Exploring Black Peoples' Experiences of Secondary Mental Health Services.

A thesis submitted in partial fulfilment of the requirements for the Doctorate in Clinical Psychology

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Declaration

This thesis has been submitted for the award of Doctorate in Clinical Psychology at the University of Sheffield. It has not been submitted to any other institution, or for the purpose of obtaining any other qualifications

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Lay Summary

Literature Review: Data suggests there are inequalities in prevalence of mental health difficulties; and in access to and outcomes of mental health services for Black people in the UK. A qualitative evidence synthesis was conducted to synthesise the literature exploring Black peoples' experiences of mental health care and services. Three electronic databases were searched, and thirteen papers were included in the review. Thematic synthesis was conducted which identified four themes. Participants felt services held and exerted control over them and consequently people had no autonomy over their care. Participants described losses in identity and relationships, because of their mental health and being in services. Participants views on medication varied but many wanted broader interventions which offered opportunity to talk about their difficulties. Therapeutic relationships with professionals were valued, but participants felt they were not understood because of their culture and race. Participants experienced racism throughout services and proposed a broader conceptualisation of mental health to that which the medical model adopts. Recommendations were made for ways in which services could address these areas.

Empirical Report: Black people are significantly over-represented in inpatient mental health services. Review and research findings demonstrate Black people fear inpatient services and report poor views about their care. There is therefore an evident need to improve the care and therapeutic benefit of inpatient mental health services for Black people. This research study explored Black people's views of inpatient services and their perceptions of their therapeutic needs. Six Black adults who had experience of inpatient mental health services were interviewed using a semi-structured interview format. Interviews were analysed, which generated three themes. Participants wanted their personal and cultural identity to be recognised, understood, and attended to whilst in inpatient services which helped them to feel cared for. The importance of working together with staff was identified, in which participants wanted to know what was happening with their care and to be offered more opportunities to learn about their mental health and ways of managing it. Meaningful activities were enjoyed and beneficial for all participants. Participants valued connections with aspects of their community including family and religion; and wanted inpatient services to better meet these needs. Recommendations were identified to outline ways in which inpatient mental health services could meet Black people’s needs.

Acknowledgements

First and foremost, I want to thank the six people who took the time to share their experiences with me. I am grateful for your willingness and courage to speak so openly about your time in services. I hope the research offered you a space to have your voice heard and I have captured your accounts honourably.

Thank-you to my research supervisor Vyv Huddy, and field supervisor, Claire Bone. Thank-you for trusting my ideas and supporting me to develop this research study in an area I am passionate about. Your knowledge, guidance, and reassurance (oh and metaphors, Vyv!) have been a great source of support and I am proud of what we have achieved together; it has been a privilege to work with you both.

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Thank-you to my incredible friends and family - my mum, Andrew, Grant, and Katie, you are my biggest cheerleaders and have brought me light on the hardest of days. Thank-you for your endless love, hugs, voice notes, words of encouragement and chocolate; I have needed them all equally. Mum and Grant, you have both made me believe I can achieve anything I want in life, and with your love, encouragement, and care it was possible. Andrew, my incredible partner, your message has always been ‘you got this’ and I think we can finally agree, I have, but only with your constant stream of support, so thank-you.

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Section One: Literature Review

A qualitative evidence synthesis of Black peoples' experiences of mental health services in the UK

Abstract

Objectives

Data demonstrates there are considerable inequalities in prevalence, access to and experience of mental health care for Black people. This review aimed to synthesise the literature on Black peoples' experiences of mental health services.

Design and Method

Three databases were searched for peer-reviewed published qualitative studies which described working-age adults from Black backgrounds' experiences/perceptions of secondary mental health services in the UK.

Results

Thirteen studies met inclusion criteria and were analysed using thematic synthesis. Synthesis of the data revealed four superordinate themes; *'power and control'*, *'therapeutic needs'*, *'losses'* and *'system challenges*'.

Conclusions

Participants felt services held the power and consequently service-users felt a lack of agency over their care and treatment. Participants described losing parts of their identity and relationships due to their involvement with mental health services. Participants wanted more than medication as an intervention, and valued opportunity to build meaningful relationships with professionals. Participants reported experiencing racism and criticised the cultural competence of services; participants perceived the medical model to be restricted in its view of mental health.

Practitioner Points

- Professionals and services need to improve cultural competence and safety of mental health services.
- Services should utilise a holistic model of understanding Black peoples' mental health, encompassing personal beliefs and views.
- Black people should have access to talking therapies and other support which attends to social and religious needs.
- Services should be designed and developed collaboratively with Black people and aligned with their beliefs and needs.

Keywords: Black service-users, mental health services, qualitative evidence synthesis, thematic synthesis.

Introduction

Inequalities in mental health including prevalence, access to services, treatment options and outcome for racially minoritised[1] people have existed and been documented for decades (Dobson, 1999; Sashidharan, 2003; NHS Digital, 2016). The Delivering Race Equality (DRE; Department of Health [DoH], 2005) in mental health initiative acknowledged the profound failure of mental health services in meeting the needs of racially minoritised populations. The DRE set out an action plan to improve access, experiences, and outcomes for people from black and ethnic minority groups (DoH, 2005). Post-programme data and reviews suggested however that the DRE plan did not achieve its aims (Care Quality Commission [CQC], 2011; Kalathil et al., 2011; Fitzpatrick et al., 2014).

Following a change of government, the initiative was not sustained and currently endeavours aimed at improving services for racially minoritised groups are embedded within mental health initiatives more broadly (HM Government, 2011; NHS England, 2016); an approach that was criticised previously as it lacks specificity and applicability to ethnically diverse populations (Sashidharan, 2003). The impact is perhaps evident in that inequalities are still prevalent throughout mental health services (Bignall et al., 2019; Dyer et al., 2020).

