 8</div>

The impact of workforce race inequality is particularly evident when it comes to influencing change at more senior levels within the service or MHT.

"When you think that the senior leadership team and the head are White, that diversity is definitely an "other", Blackness is definitely an "other" issue. That they know it applies, but it's not necessarily actively taken up."

<div align="right">Participant 3</div>

3.3.2.2.   Sub-theme Two: Lack of Accountability

This sub-theme related to the issue of accountability within service structures and professional roles. Seven participants talked about how easily issues of race fell off the agenda when staff and / or services perceived it as being surplus to their remits. When there isn't a specific role or policy where racial disparities in mental health outcomes are adequately addressed, then it falls to the individuals within the service to be willing and capable of taking on the challenge. In this instance, there becomes a bit of a hot potato effect, where people toss around the responsibility, until it falls off the agenda entirely.

"I think it makes it harder to talk about because, I guess, some of the conversations are tricky and people feel uncomfortable. And I feel like sometimes if there's not really a champion, per se ... "champion" who brings it up in their team, just often it's easier to just put it under the

carpet a bit because it feels uncomfortable. So people would rather avoid it."

<div align="right">Participant 1</div>

"That's interesting, yeah, mm, that's some valid points, yeah." That's how I think they would respond because I haven't really said anything new but it is about, you know, "That's great, but who's gonna take it". It will become, sort of swamped in the practicalities of it and no one's got time to do additional work, really….

..Then I'll become the diversity lead, which I think somehow undermines, undoes, what's been trying to be done, which is about everybody's responsibility"

<div align="right">Participant 3</div>

Even when there are actions being taken towards improving outcomes for service users, without an overarching or coordinated strategy, the effort to eradicate race disparities can be thwarted by the lack of accountability within services and MHTs.

"But actually holding in mind, that because we've done one audit. Doesn't mean that ... it's not a tick box kind of thing that, okay, yes we've done an audit, check. Or, we've translated a letter, check. And actually we can sit down now because I've done my part for the year.

But actually, this is an ongoing thing, and how do we make this more a part of the service, not in particular meetings we have certain questions."

<div align="right">Participant 2</div>

Further, when there aren't any reporting structures within or outside of an organisation, and no pressures to monitor or evaluate progress on racial disparities, the situation persists, with no opportunity for meaningful intervention or change.

"We don't have any mechanism for monitoring demographics, to see whether there is any indirect disadvantage to certain groups, who access these funded placements. We don't look at that at all. In terms of our service leadership, it doesn't appear under ... We talk broadly about outcomes, but nothing about, "Is one group doing better or worse?" So no, there is quite an absence of it, across those meetings…

….And commissioners are not necessarily requesting this either. So commissioners request lots and lots of data from us to demonstrate outcomes, and never once have they request for data about how our BAME clients are doing. And that is one of the challenges"

<div align="right">Participant 6</div>

"How that's monitored or thought about, I actually don't know. I feel like it's a little bit self, it's kind of like within the trust, and they say they're doing it, and then that's enough. It doesn't feel like it's been looked at by any kind of wider body at all, not at all, no."

<div align="right">Participant 9</div>

3.3.2.3.   Sub-theme Three: Limited Resources

This sub-theme was concerned with the impact of services being chronically under-resourced. Four participants reflected on how inadequately addressing issues of race disparity, or avoiding them all together can easily become justified, and part of the culture within a MHT or service when resources are limited.

"They're just phenomenally busy, and so I think that there is just so much always firefighting to do, that it's really easy for some of the more distal things to get dropped off the radar."

<div align="right">Participant 2</div>

"I think it's easy to talk about issues to do with class and money and that way of thinking about deprivation, rather than thinking about race, history, oppression. Because that feels much more of a challenging conversation and I think where the service has been restructured, the

idea, formally, is to improve access. But it seems to be the undercurrent is to prevent access because services are overwhelmed. So, it's about finding ways to not accept people"

<div align="right">Participant 3</div>

"I feel like people are interested, but people are so busy you just need someone to kind of take the lead and say, "We're gonna do this", and then people will sort of get involved, seem interested. I think maybe it's busyness that is kind of not on people's radars as much."

<div align="right">Participant 4</div>

"But no one really seems to be that focused on it, with all the cuts and constraints on services, people just want to be doing their minimum, and see this as almost an over, kind of cherry on the cake, rather than part of the core of things that we need to be addressing."

<div align="right">Participant 6</div>

"There are some things going on, but whether, I guess, think about, like, wider conversations and what accessibility means in the current climate, we've got loads of pressures and targets and two week waits, and where the flexibility of our service or trying to think about everything, I think it's pushed more to the side lines as people feel more pressured in the meeting of the targets and doing paperwork and not seeing an individual"

<div align="right">Participant 1</div>

3.3.3. Theme Three: Factors that Reduce Racial Disparities in Mental Health Outcomes

This theme was concerned with factors that participants suggested would likely reduce racial disparities in mental health outcomes. All ten participants spoke about this in different ways, however, the main sub-themes of responsibility and taking race personally have been outlined below.

3.3.3.1. Sub-theme One: Responsibility

This sub-theme is based on the importance of being held accountable when it comes to making meaningful and sustained changes in addressing racial disparities in mental health outcomes. All ten participants talked about accountability in the form of responsibilities and obligations, both ethical and professional, as vehicles for reducing racial disparities in mental health outcomes. Although, there was a general consensus that racial disparities in mental health outcomes should be everyone's responsibility, job-specific recommendations were put forward; it was felt that because of their training and values embedded within the profession, Clinical Psychologists were well suited to reducing racial disparities in mental health outcomes:

> *"Clinical Psychologists need to step out of their roles more, or at least their traditional roles - the roles that they have been taught to have, and to do more to name abuse of power and oppression and racism and other forms of, kind of, social violence. Name them as important issues in the work that we do in understanding well-being and mental health. I think that's a really important role that psychologists can be a part of"*
>
> Participant 5

> *"Even though it's everybody's responsibility, I think our training and our skills that we have might put us in a position to be able to formulate systems…*
>
> *…Even guiding the service and thinking about issues are important. And thinking about diversity should be the bread and butter of psychologists, and actually training that should talk about that more and address that. As well as the profession in the whole because, kind of, that is what we're ready for. So, I think we probably have quite a lot of responsibility to do that."*
>
> Participant 1

It was suggested that Clinical Psychologists at the forefront of recruiting and training the next generations of professionals should be tasked with developing

programmes that equip the workforce with the skills and confidence to address issues of race inequality:

> *"Then as a training course, we need to do more to encourage to think of clinical psychology as, not just about leadership and management at service level, but it's about leading MHTs, getting a mental health trust to think more collectively about what they're doing with diverse communities."*

> Participant 2

> *"I think what they can do is pay greater attention to who we recruit, and how we recruit, and how we assess. That's, for me, is really important, because then the other bits of work will follow from there…*
> *… What I think clinical psychology could do on a much more meta-level, really, is think very carefully about the people that we're bringing in, the recruits, because fundamentally, for me, that is really key"*

> Participant 7

Participants talked about senior management's responsibilities in addressing issues of racial disparities in mental health outcomes.

> *"Whilst I'm happy to be part of change and a driver, the burden, the shame if you like of being part of a system that promotes this inequality, should be on senior managers shoulders, and I feel like actually that it's almost like a kind of disconnect, they sort of shrug it off a bit. So I think if I had my magic wand I'd get them doing that a bit more"*

> Participant 2

> *"I think if I had my magic wand, it would be to get senior management to acknowledge positions of privilege and to make them more responsible for the burden of this dis proportionality"*

> Participant 1

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Directorate level responsibilities were cited:

"Why not get directorate level position on this, where someone is actually responsible for charting, for collecting this data that people are really kind of, where's the data, and for implementing change. I think that's the way that it has to happen, is to be given the platform that it needs in order for real change to ... Otherwise, you have what we have now, which is really enthusiastic well-meaning clinicians that don't get the platform to afford the change."

<div align="right">Participant 2</div>

The idea that national bodies and organisations should hold responsibility for addressing these issues was mentioned.

"Actually, this needs to be a Department of Health, to NHS England, to chief execs, saying, actually, you need to see this within our outcomes data. On a certain level, IAPT services have to do this. And so it would take a huge amount of ... and it's not necessarily up to individual clinicians to kind of take it on, 'cause what happens if I leave, and there isn't someone else who's as interested in it? So yeah, I would say it does need a national initiative. As has already been done in terms of all the background work from DRE, yeah, all of that is already kind of out there. Knowing it's not going to cost a huge amount, for that to be disseminated through. So yeah, I think probably more at the national level"

<div align="right">Participant 6</div>

3.3.3.2.   Sub-theme Two: Taking Race Disparities Personally

This sub-theme is underpinned by the idea that if mental health services are to really improve racial disparities in mental health outcomes, then the professionals working within them need to take these issues personally. The distinction here is that it is important to take these issues seriously, but that it is more effective when professionals take it upon themselves personally to make a difference.

"I think ... I hope we just ... just more ease at which people feel able to talk about these issues, but to not just talk about them from a kind of detached way, or any kind of detached way, but to really own the importance of them and to take them personally. Not even just seriously. I don't have any doubt that many people, many White people within the profession or within the mental health system, take racism seriously, but I think it's more than just taking it seriously. I think it's taking it personally. Seeing it as something that is important to you, personally. That if well-being and mental health is important to you personally, if empowerment is important to you personally, if justice is important to you personally, then thinking about issues of race and difference, power indifference, racism, really needs to be something you care about personally, which means that it's part of every aspect of your life and not just academic thought or a way that you're supposed to think."

Participant 5

"And it needs to be that embedded on the agenda, that it doesn't necessarily need that Black person in the room to raise it, or the person who's interested in it to raise it. That actually, everyone's interested in it."

Participant 6

"I think in terms of, like, my team, I'm very interested in those ideas so I talk about it in our team meetings and our referral meetings. Or I bring up different difference issues as a way ... I use myself and my own experience in reflective teams just as a way to actually ... I've never opened that here. It's really tricky to talk about but we ask our clients to talk about tricky things all the time. How do we talk about things that are important to them? To us as a service. So I feel like if there's not somebody in there who's willing to put it on the table, then it just won't ... people might have a thought but just won't say it or talk about it, in a way."

Participant 1

3.3.4. <u>Theme Four: The Burden of Race</u>

The final theme, the burden of race, is centred on the professional and ethical issues that participants encountered personally in their pursuit to reducing racial disparities in mental health outcomes within their services. This challenging complex and challenging ideal is explored in the discussion. All ten participants talked about their personal experiences of engaging with these complexities and challenges in the context of being in the minority as a Black Clinical Psychologist in relation to their White colleagues.

3.3.4.1.   *Sub-theme One: Minority Burden*

This sub-theme was concerned with the burden of being in the minority as a Black Clinical Psychologist. Seven participants talked about having to take on additional responsibilities or hold positions within their teams or services they wouldn't ordinarily want to hold, and wanting that to be shared more fairly with other people:

> *"Because you're Black, you're just assumed to always be the person of knowledge that knows everything about every BME group under the sun. And it's like, actually I don't!"*
>
> Participant 4

> *"I think I've had to be very open, and because with my supervisor and everything, I've had to really say "This is what happens. This is how if feels." And "This actually isn't okay." I was thinking in my head, way further up the parapet than I probably am personally comfortable with." I'm not particularly into that, but I've had to go way further than I'm more comfortable, because I felt that it's just not on."*
>
> Participant 9

> *"Rather than leaving it to Black Clinical Psychologists, in terms of Clinical Psychologists as a whole team could take on much more of that role, in terms of greater emphasis on issues around diversity, or training, or how*

Clinical Psychologists could drive those kinds of change in the services they end up working in."

<div align="right">Participant 6</div>

"I think I kind of end up sitting there and it's a bit like a pressure cooker. Something happens, it's like its boiling, it's boiling, it's boiling. And it's like, "Aah, is anyone else gonna... No, it's gonna be me". So, I end up saying it and I think I'm often I two minds, because I don't want to be known as the Black psychologist, I don't want to be known as a person who's always advocating for Black issues, I want it to be everybody. So, I feel some responsibility and a sense of, "Do you not see me?"..
… And I think psychologists taking more of an active role, but again it, it feels sometimes so draining for it to be our fight, and especially if you're a Black Clinical Psychologist, it's like, "Why does it have to be lumbered with me, I have the responsibility, but why?""

<div align="right">Participant 3</div>

Five participants talked about these responsibilities as being part of a fight or cause that they were committed to in a way that was different to their non-BME peers:

"You do just feel like you're out there alone fighting against the system and really frustrated and really just like, really ... it just feels really ridiculous and I'll be just like, am I always the person that's like, difference and diversity? And I only mention that in a meeting, let me ... and it feels a bit relentless at times, but I think that sometimes we are like looking after yourself and just be like, hey there is a reason. It's an uphill ... it feels like an uphill battle."

<div align="right">Participant 1</div>

"So I've chosen to work in an arena where the narrative of BME experiences has been marginalised in a bid to bring that back to the forefront. So for me it's kind of expected that it will be a bit of a continual

battle as it were, to continue to get staff team members, managers, other people to think about their responsibility"

<div align="right">Participant 2</div>

"There aren't very many Black people, and it definitely comes with its challenges because of that, so you feel a little bit more like a pioneer than maybe you would have initially thought, and you can't escape that role. I don't think. I've not been able to escape that role. Yet."