Data has presented a particularly unfavourable picture for Black people[2] (Cabinet Office, 2017; Baker, 2021). Survey data demonstrated 29% of Black women have experienced a common mental health disorder compared to 21% of white women; and Black

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[1] The author will utilise the term ‘racially minoritised’ when referring to a group of people, which correctly identifies it is a social process underpinned by power in which people are minoritised, not reflective of their ethnicity being in the minority (Predelli et al., 2012). There is a recognised need to stop utilising phrases such as “black and ethnic minority” or associated acronyms “BAME” as it is considered reductionist by collectively referring to all ethnic groups outside of the white population under one umbrella term (Sewell et al., 2021). However, this will be utilised throughout the thesis when citing previous research or literature to ensure correct report from the source.

[2] Data refers to Black people as those from Black African, Black Caribbean, Black British and/or mixed Black backgrounds (Cabinet Office, 2017; House of Commons, 2021). The word ‘Black” will be capitalised throughout this thesis to recognise that this is a political and descriptive term used for people from African and Caribbean descent (Selvarajah, 2020).

men were ten times more likely to have suffered from a psychotic disorder compared to white men (Cabinet Office, 2017). Black Caribbean and Black British people were also 20% more likely to be in contact with mental health services (Baker, 2021); and four times more likely to be detained under the Mental Health Act (NHS digital, 2021). Although notably, the rates of psychosis and detention in psychiatric settings are far higher for Black people in white majority populations (e.g., UK, Netherlands) compared with rates for African Caribbean men residing in the Caribbean (Salize & Dressing, 2004; Jones & Fung, 2005). This suggests there may be factors related to the context for Black people of living in the UK that creates these disparities.

Black people are also less likely to seek or have GP support for their mental health; and more likely to be referred to specialist services (Morgan et al., 2005 Halvorsrud et al., 2018). Additionally, they are more likely to present at services in crisis and have police involvement around detentions to inpatient mental health services (Bhui et al., 2003; Halvorsrud et al., 2018). Disparities in treatment are also evident as Black service users are less likely to be offered psychological or family therapy, and more likely to be prescribed depot medication as treatment (Das-Munshi et al., 2018). Ratings of overall satisfaction with mental health services, however, did not significantly differ between Black and white service users (Raleigh et al., 2007; Boydell et al., 2012; CQC, 2021). Notably though, ratings overall were not high and Black people reported significantly lower satisfaction with access to and the interventions offered (Raleigh et al., 2007; Boydell et al., 2012).

Some advocate there is a need to go beyond epidemiological data, as it fails to capture service users' subjective perspectives or gain a deeper understanding as to why disparities exist (Bowl, 2007; Boydell et al., 2012). Policies still demonstrate a focus and importance of improving service users' experiences of statutory[3] services (DoH, 2005; NHS,

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[3] Statutory services are those that are funded and provided by the government, such as National Health Service (NHS) or social care (Department of Health and Social Care [DHSC], 2021).

2016). Understanding service users' perceptions on why care does or does not help may aid service change or improvements (Bhui et al., 2003; Bowl, 2007; Grey et al., 2013), thus reinforcing the need to understand peoples' experiences beyond data. Research focused on exploratory questions, like experiences, is more commonly adopted, and achieved by qualitative research (Flemming & Noyes, 2021).

There is a growing evidence base of qualitative research studies exploring experiences of varying statutory mental health services using qualitative methodologies, for different groups of people from several racially minoritised groups (e.g., Bowl, 2007; Greenwood et al., 2009; Edge, 2008). Moreover, there have been several recent systematic reviews which have synthesised the literature to consolidate experiences of a particular subgroup of people or service provision. A systematic review of the views of services from black and ethnic minority carers found problems with language barriers and recommendations for services to be more inclusive, culturally accepting, and accessible (Miller et al., 2021). Although, the views of carers may significantly differ from that of service users, given the different proximity and involvement with services they experience.

Additionally, Watson et al., (2019) completed a systematic review of the literature which described women from ethnic minorities' experiences of perinatal mental health services. The findings indicated people perceived services as culturally incompetent, insensitive, and dismissive. The findings from this however are restricted to perinatal services, a specialist service, and may not represent peoples' experiences of other secondary mental health care.

However, the synthesis of views from racially minoritised groups as a 'collective' are considered reductionist, as this fails to consider cultural idiosyncrasies that exploring ethnic groups or cultures individually would enable (Suresh & Bhui, 2006; Bhui et al., 2018; Watson et al., 2019). As such, Prajapati and Liebling (2021) recently synthesised qualitative research exploring experiences of mental health services for south Asian service users. The findings highlighted specific problems with a lack of information, choice, trust, and cultural competence in services.

A systematic review of the views of mental health services among Black Americans, outlined peoples' experiences were inclusive of discrimination, racism, distrust, and poor practitioner expertise (Gaston et al., 2019). However, the applicability of these findings and implications to the UK is difficult, given the significant structural and system differences between UK and USA healthcare services. To the authors knowledge, to date, there is no systematic review of the literature to consolidate this research specifically for Black people. A pertinent gap, which is surprising, given disparaging epidemiological data for Black African and Caribbean people. Data demonstrates specifically Black people experience poorer access to and outcomes from statutory secondary[4] mental health services, highlighting a particular need to review the literature of this area (Baker, 2021; NHS Digital, 2021).