<div align="right">Participant 9</div>

Four participants reflected on the experience of having to be careful with how they brought up issues of race inequality amongst their colleagues. They reported doing this to avoid being labelled as the one who is pulling the race card, or always talking about race in a way that makes others feel uncomfortable:

"It becomes a kind of, "Oh, you're just saying that because you're Black." In terms of the person who's always then saying, about, you know, what we're doing to encourage more offers for family intervention to BAME clients, 'cause there can be a tendency that kind of care coordinators would feel quite distant, and not identify with, and then not see that themselves as someone who is able to support that family or offer anything to that family, and all these kinds of, you know…
…. then I very quickly become the person who was crying race, or using race as an opportunity"

<div align="right">Participant 6</div>

"Because I guess what I'm aware of is how maybe if I were to let them know my experience, I would absolutely want kind of my points to be heard and received in the spirit they were intended to be communicated and received."

<div align="right">Participant 8</div>

"Doing this bit of a dance between let's talk about diversity, and I don't want to make you feel too uncomfortable because I'm like, well it's uncomfortable for me, too. So it feels like a bit of a dance and a bit of a back and forth. But it's funny talking about it, just how much you end up doing it day to day. Like, it becomes a natural part of your routine"

Participant 1

3.3.4.2.   Sub-theme Two: The Equality and Diversity Agenda

This sub-theme was concerned with the participants' observations of the different ways in which the spotlight was taken off race, and amalgamated into an MHT equality and diversity agenda. Four participants talked about the importance of thinking about different differences additionally to, rather than instead of racial issues:

"Other types of inequality are more readily spoken about and are more readily accepted, maybe. I find that when it comes to racial inequality, there's often only a very small cohort of people arguing in favour of that where I guess, in comparison to other types of inequality, there might be a more heterogeneous group fighting for equality in that area. Yeah. Like I say, kind of it then feeling quite tokenistic and isolating actually. It's just a perpetual cycle that gets played out."

Participant 8

"Sometimes I find it frustrating when it's like, you talk about one difference [race] that's an issue and all other differences kind of get mentioned. And it's not saying that those ones aren't important, but this is something that someone's bringing as an issue. Can't we just talk about this and I can take it one step at a time? So sometimes I feel that that can be a bit undermining, maybe.

Participant 4

Three participants talked about race as a problematic construct to focus on when trying to improve disparities in mental health outcomes, and advocated for staff as well as services to be more curious about the communities they serve:

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"It's about raising the outcomes for all, not specifically the person with this particular colour or religion…

…For me, anyway, race is one thing, but because there's so many different bits now, I just think you can't ... It's the whole intersectionality and that, but you can't afford to advance one group, and dump on another, because we're really just one group."

<div align="right">Participant 7</div>

"So everyone's always Black, but where does she come from? She's Black, but where does she, like, she's just Black. What does that mean? I'd like them to actually understand that Black isn't a place"

<div align="right">Participant 9</div>

4. DISCUSSION, IMPLICATIONS, FUTURE DIRECTIONS AND CONCLUSION

4.1. Overview of Chapter

In this chapter, I will address the main research questions, and will discuss how the findings relate to relevant literature. I will then present the clinical and research implications of these findings, the strengths and limitations of the study. I will share some personal reflections on the process of carrying out this research. The chapter will conclude with a summary of the main lessons learnt from this study, and the plans for dissemination.

4.2. Discussion

The first aim of the project was that the findings would capture the current landscape of national and local initiatives, programmes, or policies that are attempting to redress racial disparities in mental health outcomes. The second aim of this project was to identify examples of good practice with respect to redressing mental health outcomes, as well as areas for development. The final aim of this project was to stimulate conversations about redressing racial disparities in mental health, as well as how to achieve this, by focusing on the mental health outcomes of Black service users. I will now use the findings from both the FOIRs and interviews, to address the main research questions and aims. I will discuss how these findings fit with each other, as well as relevant literature and policies.

4.2.1 Research Question One: What are MHTs in England Doing to Improve Mental Health Outcomes for Black Service Users?

4.2.1.1. EDS2 & WRES as Race Equality Programmes

In the absence of any national race equality policies or initiatives, most MHTs are drawing upon the EDS2 and WRES to support their thinking as well as develop action plans to address issues of inequality within the services they provide. I wondered whether this was reflective of the "catch all" approach to improving disparities through the equality and diversity agenda or the

assumption that equality will mean equal outcomes for all. However, special considerations should be taken to address the differences in experiences, needs, treatment and resultant mental health outcomes so that becomes an integral and meaningful process within NHS. Mental health services should take seriously the issues of structural and institutional inequality in a more concrete and measurable way, so as not to maintain racial disparities in mental health outcomes (Fatimilehin, 1989; Patel & Fatmilehin, 1999).

For the MHTs that have their own race equality strategy, it is positive to know that the needs of Black service users are being considered; it would be useful to know what it is that made it possible for these MHTs to view the mental health needs of Black people separately to other BME groups and whether the existence of a race equality strategy leads to better outcomes for Black people or not. Further, given that these frameworks are mandatory within the NHS, the finding that there are some MHTs that may not be using one or both of them is concerning. It raises the question about the culture of accountability within the mental health system, and whether MHTs are sufficiently motivated to engage with these initiatives. Although this finding was concerning, it may be a way of opening up dialogue with MHTs to understand what it is they are doing, whether there are any issues with the EDS2 & WRES or if there are any other factors that would help to explain why they aren't using it. Opportunities to learn from both good practice and the absence of evidence about practice could promote culture of transparency and curiosity, as opposed to one that could put services under more pressure and reducing likelihood that they will be able to think about or find resources to deal with racial disparities in mental health outcomes.

This study highlighted that there were no initiatives which focused directly on improving mental health outcomes for Black service users specifically. However, initiatives or programmes that focus on improving mental health outcomes for BME people at a workforce and service delivery are viewed within MHTs as the main strategy for improving mental health outcomes for Black service users. For example, the BME mentoring schemes and cultural competence workshops were developed to encourage teams and services to

think about BME people in terms of disparities in mental health outcomes, experiences and treatment within mental health services. These initiatives are designed to encourage more thinking and attempts to improve outcomes for the groups that are the most marginalised within the mental health system, as well as within society. However, there is not enough interest and willingness to engage with these initiatives at an individual as well as service or MHT level. Issues of inequality are perceived as being surplus to individual as well as MHT remits. Therefore, the scope to actually reform services in a way that benefits those who are most marginalised within them is limited by the lack of people invested in making the necessary changes. This finding echoes Patel and Fatimilehin (2005)'s reflections that when issues of race and ethnicity are included within service planning and development, they are not regarded as part of generic services; they are instead, seen as an "add-on", which leads to: the "ghettoization of services for Black and minority ethnic communities, and locates them mainly in the voluntary sector with no way of influencing mainstream provision" (Patel & Fatimilehin, 2005 p.21)

4.2.1.2. Local Initiatives

In addition to the Identifying and Redressing Disparities in Mental Health Outcomes two MHTs that have developed race equality strategies, this study found that at least three adult mental health services have developed projects or initiatives that have held in mind the experience of and outcomes for Black service users (e.g. the academic papers focusing on the experiences of Black men). Important work is being carried out by individual practitioners, and their teams; participants highlighted their active roles in trying to change the culture and practices within their services by holding Black service users' experiences in mind within team discussions or in their clinical work. Participants talked about their involvement in reminding the team to keep issues of race inequality on the agenda, to be mindful of the language used to conceptualise Black people's experiences and taking issues of race inequality personally.

These actions would likely complement or fit into a broader race equality strategy or initiatives that are designed to improve outcomes for Black service users specifically. However, in the absence of a coordinated approach to

tackling or addressing these issues at an MHT or national level, it is likely that the work carried out on an individual or personal level is not being captured, monitored or evaluated in a meaningful way. Therefore, it may not be possible to develop an accurate view of what is currently being done without speaking with more clinicians. Patel and Fatimilehin (2005) pose important questions about this issue, namely "Are we really saying it is more important to do something regardless of how ineffective it may be?", "Do we not genuinely want to know what people think of what we are doing or offering?" and "Do we not want to know if what we are doing is actually making a difference, however this is defined by the recipients of our services?" (Patel & Fatimilehin, 2005 p.22). Until MHTs are seen to actively evaluate the relevance and effectiveness of their provisions for Black service users, they will not be in a position to confidently answer yes to any of the above questions; rather they will be seen as complicit in maintaining these disparities through lack of action and accountability.

4.2.1.3.   Identifying and Redressing Racial Disparities in Mental Health Outcomes

Most of MHTs stated that they do routinely record the ethnicity of their service users, and most could provide their data for 2016. However, there are some questions about how meaningful this data is owing to the high percentages of missing ethnicity data reported by the MHTs. It is likely that important information about who accesses different services is not accurately being captured, which would have implications for the sense that is made of mental health outcome data. For example, in order to justify taking action to redress racial disparities in mental health outcomes, (e.g. developing strategies and initiatives) there needs to be evidence that these disparities exist. Without accurate data, it may not be possible to show the existence of such disparities, which may limit MHTs in their ability to provide services that are responsive to the needs of the population they serve. Further, if accurate ethnicity reporting shows that racial disparities do not exist, there will be opportunities to identify examples of good practice and learning that could be applied in other services, or to redress other types of disparities.

The mechanisms for capturing, analysing and responding to disparities in mental health outcomes were not consistent across MHTs. Although indirect outcome measures are used routinely within most of MHTs that responded to the FOIRs, compiling this information proved a difficult task for most MHTs. A large proportion of them were unable to provide mental health outcome data, or use of the MHA presented alongside ethnicity data. This raises questions about how well-equipped MHTs are to effectively monitor and address racial disparities in mental health outcomes in a way that takes into account the performance or needs of a specific service. Further, it indicated that there may be issues with the systems (e.g. electronic patient records), the outcome measures or the way that information is communicated and used within MHTs that need to be reviewed at a local level (e.g. internal audit), and at a national level (e.g. standardised ways of capturing and analysing mental health outcome data). This also echoes the concerns raised by Fitzpatrick, Kumar, Nkansa-Dwamena and Thorne (2014) who identified the paucity of data showing the relationship between ethnicity and mental health owing to the lack of routine data collection and out of date studies.

This finding also raises questions about the relative usefulness of the data that MHTs are able to collate regarding the use of the MHA, in terms of being able to identify and address any disparities in this particular outcome, as well as continually monitor and evaluate progress towards achieving or maintaining this within a specific service. There is also no pressure on MHTs to use this data to regularly and systematically monitor and check their progress towards addressing disparities in mental health outcomes for Black service users. This was reflected in the lack of consistency across and within MHTs in their responses to the FOIRs. There were large differences in their ability to collate outcome and ethnicity data in a timely fashion and present it in an accessible format. This limits the possibility for a MHT to understand its performance in improving outcomes for Black service users in relation to previous evaluations or the performance of other MHTs.

The number of ethnicity categories used across and within MHTs varied immensely, with one MHT only using two categories (e.g. "White" and "BME"), and another using as many as 85. There does not seem to be any consistency regarding the use of ethnicity labels, which presents an additional challenge for the monitoring and analysis of outcomes at a local and national level. Given that there are recognised and agreed census categories on ethnicity used by public authorities, this finding was particularly worrying. This is because it illustrates that joined up thinking and strategies across mental health services in the NHS with respect to racial disparities, are lacking. Though ethnic or racial categories are problematic, they can be used sensitively to help services monitor and improve their provision for groups who are shown to experience worse outcomes. Without the right infrastructure (e.g. technology and culture within services) to record and analyse important information such as ethnicity alongside outcome data, mental health services will not be held accountable for, or even incentivised to redress the widely documented disparities. Further, it will present MHTs as reluctant to seriously address issues that affect Black, which has also been identified as a factor that may be contributing to racial disparities in mental health outcomes (Fatimilehin, 1989; Nadirshaw, 1992, 1994; Howitt & Owusu-Bempah, 1994).

4.2.2. Research Question Two: As mental health professionals who hold "outsider-within' status, what do Black Clinical Psychologists have to say about their MHTs' current attempts to improve mental health outcomes for Black service users?

4.2.2.1. Workforce Initiatives

Almost all of the participants could name or give an example of work that is currently being done within their MHT to improve outcomes for BME service users or staff. Although there was a general sense that more could be done to engrain these practices in the culture of their MHTs and services, eight out of 10 participants were aware of at least one workforce delivery initiative currently deployed within their MHT. BME networks were the most commonly mentioned initiative, however, a support forum, mentoring programme and cultural competence training were cited.

4.2.2.2. Service delivery initiatives

Seven out of 10 participants talked about initiatives that were aimed at improving service delivery for BME people. There initiatives were varied. The development of specific BME engagement services, attending local community events, engaging with community projects funded by the local authority, and actively capturing as well as monitoring patient demographic details were highlighted as useful action-oriented mechanisms to addressing disparities in mental health outcomes.

4.2.2.3. Initiatives for Black service users

Few participants spoke about initiatives where the benefits for Black people had been considered. Only one example of work that had been carried out to address disparities in mental health outcomes for Black people specifically was described: an academic paper focusing on the experiences of Black men. The other examples, including sitting on a BME mental health board, and using Afrocentric therapies such as Tree of Life, were described as having potential benefits for Black people.

4.2.2.4. Professional and Ethical Issues Associated with Reducing Racial Disparities in Mental Health Outcomes

The participants discussed several professional and ethical issues that can affect how well MHTs are able to address disparities in mental health outcomes. A general sense of discomfort around talking about race was mentioned as having a negative and silencing effect on services' ability to improve outcomes for BME people. Workforce race inequality and a lack of accountability within MHTs and teams were highlighted as being particularly problematic because they resulted in a lack of focus and drive to address disparities in mental health outcomes for BME people. The context of austerity and limited resources was cited as having a detrimental impact on the prioritisation of race inequality over other service demands or other equality and diversity agendas.

4.2.2.5 Factors That Affect Racial Disparities in Mental Health Outcomes

Most participants reflected on the impact of workforce race inequality on mental health outcomes for Black service users. They referenced the associated power

imbalance that comes with belonging to an ethnic minority group by highlighting how decisions made by people belonging to majority groups (e.g. White clinicians) made it harder for them to raise and adequately address this issue. Participants observed that White professionals often chose not to speak about race due to feelings of discomfort and embarrassment underpinned by fears of being seen as racist or "getting it wrong". Conversely, when talking about their own experiences, the participants described feeling discomfort that was characterised by the absence of interest or opportunities or support to talk about race. This is consistent with Fitzpatrick et al. (2014)'s finding that the silencing and suppression of Black voices in academic as well as clinical spaces is isolating for Black mental health professionals, and can lead to Black mental health professionals becoming "a receptacle for anxieties and fears about race" within those spaces (Fitzpatrick, et al., 2014). They also noted that other systemic barriers, such as the "self-exclusion or disengagement of committed White professionals from discourse around ethnicity" can also impact on how safe professionals from all ethnic backgrounds feel to talk about race (Fitzpatrick, et al., 2014).

Participants talked about racial disparities in mental health outcomes not having personal resonance with those who are not affected by it. This can happen as a result of the unconscious investment in maintaining the status quo that is possible if the "colour dynamics" are blanked out; namely "if it doesn't exist in the first place, then it cannot be changed" (Dalal, 2002, p. 219). Therefore, underrepresentation of Black or BME staff at senior levels, presented an additional challenge in terms of prioritising race disparities in mental health outcomes, and having real power and influence within the NHS to make meaningful changes. The concern, was that conversations around race either became subsumed (or possibly lost) under the broader equality and diversity remits or taken off the agendas entirely. The presence of WRES within 88% of the MHTs that responded to the FOIR requests would suggest that some thought around racial disparities in mental health outcomes is taking place within mental health services. However, the accounts from the participants

indicate that much more needs to be done for the WRES to benefit service user outcomes more directly.

Another factor identified was the lack of accountability for the disparities within mental health services. Several participants talked about the importance of having specific race equality roles, strategies or reporting structures in place to monitor or analyse ethnicity data. They expressed their frustration with MHTs and services not having any real incentives that would encourage or put pressure on them to address disparities in mental health outcomes. Rather, striving for race equality was seen as a "tick box" exercise. Without there being any visible processes that would either allow or encourage services to demonstrate their progress towards improving outcomes, services were not being held to account internally (e.g. by senior management) or externally (e.g. by commissioners or the government). This in turn, made it difficult for meaningful steps towards addressing disparities in mental health outcomes to be made, or for anyone to be held accountable in the event that disparities worsened or stayed the same. The importance of having the buy-in from senior management was also noted by Shared Intelligence (2012).

MHT responses to the FOIRS painted a similar picture in terms of the quality and usefulness of the data returned. While most MHTs could provide information about the ethnicity of the patients seen in their services, only a small proportion of MHTs could provide patient outcome data (10%) or use of MHA (15%), and link it to both their ethnicity and the service within which they were seen. Of the 13 MHTs that raised concerns about how much time and / or money it would cost to collate the information requested, 54% of them were in response to the request for outcome, ethnicity and service data. This was an important finding because it raises questions about why it was so difficult for some MHTs to provide this information. It opens up the issue of consistency and communication across and within MHTs: each MHT presented their outcome data in different ways, possibly due to using different systems, or having different protocols within their FOI team or across their MHT. The implications of this will be discussed later in this chapter.

Several participants talked about limited resources within the NHS having a negative impact on MHTs' ability to focus on improving outcomes for Black service users specifically. Services were described as being so phenomenally busy focusing on other pressing issues, that staff were unable to keep racial disparities on their radar. Participants talked about how individuals and services therefore viewed race equality as surplus to their remits, as opposed to part of their core responsibilities and objectives. One participant even described their service as being so overwhelmed by all of its commitments and obligations, it has restructured itself in a way that actually denies, instead of improves, access to patients. The chronic underfunding of Mental Health Services has been well documented within all of the policies aimed at improving and reforming the NHS. As are the disparities in mental health outcomes for Black or BME service users.

This echoes one of the findings from the independent review of the EDS, conducted by Shared Intelligence (2012); lack of resources presented a challenge for MHTs and affected how easy it was for them to focus on and address disparities in mental health outcomes. However, what has changed, is, the emphasis placed on the importance of focusing on racial disparities for service users. Since 2010, the NHS has moved towards a broader equality, diversity and inclusion strategy. However, this change has not necessarily led to any significant improvements as far as disparities in mental health outcomes for service users are concerned. Participants reflected on the impact of this absence of a specific focus on racial disparities in for service users and the lack of resources available to make the necessary changes. These factors were identified as limiting opportunities to improve outcomes for Black service users.

MHTs already have a responsibility to ensure their services do not discriminate against people on the grounds of their race, mandated through the Equality Act (2010) and Public Sector Equality Duty (2011). The WRES and/ or EDS2 should provide a set of standardised processes that support MHTs in their quest to deliver on those responsibilities. These initiatives require that MHTs demonstrate their commitment to non-discriminatory practices by monitoring

and reporting their performance across several indicators. These processes may make it easier to hold MHTs to account internally and externally, if there are racial disparities in the experiences and outcomes for their service users. However, as outlined above, in this current climate, race equality seems to be viewed as surplus to MHT, service and individual practitioner remits, which means that people are less likely to take on the responsibility of improving outcomes for Black service users. This echoes the findings of Salway, Mir, Turner, Ellison, Carter and Gerrish (2016), who identified obstacles to achieving race equality within healthcare was related to the relative lack of attention to race issues in English healthcare policies, ambivalence from senior policy makers, as well as the lack of clarity in terms of expectations from and confidence in commissioning structures (Salway et al., 2016).

4.2.2.5.   Recommendations for Future Practice

All participants shared recommendations on how to address the above issues. They spoke about the division of labour by identifying responsibilities that different people and organisations could adopt and be held accountable for. There was a general consensus that race equality should be everybody's business. Participants talked about Clinical Psychologists being well suited and trained to take on a more active role in promoting race equality within mental health services. Putting race equality back on the national agenda was highlighted as a responsibility for larger organisations, such as the DoH or NHS England. Participants suggested for disparities in mental health outcomes to be addressed sufficiently, changes needed to be made to the way race equality was engaged with at both professional and personal levels. They suggested that the focus on race equality needed to be embedded within the NHS so that it became a core part of MHT, service and individual staff roles and responsibilities. The recommendations have been listed, verbatim, below:

- Race equality should be everyone's responsibility;

- Clinical Psychologists need to step out of their roles more, or at least their traditional roles - the roles that they have been taught to have, and to do more to name abuse of power and oppression and racism and other forms of, kind of, social violence;

- Thinking about diversity should be the bread and butter of psychologists, and actually training that should talk about that more and address that;

- As a training course, we need to do more to encourage to think of clinical psychology as, not just about leadership and management at service level, but it's about leading MHTs, getting a MHT think more collectively about what they're doing with diverse communities;

- Clinical Psychologists need to pay greater attention to who we recruit, and how we recruit, and how we assess;

- Senior management to acknowledge positions of privilege and to make them more responsible for the burden of this dis proportionality;

- A directorate level position is needed on this, where someone is actually responsible for charting, for collecting this data that people are really kind of, where's the data, and for implementing change;

- This needs to be a DoH, to NHS England, to chief execs, saying, actually, you need to see this within our outcomes data; it does need a national initiative.

Participants talked about the importance of taking race equality personally to have any real chance of improving outcomes for Black service users. This can be achieved if the staff working in mental health services have personal values that are aligned with improving wellbeing and mental health through empowerment. This would be supported by a professional context in which staff are encouraged to own the importance of race equality instead of talking about the issues in a detached and neutral way. It was suggested that race equality needs to be "embedded on the agenda" so "that it doesn't necessarily need that Black person in the room to raise it, or the person who's interested in it to raise it. That actually, everyone's interested in it". And when it comes to discussing race equality or difference within teams, all staff can bring themselves and their own experiences into the conversations as a way of bringing those issues to the table, instead of avoiding them entirely.

These recommendations are also in keeping with that of Keating, Robertson & Kotecha (2003). However, they also suggested more specific actions, such as

making engagement with local communities a priority area for service development; capacity building initiatives; health promotion work; and work and team based training programmes as ways of improving the outcomes of BME service users. Salway et al. (2016) also found that individual agency (i.e. individual practitioners' strong commitment to achieving race equality), developing an ethnically diverse workforce, having staff at a senior grade with clearly defined equality and diversity remits, and commissioning structures that draw on varied stakeholders were possible ways of enabling race equality within healthcare.

Amidst the evaluation of their MHTs' current efforts, and recommendations for how to improve outcomes for BME service users, the participants could reflect on the complexity and enormity of race equality as a concept; they talked about the burden they experienced as Black psychologists, which overlapped with the issue of workforce race inequality. They talked about additional duties and uncomfortable experiences that they had encountered when trying to address issues of race within their teams and MHTs; being expected to speak about issues of race in public forums such as meetings, but being castigated or isolated for doing so. As a result, participants spoke about having to think carefully about how they spoke about race, to avoid being pigeon-holed as the mouthpiece for these issues. They also talked about some of the downsides of focusing solely on race when trying to improve outcomes for BME service users, and the importance of holding in mind the multiple identities that we all carry; both as staff and clients.

Being mindful of the professional and ethical issues that can arise when talking and thinking about racial disparities in mental health outcomes will benefit Black service users. By giving staff space to acknowledge and reflect on the messiness and complexity that is involved with trying to achieve race equality, MHTs can ensure that the "burden" of this kind of work can be shared more equally and responsibly across services and teams. Rather than expecting that the difficult dilemmas, conversations and feelings will be dealt with by Black and/or other Minority Ethnicity staff, a willingness for all staff to share some of

the discomfort is necessary to put race back on the agenda. Additionally, having opportunities to think about what services understand by the terms "difference", "intersectionality" and "equality and diversity" when it comes to improving outcomes for the groups that are the most marginalised within and by mental health services.

4.3. Implications

The above section includes some of the recommendations and implications put forward by the participants. I will now consider the broader implications of the findings on practice and policy, drawing on literature where relevant.

4.3.1 The Absence of Strategic Direction

This study found that most MHTs do not currently have a race equality strategy to tackle the observed racial disparities in mental health outcomes for Black service users. Although MHTs are likely drawing upon the WRES and EDS2 to support their thinking and action to address these disparities, the lack of strategic direction and consistency across MHTs, with respect to monitoring and responding to these disparities, means it is difficult to get a clear picture of the extent of this issue. This, in turn, makes it harder to take appropriate action to redress it. There is even less of an impetus to redress these disparities if this issue is not mandated or embedded within policies and practices, or there aren't any consequences or incentives that are determined externally (e.g. commissioners) and have real implications for MHTs (e.g. increased or reduced funding).

This study also found that the issue of underrepresentation within professional groups (e.g. Clinical Psychology) across MHTs (including at senior positions) which means that the burden of race equality is not shared equally across teams. It is, instead, taken on by those who view it as part of, as opposed to surplus to their individual remits. Without the required engagement with this issue, MHTs are not able to assess their performance when it comes to improving disparities in mental health outcomes. This, coupled with the absence of any external pressures that hold MHTs to account for this ultimately

reinforces the idea that addressing racial disparities in mental health outcomes is the business of those who are interested; thereby making this an optional endeavour, as opposed to one that is an integral part of mental healthcare provision. This is echoes Lowe (2014)'s experiences of addressing issues of race and racism within mental health services. He identified lack of personal resonance; fears of being attacked because of previous negative experiences of training or events related to race issues; and the view that events aiming to examine racism are neither helpful nor worthwhile as reasons for mental health staff's lack of interest in redressing racial disparities (Lowe, 2014, p.18).

There is something to be said for the impact of these organisational processes, practices and policies on the mental health outcomes of Black service users. The paucity of mental health outcome data means it is of limited availability and utility in the identification of racial disparities in mental health outcomes. This is essentially the collective failure of MHTs to adequately asses the appropriateness and professionalism of the services they offer to Black service users. This is closely linked with definitions of institutional racism, where the passive and more insidious aspects of this issue are emphasised: "Institutional racism is that which, covertly or overtly, resides in the policies, procedures, operations and culture of public or private institutions - reinforcing individual prejudices and being reinforced by them in turn" (Sivanadan, 1999).