An early report by Keating et al., (2002) found people from black African and Caribbean backgrounds feared mental health services, and viewed them as inhumane, inappropriate, and unhelpful. The early research base was limited however beyond a few studies (Pierre, 2000; Secker & Harding, 2002; Keating & Robertson, 2004). Though more recently there has been an emergence of further studies exploring Black peoples' views of mental health services (Rabiee & Smith, 2013; Wagstaff et al., 2018; Lawrence et al., 2021).

Individually, research studies offer rich descriptions of people's experiences (Noyes et al., 2018), though the evidence base may be strengthened by considering all studies together (Carroll, 2017). Qualitative evidence synthesis (QES), a type of systematic review,

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[4] Secondary mental health services were defined as non-specialised community or hospital based mental health care (e.g., community mental health services, early intervention in psychosis or assertive outreach teams; Mind, 2018).

enables a greater understanding of peoples' attitudes, experiences, views, and concerns about healthcare, which can inform clinical practices (Dixon-Woods et al., 2006; Carroll & Booth, 2015; Flemming et al., 2019). Therefore, to address the gap in the literature, the aim of this review is to complete a QES of the findings within the literature on Black peoples' experiences of secondary mental health services.

Method

The protocol for this review was registered on the international prospective register PROSPERO (reference: CRD42022302718).

Search Strategy

A SPIDER tool was utilised to develop and refine the search strategy (appendix A; Cooke et al., 2012). The searches were completed in January 2021 across three databases: Scopus, Web of Science (all databases) and PsycINFO (via Ovid). Search syntaxes were inputted into Scopus and Web of Science (table 1); MeSH terms[5] were inputted to PsycINFO (appendix B). Searches had no time restraints and focussed on titles, abstracts, and keywords.

Study Selection

Papers found across all databases were extrapolated onto an excel database, and duplicates were removed. The paper titles and abstracts were then reviewed against the inclusion and exclusion criteria (Table 2). Next, remaining papers were subject to a full-text review. Additional hand searching of reference lists of the eligible papers were completed.

Studies were included with a mixed participant group (e.g., service users and carers; or Black and white service users) if either Black service users were the participant majority or

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[5] Medical subject headings. These are standardised keywords that are searched on certain data bases, including PsychINFO. Articles on this database are assigned a MeSH term to provide information on the content of the articles and are therefore found by searching these terms.

if findings were clearly identified as being generated by Black service users. A secondary reviewer[6] also screened six papers to ensure consistency and rigour, and thus increased the reliability of the selection process and the final selected papers for the review. There was a disagreement on one paper, which was discussed and resolved.

Table 1.

Search syntaxes

Construct	Search Term
Black African-Caribbean Population	“black and ethnic minorit*” OR “black African*” OR “British-Caribbean” OR “British-African” OR “black Caribbean” OR “black African-Caribbean” OR “black Afro-Caribbean” OR “African Caribbean” OR African* OR Caribbean OR Carribean OR Carribbean OR black OR “BAME” OR “BME” OR “ethnic* minorit*” OR "ethnic* diverse" OR “Afro-Caribbean” OR “black West Indian”
Secondary Mental Health Services	“Secondary mental health” OR “psychosis service” OR “mental health service” OR “community mental health” OR “assertive outreach” OR “home treatment” OR “crisis team” OR “crisis resolution” OR “early intervention” OR “acute mental health” OR “in-patient” OR “in patient” OR inpatient OR “psychiatric ward*” OR “psychiatric unit” OR “psychiatric hospital” OR “psychiatric intensive care” OR “psychiat* liaison” OR “psycholog* service” OR “therap* service” OR “therap* team”
Experience/ Views	experience* OR review* OR perspective* OR rating* OR satisfaction* OR opinion* OR expectation* OR perception* OR view* OR outcome* OR attitude* OR understanding* OR description*
Qualitative Research	qualitative OR interview OR focus group OR “thematic analys*” OR “grounded theory” OR phenomenolog* OR “Interpretative phenomenological analys*” OR “discourse analys*” OR ethnograph*

Note. individual search terms for each construct were combined with the Boolean operator ‘OR’, and broad constructs were combined with the Boolean operator ‘AND’.

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[6] The researcher’s supervisor, lecturer in Clinical Psychologist, with experience of qualitative research and systematic reviews.

Data Extraction

Data was extracted and collated, which included: author and date, aims, participants characteristics, data collection, methodology and main themes (including quotes) of each study (Table 3).

Table 2.

Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
Working-age adult participants (age 18 to 65 years)	Written in languages other than English
Black[a] service users/participants	Utilised only a quantitative research design or were systematic reviews
Primary empirical research studies exploring experiences of UK-based statutory secondary mental health services	Papers or studies from the grey literature (e.g., unpublished theses or dissertations; organisation reports).
Used qualitative methodology	Studies which only explored experiences of children or adolescents; professionals and/or carers.
Published in a peer-reviewed journal	Studies which reviewed experiences of non-statutory, voluntary, or charitable organisations.
	Reviews of primary mental health care (e.g., GP, improving access to psychological therapies [IAPT]; specialist (e.g., perinatal, veteran); or tertiary (e.g., forensic) mental health services

[a] People from any Black ethnic group including, Black-African, Black-Caribbean, Black British and/or Black-mixed background (Cabinet Office, 2017).

Researcher Reflexivity & Data Synthesis

An appreciation of a researcher’s influences (attitudes, values, assumptions, beliefs) and how these may impact on how they relate to and understand others is important in qualitative research and particularly when exploring the views of marginalised groups

(Berger, 2013). The researcher identifies as a white British female, raised within white British norms and culture. The researcher has worked in, but not utilised, mental health services. They are interested in the construction of race, and how white privilege permeates society and services, and oppresses Black people. To minimise bias and increase transparency and trustworthiness of the analysis (Dodgson, 2019), the researcher made reflective comments throughout the analysis (appendix D) and discussed thoughts within research supervision.

Data was analysed using thematic synthesis, following Thomas and Harden's (2008) stages. Firstly, relevant findings and verbatim quotes from the 'results' or 'findings' sections of each study were extracted and considered data for the synthesis. Data was extracted into NVivo software (QSR International, 2018) to undertake 'line-by-line' coding which focussed on descriptions of the data (appendix G). Initial codes were clustered together. As this inductive process continued per study, codes were translated, and analytical themes developed (appendix H). The process resulted in superordinate and subthemes.

Quality Appraisal

The Critical Appraisal Skills Programme (CASP, 2018) tool for qualitative research (Appendix C), recommended within health and social research and by Cochrane was utilised to evaluate the quality of each study (Hannes & Macaitis, 2012; Noyes et al., 2018). The purpose of this process was to identify the strengths and weaknesses of the included papers. Articles were not removed based on this process, rather a critique of the articles is included within the review.

The CASP tool consists of ten questions and additional prompts. Answer options included 'yes' (criterion considered adequately) 'no' (criterion not considered adequately) and 'can't tell' (unclear if criterion considered fully). A random selection of papers (20%, *n=3*) were appraised by an independent secondary reviewer[7], two disagreements were discussed and resolved.

Results

Summary of Included Papers

The PRISMA diagram (Figure 1; Moher et al., 2009) outlines the study selection process. Database searches yielded 2619 papers following removal of duplicates. Following title and abstract screening, 2547 papers were removed as they did not meet criteria, and 72 papers were subject to full-text review. Following which 11 papers met inclusion criteria and eligible to be included. Two further papers were found from reference searches; hence 13 papers were included in the final review.

Two papers utilised the same population but reported different findings (Rabiee & Smith, 2013; 2014). This was also the case for two papers produced by Lawrence et al. (2021a; 2021b). Contact was made with the lead authors, who explained the studies utilised the same population, but the interview transcripts were analysed from different research question perspectives, and thus generated different findings. Given that the research questions and aims of each study met this review's inclusion criteria all four papers were included.

Studies were carried out between 2000 and 2021, and all studies used only qualitative methodology. Five studies described the experiences of service users alongside other groups (e.g., carers, professionals, commissioners, and lay community members). Six studies described Black service users' experiences along with experiences from service users from other ethnic backgrounds. Three papers described exclusively the experiences of Black service-users.

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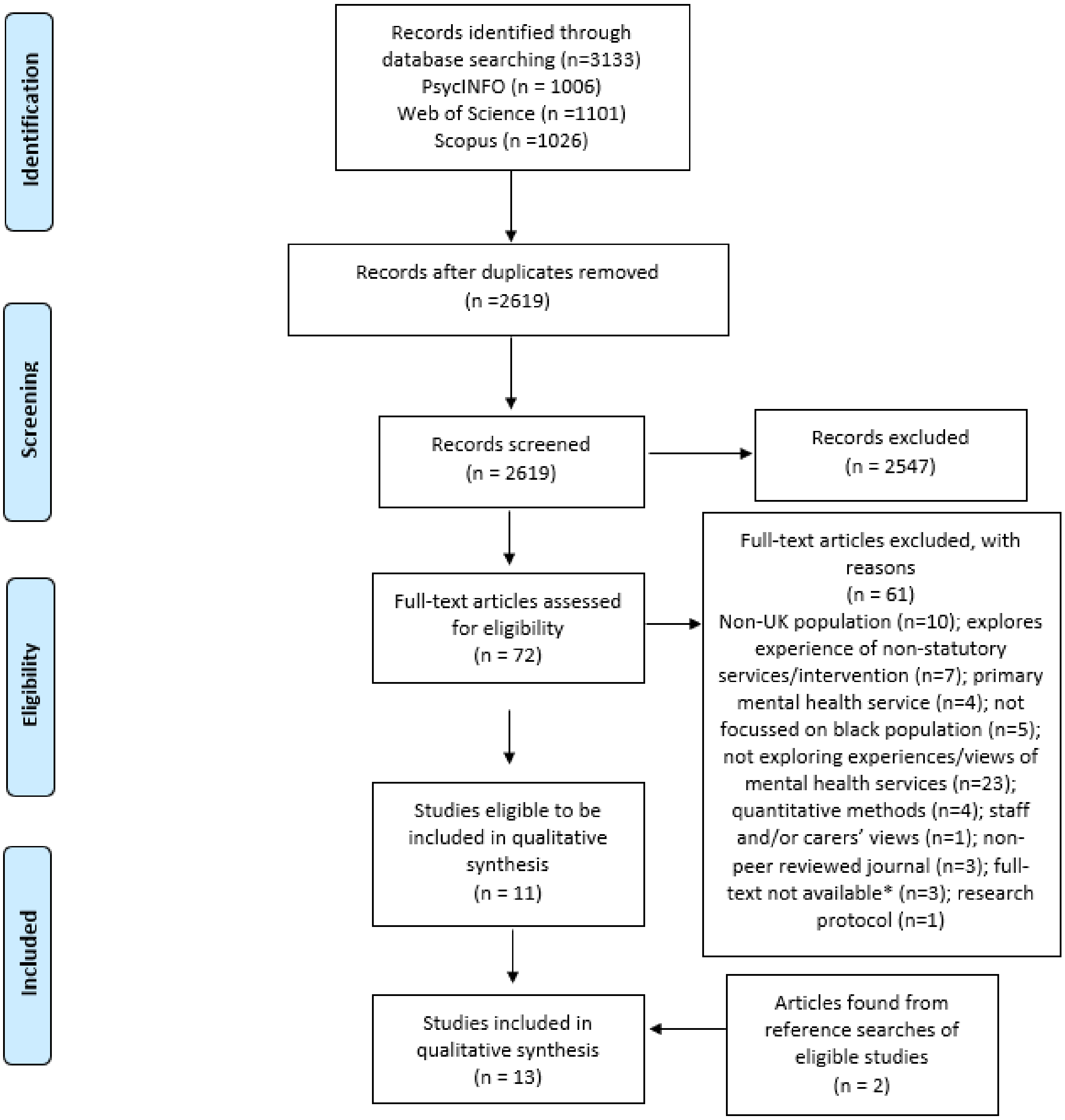
[7] Trainee Clinical Psychologist, with experience of qualitative research.