All public institutions, especially mental health services, have an responsibility to review their policies, measure their outcomes, and to develop mechanisms to guard against disadvantaging any section of the community (MacPherson, 1999). Therefore, the implications of the findings are that the absence of explicit, joined up attempts across and within MHTs to identify, and redress disparities: Black people will continue to experience much poorer outcomes than their White counterparts; and MHTs may be viewed as not doing enough to tackle institutional racism within their policies, practices and procedures. This goes directly against the values embedded within the NHS constitution for England, which stipulates that NHS services have a wider social duty to

promote equality and pay particular attention to those whose outcomes are not in keeping with the rest of the population (GOV.UK, 2015).

4.3.1. Workforce Race Inequality

Several participants talked about the impact of workforce race inequality in terms of the burden they experienced for being in the minority. Although the WRES used to address issues of race inequality at the moment, there is still a long way to go to lessen this burden and improve the experiences of Black staff working in the NHS; as of 2017, of the 1.1 million people employed within the NHS, 80.7% of staff identified as White, while the remaining 19.3% of the workforce were made up of BME staff: 9.3% identified as Asian, 5.7% identified as Black, 2.1% identified as "other", and 1.6% identified as Mixed ethnicity (NHS Digital, 2018). Although this does highlight that there are much fewer Black staff working in the NHS compared to their White counterparts, relative to the percentage of Black people living in England, which was 3% in 2011, the data shows that Black people may actually be overrepresented in the NHS workforce. Black people are nonetheless, still in the minority within the NHS. Within the field of Clinical Psychology, figures from HSIC indicate that people from BME groups represent around 9.5% of the workforce ethnic breakdown not currently available). Non-medical Black staff are in the minority within senior positions in the NHS, accounting for 1% of "very senior management" posts, 3.2% of "senior management" posts, 6.3% of "middle management" posts and 3.3 % of senior Black staff in medical roles. Black staff are more likely to experience less favourable treatment, have poorer experiences of work life and fewer opportunities for development and career progression (Naqvi, Razaq, & Piper, 2016).

The above statistics should be interpreted with caution as the data was not collected at the same time, and there are differences in the way the data was categorised (e.g. BME vs specific ethnic groups). Further, workforce data on ethnicity can vary according to geographical area and position or band within the NHS or mental health services generally. This is a criticism of the profession that has been highlighted since the 1980s (e.g. Davenhill, Hunt, Pillary, Harris & Klein., 1989). However, the implications of these findings and statistics are that

Black professionals are at a greater risk of having to face additional challenges, in the form of discrimination, isolation and frustration, when trying to address racial disparities in mental health outcomes within their MHTs. The solution is not necessarily to recruit more Black clinicians in the hope that racism will disappear through osmosis (Patel, 2010). Rather, it is about decolonising MHTs by scrutinising the methods, and practices used within them, as well as the training institutions and curricula of the staff that are recruited into MHTs. As part of decolonising MHTs, there should be opportunities for Black staff to receive additional support and consideration within teams and services.

Many participants talked about the existence of BME spaces in their MHTs, however, few of them could take the time out of their busy schedules to attend these events. Unless there is a culture of talking confidently about issues of race, discrimination and its impact, it is difficult to engage staff in discussions about strategies to address race equality (Griffiths, 2009). There should , therefore, be opportunities for all staff to be able to reflect on race embedded within the processes and practices of the services in which they work.to encourage dialogue and make race equality a priority, opportunities to reflect should enable staff to think and speak about race openly, without fear of "political correctness" (Bhavnani, Miraza & Meetoo, 2005). These opportunities should enable staff to recognise the emotive and deep-rooted nature of talking about race, to minimise the burden and onus on Black staff to take on this responsibility (Griffiths, 2009).

4.3.2. Standardised Processes and Procedures

One of the findings from this study was that there aren't currently any standardised ways of collecting, monitoring or analysing outcome or ethnicity data across the NHS. What this means in practice is that the opportunities to identify disparities in mental health outcomes are contingent on the resources and systems available within a particular MHT, as well as the practices adopted within services and by individual practitioners. The implication is that until there are standardised ways of collecting, monitoring and analysing this information, MHTs won't be in a position to identify, make sense of or address any disparities in mental health outcomes for people who access their services. It is

important that the infrastructure within mental health services is sophisticated and robust enough to support this type of work.

Previous attempts to create networks and portals that aimed to facilitate the standardisation of data across the NHS have not been hugely successful (e.g. NHS Net, N3 programmes and RiO). Prior to working within the NHS within a clinical capacity, I was employed by British Telecom (BT) as an Account Manager for Mental Health Trusts in London. I saw first-hand how complex and disparate the technological systems used within the NHS were (and still are), as well as the challenge MHTs and supplies faced when trying to streamline and standardise patient information platforms across their own sites, and across the NHS. The main issue was that MHTs operate in vastly different ways owing to various factors, including differences in funding, the population they serve, and the ethos of the MHT. Therefore, the organisation of their services, use of information systems, outcome measures etc. tended to be relevant to their local context, as opposed to a broader national context. The challenge of trying to standardise processes and systems should not be underestimated. However, the importance of enabling services to capture and monitor meaningful data so that they can improve the quality of their provisions for everyone, including those who are most marginalised, must not be taken for granted either.

Before any attempts to standardise practice or processes are carried out, thought needs to be given to the type of outcome measures that are used to identify disparities. At present, the most commonly used outcome measure within MHTs is HoNOS. This is a measure of mental health and social/behavioural functioning, and can be used to evaluate the effectiveness of a mental health intervention (Wing, et al., 1998). However, concerns regarding its validity, reliability and overall utility have been raised (e.g. Gilbody, House & Sheldon, 2002; Pirkis, et al., 2005); Thornicroft & Slade (2014). Therefore, before meaningful conclusions can be drawn about the effectiveness of an intervention, or the nature of any disparities in mental health outcomes, the data yielded from this measure, and outcome measures in general, should always be interpreted with caution and be contextualised through corroboration with other

sources of information (e.g. observation, the service users and their family, socio-political factors etc.) and other outcome measures (e.g. Recovery Star).

In addition, most outcome measures used within MHTs are insufficiently sensitive to the aspects of service users' lives which are outside the control of the mental health service (Thornicroft & Slade, 2014). The assumption held by MHTs when they focus on social functioning as opposed to social disadvantage is that they are not in a position to influence the social determinants that may impact upon service users' wellbeing (Thornicroft & Slade, 2014). One way of doing this would be to "measure valued social roles which reinforce social identity, and individual goals which contribute to personal identity" (Slade, 2010). Considering the levels of social disadvantage and trauma Black service users are subjected to (e.g. SCMC, 2002), I would be keen for MHTs to adopt an outcome measure that, additionally to the suggestion above, acknowledges service users' distress or mental health / illness in relation to their experiences of social disadvantage and traumatic experiences. This may create a context where MHTs are held accountable for achieving race equality and are assessed on their performance in addressing causes of social disadvantage and trauma.

4.3.3. Equality or Equity?

The terminology used to conceptualise the observed disparities in mental health outcomes has often positioned race equality as the ideal that mental health service, and indeed society should strive for. This concept relies upon the assumption that, politically, and legally equal, and should be treated as such" (Encyclopedia.com, 2016). A recent collaboration between Centre for Story-Based Strategy, the Interaction Institute for Social Change (IISC) sought to highlight some of the limitations of how this assumption works in practice.

Figure 5. Race Equality

EQUALITY

Source: Interaction Institute for Social Change | Artist: Angus Maguire (2016)

In Figure 5, above, they show how people who have different needs will require different support to achieve the same (or similar) outcomes. Froehele (2012) argued that providing people with equal opportunities (e.g. the same size crates) alone wasn't a satisfactory goal and that we should somehow take into consideration equality of outcomes (i.e. fairness or equity)" (IISC, 2016). This illustrates why disparities in mental health outcomes for Black service users may persist if MHTs' attempts to address this issue by using generic Equality and Diversity programmes and Race equaliy Strategies. Racial equity, conversely, "results when you cannot predict when you cannot predict an outcome by race" (Race Matters Institute, 2014). It places emphasis on recognising and catering to differences in people's needs. The mechanisms for achieving race equity are visually represented in Figure 6 below.

Figure 6. Race Equity

EQUITY
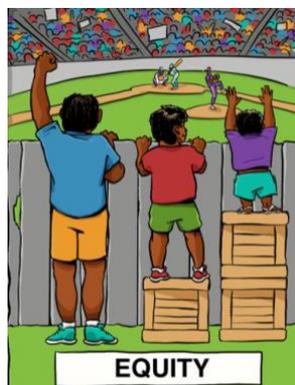
Source: Interaction Institute for Social Change | Artist: Angus Maguire (2016)

To tackle disparities in mental health outcomes for Black service users, therefore, it is important that all of their contexts are addressed during their contacts with mental health services, so that their issues "are taken into account and seen as legitimate areas of inquiry and action" (Patel & Fatimilehin, 1999, p. 67). MHTs should challenge the assumption that they are not in a position to influence the social determinants that may impact upon service users' wellbeing, as well as their outcomes (Williams, et al., 1996).

The availability of high quality information and support may also impact on race equality within mental health services. For example, if there ways of documenting and disseminating examples of good practice, new ideas, and reflections on issues of race, such that they are embedded into the processes and systems that are used within mental health services. Making use of technology to streamline these processes would likely benefit staff as well as service users. For example, the use of a shared, cross-NHS portal for staff to communicate ideas or actual examples of good practice, or dilemmas could foster a culture of transparency and openness to thinking about race that is more engaging and diverse. Creating resources that are accessible to a large number of people, for example, via YouTube or using posters to convey these messages may also enhance the visibility of important work being carried out.

4.3.4. The Government and National Bodies

Participants recommended that the government and national bodies, such as the DoH and NHS England should have a more active role in improving the outcomes of Black Service users. During their debate in the House of Lords (2018), politicians acknowledged a more coordinated response from the government is needed. Within the government's race disparity audit, they stated that "collecting the data is not enough. We must ensure data is published, accessible, transparent and, most of all, used to inform how we can improve our country for all" (Cabinet Office, 2018). Given the enormity and importance of this topic, future attempts to identify, monitor and address this issue should form part of a national strategy or approach to improving the quality of service provision across the NHS.

Without the investment from the government and national bodies, attempts to achieve race equality in MHTs will be futile, replicating the current landscape of disparate systems and approaches. Although there are signs that these issues are being considered at a national level, race needs to be put on the agenda such that MHTs are held to account by the government and national bodies when disparities in mental health outcomes for Black service users are present. This would involve the government supporting MHTs to standardise the collection, monitoring and analysis of outcome and ethnicity data. There should be ways that all of this data can be monitored and analysed at both local and national scales. Most importantly, race equality must be seen as integral to MHT remits, with an emphasis on creating spaces to think and talk about ways of reduce disparities in the monitoring of MHTs performance in tackling this issue. I propose that there are annual national audits and opportunities to evaluate MHT performance in this regard, with a view to supporting as opposed to penalising MHTs that are underperforming.

4.3.5. The Role of Clinical Psychologists

As I have outlined earlier in this discussion, it is the responsibility of all professionals working within mental health services, to redress racial disparities in mental health outcomes. This study has also highlighted specific responsibilities that Clinical Psychologists can take on as an integral part of their role. For example, participants suggested that psychologists step outside of their traditional roles more, name the abuse of power, develop better recruitment strategies, make use of our training to think and work more systemically, and develop clinical psychology training programmes that equip trainees to address racial disparities in mental health outcomes. These recommendations are in keeping with the view held by Vera, Camacho, Polanin and Salgado (2016) who suggest that Clinical Psychologists should in addition to fostering inclusion and equality, develop anti-racism awareness and practices (Wood & Patel, 2017; Patel, et al., 1999). Turpin & Coleman (2010) also add that it is important to recruit a diverse selection of people onto clinical training courses. Furthermore, they suggest that clinical courses must also be aware of and sensitive to the needs of diverse trainee cohorts, as well as the diverse

clinical populations served by trainee Clinical Psychologists (Turpin & Coleman, 2010). Clinical psychologists providing training can also support doctoral programmes to provide a broad range of cultural knowledge, and also help future trainees develop the skills necessary to acquire relevant cultural knowledge themselves (Turpin & Coleman, 2010).

There may also be an overlap with Clinical Psychologists' responsibilities and those that the participants ascribed to senior management. This is because Clinical Psychologists can occupy these spaces within mental health services, therefore those working in a senior management position should use their relative power and influence as an opportunity to actively redress racial disparities in mental health outcomes. Ellix and Subbuswamy (2008) highlight a number of ways in which this can be achieved. For example, linking agendas around alternatives to the medical model (e.g. social models/recovery/person centred approaches), providing safe spaces for employees and service users/carers to explore and discuss issues affecting recovery or practice (including the impact of racism); working to develop more representative mental health workforces; and learning from innovative practices (Elix & Subbuswamy 2008, p. 66-68). A clearer strategy for tackling racial disparities in mental health outcomes and needs to be developed within and by the profession (e.g. the BPS) and embedded within the main role and responsibilities of Clinical Psychologists.

4.3.6. Strengths and Limitations
Some of the limitations and ethical dilemmas of this study, with respect to its design, and methods, have been addressed in earlier chapters. I have used Spencer and Ritchie (2011)'s guidelines to support my thinking further.