Figure 1.

PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses; Moher et al., 2009) diagram of study selection process.



**Note*. Library requests for inaccessible studies and contact to authors were made; however, these were unsuccessful, and no responses were received at the time of writing.

Table 3.

Table of characteristics

Author(s), Date	Aims	Participants' Characteristics*	Data Collection and Analysis Method	Main Themes
Islam et al., (2015)	Understand challenges for people from black and ethnic minority groups accessing EI services.	N=22 (male, 11; female, 11; age range 18-35). Black/Black British-African, 3; Black/Black British-Caribbean, 8. Asian/Asian British Pakistani, 9; Asian/Asian British-Bengali, 1; other, 1.	Service user focus groups, n=6, thematic approach	Help-seeking, culture and beliefs, social stigma and shame, experience of EI services, improving BME access and experience of services.
Keating and Robertson (2004).	Understand the experiences and relationships of Black people with mental health services.	N=29 (male, 19; female, 10; age range 20-60). African, 18; African-Caribbean, 11.	Focus groups (n=5). Qualitative analysis, coding techniques	Sources and content of fear, impact, or consequences of fear
Lawrence et al., (2021a)	Investigate experiences of living with psychosis and navigating mental health services among Black Caribbean and white British people	N=35 (male, 17; female, 18; age range 21-50). Black Caribbean, 17; white British, 15; white other, 3.	Interviews, narrative analysis	Entering mental health services, admission to an inpatient unit, experience of inpatient wards, positioning of medication, attitudes towards diagnosis
Lawrence et al., (2021b)	Understand the social and cultural processes in shaping responses to mental illness and	Same as Lawrence et al., 2021a.	Interviews, thematic narrative analysis	Losing self within the system, steadying self through the system, finding strength beyond the system

	experiences of mental health services			
Mclean et al., (2003)	Understand perspectives on mental health services	N=30 divided evenly across four groups of African-Caribbean people: statutory organisation members, voluntary agency members, carers and service users, lay community members	Service user and carer focus groups (n=1). Grid coding method.	Cultural exclusion, institutional exclusion, socio-economic exclusion.
Pierre (2000)	Determine the responsiveness of mental health services in meeting needs of Black service-users.	N=18, all identify as Black. No demographic details.	Interviews, thematic content analytical procedures	Appropriateness, counselling, rights, medication, cultural, diversity, racism, education, staff support, consultation.
Priebe et al., (2005)	Experiences of disengagement and reengagement from assertive outreach teams for service users.	N=40 (Male, 29; female, 11). African Caribbean, 18; White, 16; African, 4; Other, 3.	Interviews, thematic analysis and grounded theory	Desire to be autonomous and able person, lack of active participation and poor therapeutic relationships, loss of control due to medication and its effects, time and commitment, social support and engagement without focus on medication, partnership model of therapeutic relationship, stigma and peer pressure for disengagement, compliant rather than engaged relationship.
Rabiee and Smith (2013)	Explore the views and experiences of service users and carers.	N=25 (male, 11; female, 14). African, 12; African-Caribbean, 13.	Focus groups Krueger's framework and Rabiee's guidelines.	Range of mental health services utilised, role of voluntary organisations in providing and improving mental health services, role of service users and carers in improving mental health services, accessibility, and responsiveness of services, providing

				culturally sensitive mental health services for black people.
Rabiee and Smith (2014)	Experience of accessing services among black African and African-Caribbean service users and carers.	Same as Rabiee et al., 2013	Focus groups (n=9); interviews (n=4). Krueger’s framework and Rabiee’s guidelines.	Loss, social stress, trauma, diagnosis of mental illness, networks, support and material deprivation, issues relating to integration, positive experiences, medication, negative experiences, racism.
Secker and Harding (2002)	Explore clients’ previous experiences of services and inpatient services.	N=26 (Male, 16; female, 10; age range 18-64). African-Caribbean, 18; African, 6; unknown, 2.	Interviews, content analysis	Loss of control, experiences of racism, relationships with staff
Wagstaff et al., (2018)	Explore experiences of mental health services for Black men with a diagnosis of Schizophrenia, who have a history of disengagement services.	N=7 (Male, n=7; age range 31-64). Black, 7.	Interviews (n=7) and second ‘clarifying’ interview (n=6). IPA.	“People just keep hounding me”, antipathy to medication, choice and value of services, stigmatisation, and identity.
Watts and Priebe (2002)	Explore experiences of mental health services	N=12 (Male, 8; female, 4; mean age, 38years). British African-Caribbean, 9; British-Asian, 1; White British, 2.	Interviews, grounded theory	Early help seeking behaviours, identity, the therapeutic relationship, provider perspectives
Weich et al., (2012)	Explore participants’ accounts of recent episodes of mental illness and their care.	N=40 (male, 22; female, 18). Age: >25 years, 3; 25-44 years, 19; >45 years, 18. South Asian, 16; Black, 8; White, 16.	Interviews. Pathways to care model of analysis	Perspectives on their difficulties, contribution of family and friends, experiences of acute care

Note. BME (Black and Minority Ethnic); EI (Early Intervention in Psychosis Services); IPA (Interpretative Phenomenological Analysis).