4.3.6.1. Rigour
Rigour is often viewed as being synonymous with the validity of the method (Spencer & Ritchie, 2011). A study that is rigorous is transparent as a result of the careful documenting and reporting of research decisions, orientations, roles and impacts (Lincoln & Guba, 1985; Merrick, 1999). I ensured that there was a clear logic of inquiry by describing how the project was developed, as well as

providing a detailed overview of the project design, methodology, data collection and analysis phases (e.g. excerpts of raw data and how it was analysed in Appendices M-P). This was done to showcase the thinking that took place to ensure the study was able to meet its aims (Fournier & Smith, 1993; Mason, 2002; Patton, 2002; Mitchell & Bernaurer, 1998; Strauss & Corbin, 1998). I used reflexivity within these sections to document my consideration of and attempts to address ethical dilemmas.

4.3.6.2. Contribution

Spencer and Ritchie (2011) talk about contribution as the value and relevance of research evidence produced by a project. This is in terms of enhancements to existing theory, policy, practice, methods and or the lives and circumstances of individuals. The topic of racial disparities, racism within mental health systems and disparities in the experiences and outcomes of people from BME backgrounds has been written about extensively. It was beyond the scope of this study to document and examine all in depth all of the previous attempts to redress racial disparities that have taken place in the UK; it has overlaps with huge, complex areas such as public health policy, and is deeply interlinked with national and international socio-politico-historical and legal developments spanning several centuries.

In addition, the recommendations previously put forward by mental health professionals are still extremely relevant, and applicable to the disparities described in this project. However, it is equally important to revisit and generate new ideas about how to tackle racial disparities on a small scale (e.g. recording ethnicity on patient information systems), as well as at a national level (e.g. race equity strategies). Therefore, the main contribution of this study is that it demonstrates why it is important to keep race on the agenda. It is a conversation piece, and an opportunity to reflect on the current state of mental health service provisions within the NHS. I will be joining the mental health workforce as a qualified Clinical Psychologist, and in the lead up to this, I wanted to use my "outsider-within" status to conduct this research not to undermine the extensive work that has been carried out previously to address

this issue, rather, it was to demonstrate my commitment to dismantling institutional racism, and developing services that are truly equitable to all. It is also an invitation for those who are share a similar passion or are committed to this plight in other ways to connect with me or each other on this topic.

Other more specific contributions include the fact that this is the first study to investigate what is currently being done within the NHS to improve outcomes for Black service users specifically, as opposed to the broader category of BME service users. As such, it has contributed to existing knowledge about attempts to reduce disparities in mental health outcomes for Black service users by providing a snapshot of the current landscape of the race equality strategies, policies and practices used within the NHS. And also offers some recommendations about how to improve practice. The literature review, additionally, provides an updated and more thorough overview of the historic developments in racial policy, legislation and guidance in England, as well as their relevance within mental health services and to Black service users.

Previous studies involving interviews with Black psychologists or therapists have tended to focus more explicitly on the participants' relationship to the profession, and their identity (e.g. McNeil, 2010; Shah, 2010; Paulraj, 2016; Adetimole, Afuape & Vara, 2005). This study focused, instead, on Black Psychologist's perspectives of the current policies and practices within their services and MHTs in the absence of a national race equality strategy. There were, nonetheless, some overlaps with previous studies, in that the findings from the interviews were underpinned by the participants' relationship to their identity and the profession. However, this was not the main focus. By combining the findings from the FOIRs and the interviews, this study offers an insight into some of the factors that might enrich understandings of the current professional and ethical issues entangled with reducing racial disparities in mental health outcomes.

4.3.6.3.   Credibility
Spencer and Ritchie (2011) refer to credibility as the defensibility and plausibility of the claims made by researcher, or the 'believability' of the findings. To

enhance the credibility of my findings, I developed the questions in conjunction with a variety of stakeholders with various specialist knowledges, to enhance the validity of the questions. In doing so, the questions used in both the FOIRs and interviews were relevant to the overarching research questions. Additionally, I drew on the guidelines of experienced researchers (e.g. Braun & Clarke, 2006) to systematically collect and analyse my qualitative data. I reviewed my preliminary findings for both FOIRs and interviews with my research supervisor, and made adjustments where necessary (e.g. where themes needed to be refined or where descriptive statistics needed to be revised).

4.3.6.4.   Limitations

The main limitations were related to the size of the research areas covered. I talked very broadly about the disparities in direct and indirect outcome measures for Black service users. Initially, I made the decision to steer away from a more specific outcome measure to allow for the variation in outcome monitoring processes and tools used within different MHTs. However, by keeping the definition of outcomes so broad, I struggled to draw many meaningful conclusions about the mechanisms for capturing and monitoring outcomes across MHTs. This also had implications for the literature included in the introduction and the discussion sections, as "race" and mental health policy are complex areas that have been written about extensively in different ways. I may have benefitted from making the focus of the project much more specific by looking at one particular mental health outcome (e.g. use of MHA, or HoNOS) or even one particular ethnic group (e.g. Black Africans). I imagine that doing so may have enabled me to make more specific observations about the use of outcome measures as well as what this meant for a particular ethnic group. I talked broadly about what MHTs are doing with regards to Adult mental health services, and Black service users. As a result, the findings from this study would not be able to justifiably make claims about service users' outcomes on specific measures, within specific services that relate to specific ethnic groups (e.g. African or Caribbean).

I also acknowledge that by focusing on only the perspectives of Black Clinical Psychologists, the wider picture of why there are disparities in mental health outcomes for Black people is narrowed significantly. Speaking with mental health professionals from other disciplines and trying to capture a multidisciplinary team or service perspective may have enabled me to get a richer understanding of how these disparities in mental health outcomes are conceptualised within the wider mental health system. It may have also been a good opportunity to get a sense of how other disciplines have attempted to redress these disparities, and what ideas they have about how to improve mental health outcomes for Black service users.

Other limitations relate to the methodological approaches used. Although there are several benefits to using FOIRs to conduct research on a large scale (see Methodology chapter) a major drawback of using its approach is the information collected is subject to several extraneous variables that cannot be controlled by the researcher. Namely, FOIRs are usually responded to by a dedicated FOI officer or manager. However, in reality, the FOIRs were responded to by several different people, including (but not limited to) an FOI officer, an assistant psychologist, a Human Resources Advisor, an Information Rights officer and an administrator. Data collected using FOIRs is based on the information that the FOI officer is able to obtain via their MHT reporting structures, their own workload, the reasonable request limits and knowledge of the FOIR topics. The impact of these extraneous variables could be seen in the variations in the way MHTs responded, in terms of how the requests were interpreted, as well as the quality and presentation of the information.

Although I was able to standardise the data analysis process to minimise the impact this had on the quality of the findings, it meant that some of the data that was provided by the MHTs was either uninterpretable or could not be compared with the information provided by other MHTs. It seems that some of the information shared by the participants about the work that is being done in their services to improve outcomes for Black service users was not included in the information collected using FOIRs. The findings from the FOIRs may not,

therefore, accurately reflect all of the work that is going on inside MHTs to address disparities in mental health outcomes for Black service users. Rather, they are reflective of what the FOIR officer was able to report based on their access to certain information and resources.

4.4. Future Directions

4.4.1. Future Research
There are several aspects of this topic that were not covered because they were beyond the scope of the present study. However, future researchers may be in a better position to explore these areas after reviewing the findings and critical evaluation of this study. For example, this study may have benefitted from focusing on MHT's use of one or two specific outcome measures (e.g. the use of Mental Health Act or HoNOS), and also focusing on specific services (as opposed to all Adult Mental Health Services), and / or specific ethnic groups (e.g. African or Caribbean).

There may also be value in using additional methods that facilitate data collection that benefits from both the breadth of information that can be obtained using FOIRs, and the context and relative depth afforded to research through the use of interviews. Perhaps this could be achieved through a series of projects which evaluate an individual MHT's work to improve outcomes for Black service users across all its services / directorates, and then replicate this across all the MHTs in the UK. Other avenues for future research could also include capturing the experiences or perspectives of other people, including Black service users, non-clinical staff, commissioners, and/ or clinical staff from other disciplines and of different ethnic backgrounds. This could serve as an additional source of important information about what MHTs are currently doing and what they may need to do differently to improve outcomes for Black service users. The use of focus groups, or individual interviews drawing on different epistemic and ontological assumptions may also be useful in highlighting the intricacies of experiences and perspectives held by different people and systems within MHTs.

4.4.2. Future Practice

A number of recommendations for future practice have been highlighted earlier in the discussion. For example, it is crucial that standardised processes and procedures, with respect to the recording of ethnicity, are implemented within mental health services and indeed all public services. Not all MHTs, services or clinicians will use the same clinical outcome measures, however, it is important that the measures being used are used meaningfully and that there is scope to examine mental health outcomes alongside race/ethnicity, other demographic information and experiences of social disadvantage. This may help MHTs be more responsive to the specific needs of Black service users, and put them in a better position to identify and challenge the social determinants that may impact upon service users' wellbeing, as well as their outcomes.

National bodies, such as the DoH, and NHS England, will be integral to national attempts to redress racial disparities in mental health outcomes. A clear, race equality strategy that is aligned to a performance framework will be required to monitor progress towards achieving race equity in mental health outcomes. Such frameworks would also be useful in identifying MHTs that may require additional support or resources to realise this commitment in full.

As a clinician, it has been useful to see first-hand, how something as concrete and immediate as keeping good records, (e.g. demographic and clinical outcome data), can have an important role in identifying and redressing racial disparities in mental health outcomes. Although I had an appreciation for this before, I feel that the learning I have taken away from this process will enable me to have discussions with my colleagues about the small daily contributions we can make to reduce racial disparities and how they fit into a much larger race equity strategy within the service or Trust. It will also encourage me to think more creatively about how to identify, monitor and address disparities in other ethnic groups or for other aspects of people's identities that predispose them to poorer outcomes within mental health services. I also hope to seek out opportunities work alongside colleagues, service users, carers and families to

develop, monitor, evaluate and / or refine initiatives, policies or guidelines that aim to reduce racial disparities in mental health outcomes.

This project has also highlighted the importance of developing and maintaining networks of support in personal and professional contexts, especially with other people from BME backgrounds. As such, I anticipate that I will be much more active in seeking out and developing relationships with or within these networks. For example, within established spaces like The Black African and Asian Therapy Network (BAATN), Race On The Agenda (ROTA), and Minorities in Training Group. I would also be interested in offering a form of mentoring or peer support to those who are interested in doing research in a related field. I think I would have benefitted from this immeasurably during this process, and feel I have a lot to contribute in terms of the learning from dilemmas and challenging situations that could be of use to other people.

4.4.3. Dissemination

One of my aims was to stimulate conversations about addressing racial disparities in mental health outcomes. Therefore, it is important that the findings from this study are accessible to as many people as possible. With the support of my research supervisor and research team at the University of East London, I intend to publish the findings in a peer-reviewed journal. I hope to summarise my findings in poster and video formats, so that they can be shared across several professional networking platforms, such as the UK-wide Clinical Psychologist Facebook group, and Minorities in Training Group.

I have also spoken with the Black Clinical Psychologists who participated in this study about arranging a follow up meeting where I will share with them the findings from the research, and also offer them an opportunity to connect with each other and discuss their experiences of being part of this project. It is also hoped that if participants feel comfortable, that participants will also contribute to the dissemination of the findings by sharing their experiences with their friends, families or colleagues.

4.5.   Reflexive Review

As noted in the introduction, reflexivity is an important part of conducting ethical research (Attia & Edge, 2017). I will now present a reflexive review that focuses on the effect I had on the findings (prospective) as well as the effect the research had on me (retrospective). Additional reflections documented throughout this process can be found in Appendix Q.

4.5.1. Prospective Reflexivity

Jordan, Bogat & Smith (2001) have suggested as a Black Trainee Clinical Psychologist, my race or ethnicity likely predisposed me to "initiate debate and research on race and cultural issues, and to advocate on behalf of Black communities". In terms of execution and analysis, it is difficult to say to what extent my identities, both personal and professional, have impacted on how I interacted with the participants, what I attended to during the interviews and analysis, or on how the project was written up. However, I attempted to explore this in a more "objective" way, by asking the participants "What was it like being asked these questions by a Black Trainee Clinical Psychologist?". On the whole, participants shared that they felt validated, safer and more comfortable speaking with me because I am Black. They acknowledged this feeling was likely underpinned by an assumption that we had shared understandings and possibly experiences in relation to the research topics. This in turn seemed to enable them to be more open and less tempered in the interviews.

4.5.2. Retrospective Reflexivity

In the introduction, I talked about how the experience of moving from a multi-ethnic area to a predominantly White one had a profound effect on my understanding of what it means to be Black. I believe this affected my ability and / or willingness to engage with important aspects of my identity, including my family history and the histories of other Black people. As a result, I never really felt like I had a good grasp of the socio-political and historical context of Black people's lives and experiences. So when I embarked on this project, although I was initially excited about having the opportunity to finally connect

with a part of me that I had disavowed from an early age, I was completely overwhelmed by the breadth and depth of the topics I chose to research.

Owing to the overreliance upon the term BME in the literature, this was the first study to look specifically at the outcomes for Black service users. Consequentially, I did not know where or how to start, and often felt as though I wasn't doing a good enough job to explore and highlight issues of this magnitude and importance. I was haunted by statistics I had come across about BME Trainee psychologists not performing as well academically as their White peers (e.g. Scior, Bradley, Potts, Woolf, & Williams, 2014). The focus on Black Clinical Psychologists and Black service users caused me to put a huge amount of pressure on myself to do the project "justice"; although, I can't say I know what I meant by this. In any case, throughout all stages of this process, I felt paralysed by the enormity of the task in front of me, and wondered whether I ever had a chance at proving to myself, and others, that I would beat the odds.

Developing, executing and writing up this project has definitely been one of the most difficult things I have ever done in my life. It also helped me to be more appreciative of those who have contributed to the literature and discussions on racial disparities in mental health services. It also enabled me to be understanding of those who may choose not to take on this endeavour in a formal capacity (e.g. academic writing). The main thing I have taken away from this process is that there isn't a perfect way to "do race" in research. Rather, there are several dilemmas and challenges that are inextricably linked with this topic. Instead of thinking about the enormity and painfulness of the topics as barriers to engaging with issues of race or racial disparities in mental health outcomes, these dilemmas and challenges can serve as an opportunity to connect with the feelings of discomfort and pain that are necessary for real growth and change to take place. Instead of putting pressure on myself to produce the perfect thesis, I started to view this project as laying the foundation for future research and conversations. It was by understanding this that everything had purpose and meaning: I was able to embrace the difficult feelings I experienced throughout and appreciate that this project is bigger than

me. The possibility that my findings could positively impact on the lives of others kept me going.

5. CONCLUSION

I hope that this project has been able to show that although there aren't many published policies, initiatives or programmes designed to improve the outcomes of Black service users specifically, it is nonetheless an important issue that demands the attention, investment and coordinated involvement of the government, national bodies like the DoH and NHS England, as well as MHTs, and individual practitioners. The current landscape requires further interrogation before national policy recommendations are rolled out. However, in the absence of any overarching race equality strategy, it is everyone's responsibility to acknowledge and challenge racial disparities in mental health outcomes and protect the human rights of those who are most marginalised within and by mental health services, and society on the whole.

I will conclude by stating that the findings, implications and their associated recommendations should not become part of another tick-box exercise, nor should they be subsumed under another Equality and Diversity initiative. Racial disparities in mental health outcomes is a big enough issue on its own, and it deserves to be dealt with as such.

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7. APPENDICES

UNIVERSITY OF EAST LONDON
School of Psychology

APPLICATION FOR RESEARCH ETHICS APPROVAL

FOR RESEARCH INVOLVING HUMAN PARTICIPANTS

FOR BSc RESEARCH

FOR MSc/MA RESEARCH

FOR PROFESSIONAL DOCTORATE RESEARCH IN CLINICAL, COUNSELLING & EDUCATIONAL PSYCHOLOGY

*Students doing a Professional Doctorate in Occupational & Organisational Psychology and PhD candidates should apply for research ethics approval through the University Research Ethics Committee (UREC) and not use this form. Go to: http://www.uel.ac.uk/gradschool/ethics/

If you need to apply to have ethical clearance from another Research Ethics Committee (e.g. NRES, HRA through IRIS) you DO NOT need to apply to the School of Psychology for ethical clearance also.
Please see details on www.uel.ac.uk/gradschool/ethics/external-committees.
Among other things this site will tell you about UEL sponsorship
Note that you do not need NHS ethics approval if collecting data from NHS staff except where the confidentiality of NHS patients could be compromised.

Before completing this application please familiarise yourself with:

The *Code of Human Research Ethics (2014)* published by the British Psychological Society (BPS). This can be found in the Ethics folder in the Psychology Noticeboard (Moodle) and also on the BPS website
http://www.bps.org.uk/system/files/Public%20files/code_of_human_research_ethics_dec_2014_inf180_web.pdf

And please also see the UEL Code of Practice for Research Ethics (2015)
http://www.uel.ac.uk/gradschool/ethics/

HOW TO COMPLETE & SUBMIT THIS APPLICATION

1. Complete this application form electronically, fully and accurately.

2. Type your name in the 'student's signature' section (5.1).

3. Include copies of all necessary attachments in the ONE DOCUMENT SAVED AS .doc (See page 2)

4. Email your supervisor the completed application and all attachments as ONE DOCUMENT. INDICATE 'ETHICS SUBMISSION' IN THE SUBJECT FIELD OF THIS EMAIL so your supervisor can readily identity its content. Your supervisor will then look over your application.

5. When your application demonstrates sound ethical protocol your supervisor will type in his/her name in the 'supervisor's signature' section (5.2) and submit your application for review (psychology.ethics@uel.ac.uk). You should be copied into this email so that you know your application has been submitted. It is the responsibility of students to check this.

6. Your supervisor should let you know the outcome of your application. Recruitment and data collection are **NOT** to commence until your ethics application has been approved, along with other research ethics approvals that may be necessary (See 4.1)

ATTACHMENTS YOU MUST ATTACH TO THIS APPLICATION

1. A copy of the invitation letter that you intend giving to potential participants.

2. A copy of the consent form that you intend giving to participants.

3. A copy of the debrief letter you intend to give participants (see 23 below)

OTHER ATTACHMENTS (AS APPROPRIATE)

- A copy of original and/or pre-existing questionnaire(s) and test(s) you intend to use.

- Example of the kinds of interview questions you intend to ask participants.

- Copies of the visual material(s) you intend showing participants.

- A copy of ethical clearance or permission from an external organisation if you need it (e.g. a charity or school or employer etc.). Permissions must be attached to this application but your ethics application can be submitted to the School of Psychology before ethical approval is obtained from another organisation if separate ethical clearance from another organisation is required (see Section 4).

Disclosure and Barring Service (DBS) certificates:

- **FOR BSc/MSc/MA STUDENTS WHOSE RESEARCH INVOLVES VULNERABLE PARTICIPANTS:** A scanned copy of a current Disclosure and Barring Service (DBS) certificate. A current certificate is one that is not older than six months. This is necessary if your research involves young people (anyone 16 years of age or under) or vulnerable adults (see Section 4 for a broad definition of this). A DBS certificate that you have obtained through an organisation you work for is acceptable as long as it is current. If you do not have a current DBS certificate, but need one for your research, you can apply for one through the HUB and the School will pay the cost.

  If you need to attach a copy of a DBS certificate to your ethics application but would like to keep it confidential please email a scanned copy of the certificate

directly to Dr Mary Spiller (Chair of the School Research Ethics Committee) at m.j.spiller@uel.ac.uk

- **FOR PROFESSIONAL DOCTORATE STUDENTS WHOSE RESEARCH INVOLVES VULNERABLE PARTICIPANTS:** DBS clearance is necessary if your research involves young people (anyone under 16 years of age) or vulnerable adults (see 4.2 for a broad definition of this). The DBS check that was done, or verified, when you registered for your programme is sufficient and you will <u>not</u> have to apply for another in order to conduct research with vulnerable populations.

<u>Your details</u>

1. **Your name:** Fabienne Palmer

2. **Your supervisor's name:** John Read (Director of Studies) and Chanelle Myrie

3. **Title of your programme:** Professional Doctorate in Clinical Psychology

4. **Title of your proposed research:** What are clinical psychologists doing to redress the disparities in outcomes for Black service users?

5. **Submission date for your BSc/MSc/MA research:** May 2018

6. **Please tick if your application includes a copy of a DBS certificate** **NO**

7. **Please tick if you need to submit a DBS certificate with this application but have emailed a copy to Dr Mary Spiller for confidentiality reasons (Chair of the School Research Ethics Committee)** (m.j.spiller@uel.ac.uk) ☐

8. **Please tick to confirm that you have read and understood the <u>British Psychological Society's Code of Human Research Ethics (2014)</u> and the <u>UEL Code of Practice for Research Ethics</u>** (See links on page 1) ☑

<u>2. About the research</u>

9. **The aim(s) of your research:**

The proposed research aims to address the following questions:
- What are NHS mental health trusts in the UK currently doing to redress the disparities in mental health outcomes for Black service users?
- What role do Clinical Psychologists have in improving outcomes for Black service users?

Likely duration of the data collection from intended starting to finishing date:

The collection period is likely to take place during May 2017 – January 2018.

Methods

10. Design of the research:

This study will employ a mixed-methodology, non-experimental design.

<u>Survey:</u>
A survey, in the form of Freedom of Information Requests (FOIs) will be distributed electronically, via email, to the Freedom of Information Officers within all 71 Mental Health Trusts in the UK. The researcher will ask questions that explore what each Trust currently does to monitor, evaluate and improve the outcomes of Black service users. The sample questions, will be piloted with 3 Trusts, and refined accordingly.

Data obtained from the survey will be coded so that it can be analysed using descriptive statistics to highlight the proportion of trusts that are making some attempts to address this issue. Some of the findings will also serve to contextualise the findings from the qualitative aspect of this study. See Appendix A for sample coding system.

<u>Interviews:</u>
The researcher will conduct individual, semi-structured interviews exploring the role of Clinical Psychologists in redressing disparities in mental health outcomes for Black service users. The interview schedule will be refined in partnership with a range of stakeholders (e.g. professionals with an interest in this area).

Interviews will be recorded and transcribed into text by the researcher. The data will then be examined following Clarke and Braun's (2006) guidelines for Thematic Analysis. A top-down strategy will be employed, where the researcher will look for patterns across the transcripts relating specifically to: what trusts are currently doing, as well as the role of Clinical Psychologists in addressing disparities in mental health outcomes for Black service users.

12. The sample/participants:

<u>Survey</u>
Every Mental Health Trust in the UK will be emailed using the Freedom of Information Act (2000). The researcher anticipates a good response and participation, because the act legally obligates Trusts to respond to these requests within 20 working days.

<u>Interviews</u>
The researcher will interview 10-12 Clinical Psychologists who have been practicing as qualified staff for 3 years or more. Inclusion criteria will be determined in collaboration with other relevant stakeholders, in conjunction with the preliminary analysis of findings from the survey.

13. Measures, materials or equipment:

The study will require access to a confidential interview room, recording equipment, secure storage, transcription software, printer, paper, pens and internet.

14. If you are using copyrighted/pre-validated questionnaires, tests or other stimuli that you have not written or made yourself, are these questionnaires and tests suitable for the age group of your participants?

N/A – the proposed study will not use copyrighted/pre-validated questionnaires.

15. Outline the data collection procedure involved in your research:
(Describe what will be involved in data collection. For example, what will participants be asked to do, where, and for how long?)

<u>Survey</u>
The Freedom of Information Officers of each Mental Health Trust surveyed will be emailed Freedom of information requests. The requests will feature several questions (see Appendix B). Under the Freedom of Information Act (2000), the Freedom of Information Officers will be required to grant the researcher access to various pieces of information held by each Trust.

<u>Interviews</u>
The researcher will conduct 10-12 individual semi-structured interviews that last up to 1 hour. The researcher will summarise what the study is about, and give the participants an opportunity to ask questions. Participants will be asked to read the information sheet and sign consent form if they are happy to participate in the study. Participants will be asked questions (see Appendix B for draft interview schedule) and their responses will be recorded). The data captured from the interviews will be transcribed by the researcher.

3. Ethical considerations

Please describe how each of the ethical considerations below will be addressed:

16. Fully informing participants about the research (and parents/guardians if necessary):

The Freedom of Information requests will include a statement that the request is part of this research project

Prior to taking part in the interview part of the research, all participants will be provided with a standardised written information sheet, detailing the purpose and nature of the study, as well as the participant's rights to withdraw from the research at any time. Participants will also be given the opportunity to ask questions before, during and after the study should they need any further information and/or clarification.

17. Obtaining fully informed consent from participants (and from parents/guardians if necessary):

Each potential interviewee will be asked to sign a consent form, once they have read the information sheet and have, should they wish, asked any further questions. This

will take place before the interviews commence.

18. Engaging in deception, if relevant:

N/A

19. Right of withdrawal:

Participants will be advised of their right to withdraw from the research study within one month of the interview without any penalty or disadvantage to them. They will also be informed that they can do this without being obliged to provide any reason. This will be made clear to participants on the information sheet and consent form. If a participant decides to withdraw from the study, I would offer the participant the option for their contribution (e.g. any audio recordings and interview transcripts) to be removed and confidentially destroyed within 2 weeks of taking part in the interviews.

20. Anonymity & confidentiality: (Please answer the following questions)

20.1. Will the data be gathered anonymously?

NO

21. If NO what steps will be taken to ensure confidentiality and protect the identity of participants?

. All participant details will be kept in a locked environment and not shared with anyone else. Participant names will not feature on interview transcripts.

Participant's confidentiality will be protected as much as possible by using pseudonyms and removing any identifying references from interview transcripts and extracts in the final thesis as well as any resulting publications. Audio recording files will be stored on a password-protected computer, and will be deleted securely after the thesis has been examined. Only the researcher, and the Director of Studies, will have access to these files and a transcription will be carried out by the researcher. Transcripts will be available to the researcher and the researcher's supervisor, and be kept for three years after the study has been completed. Following this, all transcripts will then be destroyed securely.

Confidentiality may need to be broken if anything they say gives the researcher cause to believe someone may be at risk of harm. Except in extreme circumstances, where doing so would increase risk, participants will be informed of this prior to taking part in the study.

22. Protection of participants:

There are no potential hazards or risks of injury or accident to participants. It is possible that participants could become upset if they talk about topics or experiences they find to be distressing or emotional. The researcher will be vigilant, looking out for any indications that a participant is becoming upset or distressed. The researcher will then ask the participant what they would like to do (e.g. continue, take a break, resume at a later date, withdraw etc.). The researcher will provide each participant

with the details of organisations that can offer further support.