Quality Appraisal Results

A full overview of the quality appraisal is included in appendix E. The lead reviewer implemented a scoring strategy to quantify quality and support description and comparison between studies (appendix E). Nine studies were rated as high quality; three as moderate quality; and one as low quality.

All but one study explicitly identified the aims of the research. All studies appropriately selected qualitative methods but six studies failed to explain/justify the study design. Four studies failed to adequately describe the recruitment strategy and methods, but all studies described data collection methods. Three studies failed to report on the ethical considerations. Two studies did not describe the data analysis methods sufficiently and one study did not include quotes to support the findings. Three studies commented on acknowledging the relationship between researchers and participants, and/or described ways of managing this. Most studies described the findings in relation to previous research, but there was significant variance across the papers in the description of clinical and theoretical implications and study limitations.

Thematic Synthesis

Analysis of the data resulted in four superordinate and several subthemes (Table 4). The themes do not represent an exhaustive list of participants' experiences, they summarise the prevalent themes described across the data. Some aspects of experience overlap across themes. Further examples of quotes for each theme are documented in appendix F.

Table 4

Themes and subthemes

Themes	Subthemes
Power and Control	Powerlessness
	Restrictive Practices
Disconnection	Losses
	Social Isolation
Therapeutic needs	Beyond Medication
	Therapeutic Relationships
System challenges	Cultural Incompetence
	Explanatory Models
	Implicit Racism

Power and Control

This theme encompasses the relationship service users had with professionals and services. Participants felt services held and exerted power and control over them and their care. Participants also spoke about feeling controlled in both physical and biological ways.

Powerlessness. There was a pervasive view of powerlessness throughout participants' accounts. Participants felt services adopted a "them and us" approach (Priebe et al., 2005; p.439) and services "hold all the cards" (Lawrence et al., 2021a; p.3) with regards to decisions made about their care. Most studies reported participants felt overlooked, dismissed, and unheard by services (Pierre, 2000; Watts & Priebe, 2002; Priebe et al., 2002; Secker & Harding, 2002; Weich et al., 2012; Rabiee & Smith, 2014; Wagstaff et al., 2018; Lawrence et al., 2021a, 2021b).

> *"It took two years before anyone listened to me and admitted me. So, two years I was trying to be admitted but nobody would have me because they kept telling me I was*

> *fine, but two years without no treatment, no medication, nothing, and I pretty well flipped" (Watts & Priebe, 2002, p.446)*

Participants felt their care was happening 'to them' and they did not know what was happening (Priebe et al., 2002; Secker & Harding, 2002; Keating & Robertson, 2004; Weich et al., 2012; Wagstaff et al., 2018; Lawrence et al., 2021a, 2021b). These experiences culminated in participants across all studies feeling they lacked control or choice over their care and treatment, mostly regarding medication.

> *"I didn't know what I was taking, they didn't explain to me what was wrong with me, then they had meetings, but they didn't have meetings with me involved in there, so I didn't really understand why I was there." (Lawrence et al., 2021a, p.3).*
>
> *"Well it's not my choice…I ain't got a choice because I got, if the mental health people come with me or come to give me medication, I take it, you know what I mean? But deep down I really don't want it." (Wagstaff et al., 2018, p.162).*

Conversely, some participants described times of joint decision making, good communication and being afforded autonomy over their treatment which they valued, and it created a sense of hope (McClean et al., 2003; Priebe et al., 2002; Weich et al., 2018).

> *"I didn't know what to expect and he [staff member] was very kind of understanding and he just listened to what I had to say. And I think at one point he explained what was actually happening to me…what the treatment was and let me know that I would get better and that they could help." (Weich et al., 2012; p.124.)*

Some people described their sense that services would inevitably hold the control, which they appeared resigned to as it felt unchangeable (Priebe et al., 2002; Secker & Harding, 2002; Rabiee et al., 2014; Wagstaff et al., 2018; Lawrence et al., 2021b).

> *"Even if I do complain, who will I complain to? It's like complaining to the government about the government." (Rabiee & Smith, 2014; p.131)*

Restrictive Practices. This subtheme accounts for participants' description of restrictive practices and interventions. Participants described physical methods staff used to exert control including being physically held or placed in seclusion (Secker & Harding, 2002; Keating & Robertson, 2004; Priebe et al., 2005). The subsequent impact was expressed in people's harrowing words, fear about mental health services and difficulties trusting professionals (Pierre, 2000; Priebe et al., 2002; Watts & Priebe, 2002; Secker & Harding, 2002; McClean et al., 2003; Keating & Robertson, 2004; Lawrence et al., 2021a, 2021b).

> *"They didn't pin me down, they just grabbed me arms and legs, and put me in seclusion." (Keating & Robertson, 2004, p.444)*
>
> *"and like the snatch squad that would come and take you down the corridor and inject you up." (Secker & Harding, 2002, p.164).*

Some participants described other aspects to control, in the form of being made to take or given medication, sometimes administered in a physically degrading and coercive manner (Secker & Harding, 2002; Watts & Priebe, 2002; Priebe et al., 2005; Rabiee & Smith, 2014; Wagstaff et al., 2018; Lawrence et al., 2021a). People illustrated the biological control medication had, as they spoke of the side effects as horrible, debilitating and made them feel like a "vegetable" or "zombie" (Lawrence et al., 2021a, p.4).

> *"I can't do things that I want to do. I want to come off this depot…it makes me put on weight, it stiffens the joints, it's affecting my fertility, my ejaculation system. I want to have children, but I can't have children if I am on depot. So, I think it has taken over my life sort of thing" (Priebe et al., 2005, p.440).*

Disconnection

This theme encompasses participants fear of or experience of loss because of their mental health and time in services. Losses spanned both inter and intra-personal relationships that people valued.

Losses. Participants depicted losing themselves either to their 'illness' or by being in the mental health system. The nature of loss varied from losing freedom and independence, to losing personal identity (Priebe et al., 2002; Watts & Priebe, 2002; Keating & Robertson, 2004; Weich et al., 2012; Rabiee et al., 2014; Wagstaff et al., 2018; Lawrence et al., 2021b).

> *'the kind of identity of like who you are, like your job and other things that define, kind of disappear [because] you are just trying to get better…you become your sickness' (Priebe et al., 2005, p.439)*

There was sometimes a tussle between people wanting to retain their identity or independence and their mental health or being engaged with mental health services; like the two could not coexist. This resulted in oscillated engagement with services in a bid to retain 'being normal' (Watts & Priebe, 2002; Priebe et al., 2005; Lawrence et al., 2021b).

> *"I get sick, I get cracked up, and this is my life. I can't keep fighting against it and trying to be someone else…I liked independence, I liked to do my own thing, you know: To lead, and I am not in a position to lead no more." (Watts & Priebe, 2002, p.446).*

Social Isolation. Relationships and connection with others were important to participants, thus they feared losing them. Family played a crucial role for people in early help-seeking, and Black people valued and wanted to maintain family support (Priebe et al., 2005; Weich et al., 2012; Rabiee & Smith, 2012). Additionally, people feared if other people knew about their mental health or engagement with services this would negatively impact relationships, due to the stigma surrounding mental health. This therefore interfered with people's engagement with services (Keating & Robertson, 2004; Priebe et al., 2005; Wagstaff et al., 2018; Lawrence et al., 2021b).

> *"Sometimes you are scared that they will find out you have a mental health problem, and they won't want to know you anymore. I mean schizophrenia is quite a frightening world because the media made it that way" (Priebe et al., 2005; p.439).*

Others depicted actual experiences of social isolation, because of their mental health and/or journey through mental health services. People described the breakdown of relationships and feeling alienated from society, which culminated in people feeling alone (Watts & Priebe, 2002; Secker & Harding, 2002; Priebe et al., 2002; Keating & Robertson, 2004; Weich et al., 2012; Rabiee & Smith, 2014; Wagstaff et al., 2018).

> *"I started hearing voices, I started talking to myself, she couldn't take it anymore, the relationship broke up…and I ended up on my own" (Watts & Priebe, 2002, p.445)*

Therapeutic Needs

This theme covered participants' perspectives on the therapeutic aspects of services. Participants shared varying views on medication; participants also wanted interventions beyond pharmaceutical approaches and valued their relationships with professionals.

Beyond Medication. Medication was the predominant treatment offered, across people's accounts. Some described the benefits of reducing voices, blocking out trauma, and helping sleep (Rabiee & Smith, 2014; Lawrence et al., 2021b), others felt conflicted, and it was "at best a necessary evil" (Weich et al., 2012, p.122).

Conversely, other people felt medication was unhelpful and didn't work; or that it was not enough, it did not "cure" the core problem (Secker & Harding, 2002; Priebe et al., 2005; Rabiee & Smith, 2014; Islam et al., 2015; Wagstaff et al., 2018; Lawrence et al., 2021a). People specifically disliked medication side effects which were sometimes worse than the precursory problems (Pierre, 2000; Watts & Priebe, 2002; Priebe et al., 2005; Rabiee & Smith, 2014; Wagstaff et al., 2018; Lawrence et al., 2021a).

> *"These drugs, none of it chills out my mind. None of it." (Wagstaff et al., 2018, p.161)*

They wanted opportunities to talk about and understand their problems. Participants wanted talking therapies or counselling, which would help them to understand and process their difficult emotions, something medication would not offer. Several studies though reported a lack of access to these for Black service users (Pierre, 2000; Watts & Priebe, 2002; Secker & Harding, 2002; McClean et al., 2003; Rabiee & Smith 2013, 2014; Lawrence et al., 2021a, 2021b); although Islam et al, (2015) presented a contrasting experience as people felt they had adequate access to talking therapies.

> *"I was there for about two or three months, and I received medication. I wasn't offered any counselling at all even though I was bereaved" (Rabiee & Smith, 2014, p.128).*

Therapeutic Relationships. Service users valued "being understood, being respected" (Rabiee & Smith, 2014, p.132) by mental health professionals/staff, in which they wanted to be seen as a whole person, beyond their mental health and offered non-judgemental support (Secker & Harding, 2002; McClean et al., 2003; Priebe et al., 2005; Lawrence et al., 2021b).