23. Protection of the researcher:

There are no specific risks to the researcher. Interviews will be conducted at the University of East London, unless otherwise requested by the participant. This will be discussed/negotiated with the Clinical Supervisor and they will be aware of the times (and locations) of all interviews. The researcher will also confirm via text message or when they have completed each interview.

24. Debriefing participants:

This is a non-experimental study, which does not involve any level of deception. Participants will be given the opportunity to ask me questions, should they wish to, at the end of the interview. Participants will also be reminded of how their data will be stored and used, and I will confirm whether they are still happy for their data to be used in the research. I will also advise participants of their right to withdraw their data from the research by contacting me via email or telephone up to 2 weeks after taking part in the interviews.

25. Will participants be paid?   NO

26. Other:

                                                                      N/A

4. Other permissions and ethical clearances

27. Is permission required from an external institution/organisation (e.g. a school, charity, local authority)?

   YES

Permission will be sought from the individual Research and Development Departments of the organisation(s) employing the Psychologists who will be invited to take part in this study. Once obtained, this evidence will be attached to the ethics application.

28. Is ethical clearance required from any other ethics committee?
                                                                      NO

PLEASE NOTE: Ethical approval from the School of Psychology can be gained before approval from another research ethics committee is obtained. However, recruitment and data collection are NOT to commence until your research has been approved by the School and other ethics committees as may be necessary.

29. Will your research involve working with children or vulnerable adults?*

30. Will you be collecting data overseas?

5. Signatures

TYPED NAMES ARE ACCEPTED AS SIGNATURES

Declaration by student:

I confirm that I have discussed the ethics and feasibility of this research proposal with my supervisor(s).

I will follow the accepted ethical principles and appropriate code of conduct in carrying out this proposed research. Personal data will be treated in the strictest confidence and participants will be fully informed about the nature of the research, what will happen to their data, and any possible risks to them.

Participants will be informed that they are in no way obliged to volunteer, should not feel coerced, and that they may withdraw from the study without disadvantage to themselves and without being obliged to give any reason.

Student's name: Fabienne Palmer

Student's number: U1525510   Date: 24/02/2017

Declaration by supervisor:

I confirm that, in my opinion, the proposed study constitutes a suitable test of the research question and is both feasible and ethical.

Supervisor's name: John Read   Date: 27/02/2017

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants

REVIEWER: Dr Anna Stone

SUPERVISOR: Dr John Read and Dr Chanelle Myrie

COURSE: Professional Doctorate in Clinical Psychology

STUDENT: Fabienne Palmer

TITLE OF PROPOSED STUDY: What are clinical psychologists doing to redress the disparities in mental health outcomes for Black service users?

DECISION OPTIONS:

APPROVED: Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.

APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED <u>BEFORE</u> THE RESEARCH COMMENCES (see Minor Amendments box below)**:** In this circumstance, re-submission of an ethics application is <u>not</u> required but the student must confirm with their supervisor that all minor amendments have been made <u>before</u> the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.

NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED (see Major Amendments box below)**:** In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

DECISION ON THE ABOVE-NAMED PROPOSED RESEARCH STUDY
(Please indicate the decision according to one of the 3 options above)

Minor amendments

Minor amendments required *(for reviewer)*:

The data obtained in the Survey (phase 1) look like the answers to open-ended questions, which suggests that they should be analysed using textual analysis tools rather than descriptive statistics. Please explain what data are to be

collected and clarify the method of analysis. The debrief could remind participants of their right to withdraw and the procedure to do so.

Major amendments required *(for reviewer):*

ASSESSMENT OF RISK TO RESEARCHER *(for reviewer)*
If the proposed research could expose the <u>researcher</u> to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

	HIGH
	MEDIUM
x	LOW

Reviewer comments in relation to researcher risk (if any):

Reviewer (Typed name to act as signature):   Anna Stone

Date: 7th March 2017; and approved minor amendments 26th June 2017

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee

Confirmation of making the above minor amendments *(for students)*:

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data.

Student's name: *Fabienne Palmer:*
Student number: u1525510
Date: 01/06/2017

(Please submit a copy of this decision letter to your supervisor with this box completed, if minor amendments to your ethics application are required)

PLEASE NOTE
*For the researcher and participants involved in the above named study to be covered by UEL's insurance and indemnity policy, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

*For the researcher and participants involved in the above named study to be covered by UEL's insurance and indemnity policy, travel approval from UEL (not the School of Psychology) must be gained if a researcher intends to travel

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overseas to collect data, even if this involves the researcher travelling to his/her home country to conduct the research. Application details can be found here: http://www.uel.ac.uk/gradschool/ethics/fieldwork/

EMAIL CONFIRMATION OF ETHICAL APPROVAL

APPENDIX B: INITIAL FOIR SENT TO TRUSTS

Dear Colleague,

I hope this email finds you well.

My name is Fabienne Palmer, and I am a Trainee Clinical Psychologist currently carrying out research at the University of East London (UEL) as part of a doctoral thesis project.

This project aims to review of how well adult mental health services across England meet the needs of black service users.

As such, I would like to request the following information regarding ethnicity related outcome measures within the adult secondary care and adult tertiary/inpatient mental health services provided by your trust:

1) Does your trust have a policy, programme or initiative that focuses on ethnicity/diversity/cultural competence/race inequality relating to:

a.   The provision of adult mental health services?*

b.   Operational aspects of mental health services e.g. staffing / recruitment / support?*

*If yes, please include this policy in your response.**

2) Do you monitor or record the ethnicity of your adult mental health service users?

*If yes, please provide this data for January – December 2016 (including any missing data)**

3) What are the primary outcome measures/tools (E.g. the Warwick-Edinburg Mental Wellbeing Scale (WEMWBS) used within your adult mental health services?*

4) What are the outcomes, collected using the measure(s)/tool(s) reported above, for your service users for January – December 2016, broken down by ethnicity?*

5) Please provide your data for January – December 2016 regarding use of the Mental Health Act (1983 & 2007) broken down by service that includes:

a.   Aspect of mental Health Act used (e.g. Section 2, 3, 4, 5, or Community Treatment Order (CTO))
b.   Service user ethnicity

I would be grateful if you would be able to break your response down by service, indicating which is secondary and inpatient, and, where possible, provide documented evidence, to substantiate your responses.

Thanks very much for your help with this matter. I look forward to hearing from you at your earliest convenience.

Yours faithfully,

Fabienne Palmer
Trainee Clinical Psychologist

APPENDIX C: FOLLOW UP EMAIL SENT AFTER 21 DAYS

Dear colleague,

Happy New Year!

I hope this email finds you well.

I just wanted to acknowledge receipt and say thank you to those of you who responded to the FOI request I sent back in October (see below). I really appreciate you taking the time to help me with this really important piece of research.

I have had a fantastic response rate and I am still in the process of collating and analysing the information I have been sent so far. I will therefore respond to and complete the relevant satisfaction surveys as soon as I have completed this exercise.

If your service or trust has not yet been able to fulfil the request for any reason, please do still get in touch as there is scope to extend the initial deadline of **20 working days** from the **17th October** to **Friday 19th January 2018.** If this still does not feel like a manageable deadline, please do get in touch using the contact details below as soon as possible.

Thank you in advance for your all your support and hard work.

I look forward to speaking with you again soon.

Best wishes,

Fabienne

Fabienne Palmer
Trainee Clinical Psychologist

APPENDIX E: INTERVIEW SCHEDULE

[Before turning on the recorder]

- Introduce myself
- Go through the participant information sheet verbally
- Give participant information sheet to read and ask if have any questions
- Go through consent form, explain right to withdraw and get signature
- Go over areas I intend to cover
- Provide contact details for local/national support organisations
- Reiterate there's no right or wrong answer and that this is not a test etc.
- Ask if the participant has any further questions before starting

Prompts for additional information:
- What do you mean by that?
- Please, could you tell me a bit more about that?
- What was that like for you?
- How does that make you feel?
- How do you think about that?
- Can you give me an example?

Areas to cover during debriefing:

Is there anything that bothered you about the interview?
Do you have any further questions?
You can email me if you think of questions after you leave.
Would you like a summary of the findings? (If yes I will take the participant's email and signature if they'd like a summary of the findings and will store this information separate from all other data).

Field notes:

Any notable themes?
Social/organisational features of the setting
Notable participant features/characteristics e.g. physical appearance, mood, tone
My experience
Any notable events during the interview (my behaviour or theirs).
Context (Historical, political, policy etc.).

INTERVIEW QUESTIONS

1) What made you decide to take part in the research today?

2) Do you know whether your trust has a policy, programme or initiative that focus on ethnicity/diversity/cultural competence/race inequality that focuses on service delivery or workforce?

   - Have you read it? What do you think of it?

   - How is it monitored/evaluated?

3) How does this influence the way cultural competence etc. talked about/ thought about within your service/team?

4) What does this mean for the way your service understands and meets the needs of black service users specifically? Is this the same across the trust?

5) As a black psychologist, what is it like for you to work in that context / when you feel like that is the attitude within the service/team/trust?

   a. How do you respond/cope with that?

      i. Professional level?

      ii. Personal level?

6) Is that something you think your service/trust is aware of?

7) What do you think would be useful for your service to know about your experiences / observations of their commitment to addressing / tackling this issue?

8) If you had a magic wand, what would it look like if your service/trust were to take this on board?

Who do you think would be best suited to make this happen?

9) What role, if any, do you think clinical psychologists have in this?

10) How do you think your service would respond if they heard what you had to say about this?

   a. Why?

   b. Knowledge/expertise valued in the service?

11) Anything at all you'd like to add on the topics we've talking about?

   a. Is there anything I haven't covered that you would like to add?

12) How did you find the interview?

13) What was it like being asked these questions by a black trainee clinical psychologist?

APPENDIX F: PARTICIPANT INFORMATION SHEET

Dear Colleague,

RE: invitation and information about this study
Thank you for your offering to participate in my study. Before we start, please read the information below, and let me know if you have any questions, comments or concerns.

PARTICIPANT INVITATION AND INFORMATION SHEET

The Principal Investigator(s):
Fabienne Palmer BSc. (Hons), PGCert
Professor John Read

Consent to Participate in a Research Study
The purpose of this letter is to provide you with the information that you need to consider in deciding whether to participate a research study.
The study is being conducted as part of my Professional Doctorate in Clinical Psychology degree at the University of East London.

Project Title
What are Mental Health Services in England doing to monitor and address disparities in mental health outcomes for black service users?

Project Description
Research indicates that Black, Asian and Minority Ethnicity (BAME) people who access mental health services have worse outcomes than their White counterparts. Institutional racism has been cited as one of the main factors to contribute to the observed differences.

Since the completion of the Delivering Race Equality Programme in 2010, there have been no **national** initiatives that focus on redressing disparities in mental health outcomes for minority ethnicity service users.

Although numerous **local** policies and initiatives, very little is known about what they are or what their impact has been. Attempts to better understand and reduce the disparities in mental health outcomes have also obscured the differences within minority ethnic groups due to the use of the term BAME, which may make it more difficult to identify and meet the needs of specific populations.

This study, therefore, aims to better understand what the current policies and initiatives are, what the strengths and areas for development are in relation to the treatment of and outcomes for Black service users, and your experiences of working as a Black Clinical Psychologist.

What does participation involve?
The research involves me conducting semi-structured individual interviews with Black Clinical Psychologists, who currently work in Adult Mental Health Services. The interviews will last for approximately 1 hour, and the questions will relate broadly to their experiences of working in mental health services in the absence national initiatives to improve the mental health outcomes for black service users.

There are no risks or dangers involved in taking part in this research. Although, it is possible that you may feel upset if you are talking about experiences you have found

difficult or challenging. Contact details for local organisations will be provided to you at the end of the interview, should you wish to speak to someone about this further.

Confidentiality of the Data
Each interview will be carried out by me. The interview will be recorded on a digital recorder and I will have access to the files in order listen to and transcribe them. The transcript will be altered to protect your identity. As such, anything mentioned that would make you, or anyone else identifiable will be replaced with pseudonyms.

As the principal researcher, I will have access to the transcript, as will my research supervisor at the University of East London, John Read, and the examiners who will assess this research after it has been written up. The audio files may also be transcribed by an online service, and every precaution will be taken to ensure participant anonymity and confidentiality. The audio files and transcript will be stored securely on a password protected computer.

After this research has been examined, the researcher will delete the audio recordings. The written transcript will be kept as a computer file for three years and might be used for additional articles or publications based on the research.

The final research will include a small number of quotes from interviews. I also intend to share the research with other professionals, by submitting the findings in the form of an article to relevant academic journals. Hopefully this will help services develop pathways that actively address these disparities in mental health outcomes for black service users.

Location
All participants will be invited to attend an interview at the University of East London. However, alternative arrangements can be negotiated.

Disclaimer
You are not obliged to take part in this study and should not feel coerced. You are free to withdraw at any time. Should you choose to withdraw from the study you may do so without disadvantage to yourself and without any obligation to give a reason.

Please feel free to ask me any questions. If you are happy to continue you will be asked to sign a consent form prior to your participation. Please retain this letter for reference.

If you have any questions or concerns about how the study has been conducted, please contact:

my research supervisor, John Read, at the School of Psychology, University of East London, Water Lane, London E15 4LZ. Email: █████████████

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr. Mary Spiller, School of Psychology, University of East London, Water Lane, London E15 4LZ. Tel: ███████████████████████████

Thank you in anticipation.

Fabienne Palmer, Trainee Clinical Psychologist

APPENDIX G: CONSENT FORM

CONSENT TO PARTICIPATE IN RESEARCH STUDY

I have the read the information sheet relating to the above research study and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researcher(s) involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed.

I hereby freely and fully consent to participate in the study which has been fully explained to me. Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason.

Participant's Name (BLOCK CAPITALS)

………………………………………………………………………………………….

Participant's Signature

…………………………………………………………………………………………..

Researcher's Name (BLOCK CAPITALS)

…………………………………………………………………………………………..

Researcher's Signature

……………………………………………………………………………………………

Date: …………………..…….

DEMOGRAPHICS QUESTIONNAIRE

Answers to these questions will help us to know more about the people I have interviewed. If there are any questions you'd prefer not to answer, please leave them blank.

This information will be kept confidential and individual answers will not be disclosed to anyone else. Your answers will not be linked to your name.

1.   What is your gender?   _____

2.   How old are you?   _____

2.   What is your ethnicity?   _____

3.   What type of service do you work in?   _____

4.   How many years have you worked as a clinical psychologist? _____

5.   What area do you work in? (Location)   _____

APPENDIX I: SUPPORT INFORMATION

SUPPORT

Thank you for taking part in my research. I understand that this topic may have been upsetting to talk about, so if you would like to seek further support after participating in this study, the following information may be of use to you:

Advice and support about discrimination and human rights
If you need expert information, advice and support on discrimination and human rights issues and the applicable law, especially if you need more help than advice agencies and other local organisations can provide, please contact:

Equality Advisory and Support Service (EASS).
Please note: EASS is completely independent of the Commission.
Phone: 0808 800 0082
Textphone: 0808 800 0084
Email: eass@mailgb.custhelp.com

Race on the Agenda
Resource for London
356 Holloway Road
London N7 6PA

Phone: 0207 697 4093
Email: rota@rota.org.uk
Skype: raceontheagenda
Facebook: facebook.com/ROTA.org
Twitter: @raceontheagenda

Individual staff members can be contacted using first name@rota.org.uk

___

If you have any questions, comments, concerns or feedback about the study, or would like to continue talking about this with me at a later date, please do not hesitate to contact me via email: **U152551@uel.ac.uk.**

APPENDIX J: ONLINE TRANSCRIPTION SERVICE

The transcription service I used is called Rev: www.rev.com.

Before using this service, I emailed them to find out more about their data protection policies:

Fabienne Palmer

Mar 27, 13:45 PDT

From: Fabienne Palmer ███████████████████████████

To whom it may concern,

I have about 8 interviews I would like to transcribe for research I am doing in the UK. I was wondering whether you can provide a written letter/document that I can include in my appendices to show that I have taken every step to ensure confidentiality and anonymity of the participants and the information they shared during these interviews?

If you need any further information from me, please do not hesitate to contact me using the details below:

██████████████

███████████████████████

With thanks and best wishes,

Fabienne

Their response was as follows:

Wendy G. ([Rev.com](Rev.com))

Hi Fabienne,

Thank you for reaching out to us. It's my pleasure to assist you today!

Confidentiality is very important to us as well. I'd be happy to provide more information about our security practices here. We will never share your files or personal information with anyone outside of Rev. All of our transcriptionists have signed strict confidentiality agreements, and files are visible only to the professionals who have signed this agreement. If you'd ever like us to delete your files once the order is complete, just let us know.

Your files are securely stored and transmitted using TLS 1.2 encryption, the highest level of security available. We also never store credit card information – we simply pass it securely to our bank for safe-keeping. We also offer non-disclosure agreements, which can be obtained by emailing support@rev.com with a request for an NDA.

The above information is also listed on our website here:
https://www.rev.com/transcription/faq

We also have links to our Terms and Privacy information through our website here:
https://www.rev.com/about/terms
https://www.rev.com/about/privacy

I've included a link here with some more security information:
https://www.rev.com/blog/transcription-security-practices/

If you have any questions or if there is anything else we can do to help, please just let us know. Thank you for choosing Rev, and have a wonderful day, Fabienne!

Best wishes,
Wendy
[rev.com](rev.com) | [/rev](/rev) | @rev

APPENDIX K: TRANSCRIPT WITH CODING

Questions / my contributions were removed to focus on the participants' responses.

She's black, but where does she, like, she's just black. What does that mean? I'd like them to actually understand that black isn't a place, and there's a huge amount of ... I mean that what, you know, so could we just do that too? I'd like a little bit of education. I watch my staff at higher levels, yeah, that's sufficient. Obviously I want quite a lot.

Participant 9: I don't know. I mean, I suppose the ... The miserable bits, like the, you know. Everything seems to be forced, doesn't it? So, everything that comes from above comes from an email, and people usually ignore it, or moan about it. I feel like it needs to be owned by the team themselves. I'd love it if they actually were invested in something, versus it being a directive, and they just complain, and tick the box.

I would be, yes, I would want it to be something which is owned, and sustained by the team, but I'm not sure what the motivator would be, and supported from above, but it's something they were taking some sort of pride in, or recognise the importance of, and wanted to do. Maybe the team, team leaders, psychologist on the team, just not me, and also maybe not just the psychologist, because there's always this idea that the psychologist is going to be just coming with all sorts of things, but it will be good if it was a real collective, yeah, approach. That would be really nice, so it actually worked, and mattered.

Participant 9: Yeah, that everybody actually wanted to, because otherwise it's just this, another thing you've got to do. You've gotta tick this box, and tick that box, and everybody just tends to complain about those things, where they get quite heated when it's something that everyone feels really matters. It's not very

APPENDIX L: CODES AND NODES

The image below shows the multiple codes (nodes) and references (times a piece of data has been coded) for each of the interviews.
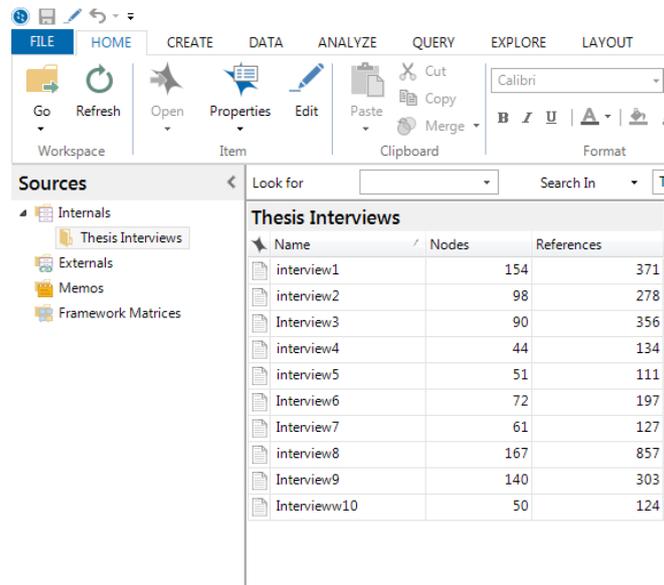
The image below shows several codes. I started looking for patterns across the codes and began grouping them together. This took place over a few weeks – kept revisiting and refining them until I started building initial themes.

APPENDIX M: EXCERPTS FROM RAW FOIR DATA – FOIRS

For transparency, I have included excerpts of my raw FOIR data spreadsheet, taken from Microsoft Excel.

collected data about the engagement/interaction I had with every MHT. For example, by recording whether they acknowledged receipt, how long it took for them to respond, whether or not they asked for an extension and whether they raised any reasonable request concerns. I also made comments, where necessary, on any additional information that the MHTs sent me, or that I observed. I did this to help me keep a track of the responses. I also hoped that recording the process would improve my understanding of this research method, specifically, what questions yield the best / worst responses etc.

I also broke each of the questions used on the FOIRs down, so I could record the MHTs' responses in a standardised way. This also helped with coding and analysis, because I also used the filter function on excel to manipulate and interrogate the data; I was able to get on screen how many MHTs were using WRES AND EDS2, or WRES and not EDS2 but provided outcome, but NOT data etc.

After making sure the data was coded in a standardised way, I summarised the data using different filter options, and functions on Microsoft Excel.
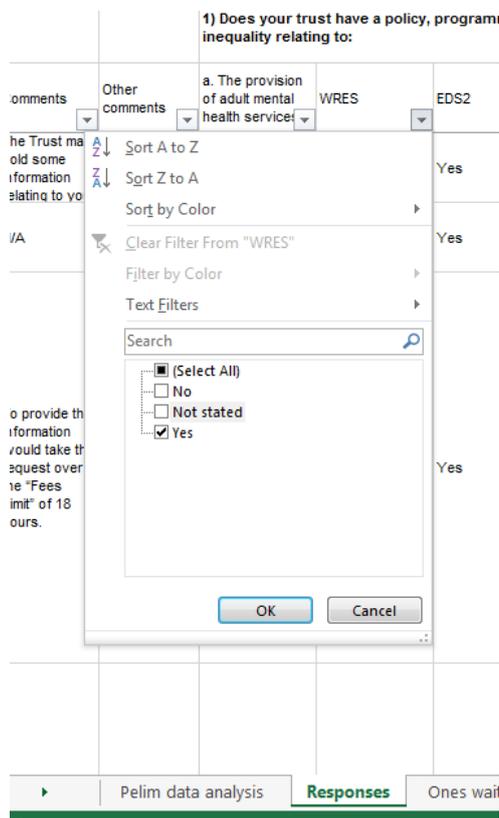
Participant 10:   I think it really is to make ... The aim of the workshop is to increase the competence of clinicians working with people from different backgrounds from themselves. And perhaps similar backgrounds to themselves. I know that there's ... I don't know if this is what you were saying about workforce, I might have misunderstood it, but I do know that there's ... I think in most trusts, actually, there is an attempt to recruit clinicians from underrepresented groups. I don't know if that's what you're meaning.

Interviewer: Yeah, yes.

Participant 10:   I think that also is something that is ... Our trust has gotten keen on. And actually not too long ago there was some sort of scheme that the trust were funding for Band 7 and Band 8A. Clinicians that self-identify as being from the BME group to go on a leadership course. So I think that was another way that the trust is trying to pool resources together to ensure that black people are represented on the higher levels of the trust. And we know that that's probably going to have beneficial impact on black service users and all black and ethnic minority service users to maybe challenge some of the institution and racist structures that every trust, every system, every part of our society is part of.

Interviewer: Okay, thank you.

Participant 10:   I hope that answers the question.

Interviewer: Yes, it does. Thank you. And how do you think this kind of ... the initiatives or the work that's being done within your trust. How do you think that influences the way things like cultural competence, race equality is talked about within your service?

Participant 10:   I think my specific team are very comfortable with talking about difference. More so than I've been familiar with in other teams I've worked in. And I think that's as a result of the agenda of the trust. In a way, putting it out there ... We are working to reduce inequalities, racial inequalities, gender inequalities, etc, etc. Those things are very much at the forefront of the trusts' initiatives. I know there's nothing like put down there, but I think the equality manager is quite passionate and that does get sort of distilled down to the teams.

And so in terms of the way it affects us, we can talk about difference in a way that's not met with a lot of anxiety and a lot of the fences around those anxieties. So if we are, for example, someone were working with someone who perhaps may have a particular challenge with working with a particular clinician, we can think about race. We do take that into account when we are formulating ... And I think that that's ... I really, really enjoy my team in that respect. I don't know, actually, maybe it's sometimes been challenging but I've thought about actually what it means for a black service user to meet a white clinician. And for that

Below are excerpts from the journal I used to document poignant reflections or feelings I had during the analysis and write up processes.

During The Analysis Process

I took for granted how difficult I would find reading and examining relevant literature (especially the inquiries into deaths of Black men), and had not truly appreciated what it would be like to listen to accounts of Black Clinical Psychologists who had faced challenging situations while working in the NHS. In addition, for various reasons, while carrying out the project, I never really found a space where, or a person with whom, I could unpack these thoughts and feelings. At times I felt extremely isolated and helpless and wondered whether I had made a mistake by choosing to do this project. I also fantasized what it would have been like to do an "easier" or more "straightforward" project that wouldn't take such a toll on my emotional wellbeing.

During The Write Up Process

During the write-up process, I also found myself revisiting some of the difficult questions I had asked myself at the beginning of my clinical training, namely, "was working within a system that is potentially harmful to people who look like me something I was prepared to do?". I wondered whether the experience of "being trained in a White, middle-class institution" (Jordan, Bogat and Smith, 2001), had influenced my decisions to talk about Black people as a monolithic category; refer to Black people in the third person; promote the idea of race equity, as opposed to the abolition of institutional racism, and focus on Blackness with respect to deficits and disadvantages, as opposed to survivorship and resilience. I'm not sure that I can answer those questions, but I will continue to reflect on and process them long after I have submitted this thesis.

During and After the Viva

To my disbelief and disappointment, my viva was probably the most difficult and painful part of the entire process; I still have not yet come to terms with what happened. I was excited to engage in a mutually respectful conversation about my research, and had hoped to come away from the process enthused and motivated to continue doing research and work in this area. However, my experience has, instead, left me feeling extremely let down, demoralised and questioning whether this is an academic or a professional space in which I could ever feel safe, supported or appreciated.