> *"He doesn't treat me as if I am insane. He treats me like a normal person and just having somebody there to guide you and to support you with things you do in your personal life, you know give you advice." (Secker & Harding, 2002, p.164).*

Being afforded time to talk with staff was a crucial factor for participants to enable them to build relationships and trust. Experiences varied as some felt staff did not offer enough time and space to talk to service users (Secker & Harding, 2002; Priebe et al., 2002; Watts & Priebe, 2002); but others felt staff provided an adequate amount and subsequently people felt staff cared, understood, and supported them (Secker & Harding, 2002; Priebe et al., 2002; Weich et al., 2012; Rabiee & Smith, 2013). High staff turnover and constant new staff impeded people's ability to build trust however (Watts & Priebe, 2002; Rabiee & Smith, 2014; Islam et al., 2015).

> *"He talks to me…gives me confidence…" (Rabiee & Smith, 2013; p.167).*
>
> *"It was a negative thing because I wasn't confident enough to disclose to someone who is new, so I had to withdraw a bit" (Islam et al., 2015; p.747).*

System Challenges

This theme covers participants challenges with and views about the mental health system overall, including experiencing racism. Moreover, people questioned the cultural competence of services and proposed broader conceptualisations of mental health.

Cultural Incompetence. Participants felt their culture was neither recognised or understood by professionals and services (Pierre, 2000; Secker & 2002; McClean et al., 2003; Rabiee et al., 2013). Some felt services recognition of differences was limited to skin colour, but participants felt it is broader than that and wanted services to better acknowledge, understand and respect their cultural idioms, identity, and needs (Pierre 2000; Secker & Harding, 2002; McClean et al., 2003).

> *"We express ourselves a bit different…because we're not white and we talk differently, so we might express ourselves differently and they feel that we are paranoid schizophrenia" (McClean et al., 2003, p.663)*

Some explained an underrepresentation of black staff meant there were no 'experts' in Black culture (Pierre, 2000; Rabiee & Smith 2013, 2014; Lawrence et al., 2021b). Although others felt Black staff would not necessarily understand their needs better and it was less about ethnic matching between professionals and service users, rather a need to understand and respect one's culture that was most important (Secker & Harding, 2002; Islam et al., 2015).

> *"It was just being different, and no one can understand my culture and my background." (Secker & Harding, 2002, p.164)*

Explanatory Models. Participants criticised psychiatry and the medical model which underpins it for being narrowly focussed on understanding distress and mental health. Participants felt the medical model did not engage with other explanatory models (Weich et al., 2012; Rabiee et al., 2013; Islam et al., 2015; Lawrence et al., 2021a; 2021b). Some described their religious beliefs or interpretations of their mental health, but felt these were not understood by services, and instead perceived as ‘mad’ (Rabiee et al., 2013, 2014; Wagstaff et al., 2018; Lawrence et al., 2021a, 2021b).

> *“I wouldn’t put it in a doctor’s…I wouldn’t use the same language you would use for it…For me it was a spiritual journey, it was a massive spiritual journey…it’s* [psychiatry] *very sterile, a lot of it is very sterile and it is very clinical, and it’s a narrow perspective of life” (Lawrence et al., 2021b, p.6)*

Other participants viewed mental health through a social lens and attributed their difficulties to social determinants (Pierre, 2000; McClean et al., 2003; Weich et al., 2012; Rabiee et al., 2013; 2014; Lawrence et al., 2021a; 2021b). Subsequently, participants valued services offering more distal interventions focussed on a person’s social context and needs (Watts & Priebe, 2002; Priebe et al., 2002; Rabiee & Smith, 2013; Wagstaff et al., 2018; Lawrence et al., 2021b).

> *“Mental illness is a social problem, I don’t think it’s an individual problem…if they haven’t got proper accommodation, if their house is leaking or if their partner’s gone off or if there’s a bereavement or divorce; all those issues can make people just flip, you know what I mean?” (Rabiee et al., 2014, p.169)*

Some participants described the impact of social circumstances affected everyone irrespective of race (Weich et al., 2012; Lawrence et al., 2021b). However, others described social exclusion, financial deprivation, and crowded living conditions as specifically prevalent for Black people which had a direct impact on their mental health (Pierre, 2000; McClean et al., 2003; Lawrence et al., 2021a).

Implicit Racism. Participants described witnessing and experiencing racism in mental health services. This appeared in covert and implicit forms, such as not being understood or misunderstood as a Black person; being negatively stereotyped; or being treated detrimentally differently to others because of their race (Pierre, 2000; Secker & Harding, 2002; Priebe et al., 2002; McClean et al., 2003; Keating & Robertson, 2004; Rabiee

& Smith, 2013, 2014; Lawrence et al., 2021a). Black people subsequently feared mental health services more and were reluctant to seek support (McClean et al., 2003; Lawrence et al., 2021a).

> *"Probably because I'm black they think I'm mad" (McClean et al., 2003, p.664).*
>
> *"…and knowing that the treatment you got seemed to be very different from those of your, of white people that were in the mental health services." (Secker & Harding, 2002, p.163)*

Although participants described racism as a part of their experiences, they found it difficult to explain and suggested it was more embedded within the system which disadvantaged and discriminated against Black people (Pierre, 2000; Secker & Harding, 2002; McClean et al., 2003; Keating & Robertson, 2004; Rabiee & Smith, 2013, 2014). Some of which mimicked that within wider society (Pierre, 2000; Keating & Robertson, 2004).

> *"Being black and female, you know I don't really stand a chance" (Rabiee & Smith, 2014; p.131)*
>
> *"It's very difficult to describe unless you're in the system, but we have to remember that there's a lot of racism exists, and there's a poor relationship between patients…and the actual working profession." (Secker & Harding, 2002, page 163).*

Discussion

This review aimed to collect and synthesise the literature which described the experiences of secondary mental health services among Black service-users. Thematic synthesis of the research papers developed four themes: *'power and control', 'losses', 'therapeutic needs'* and *'system challenges'*.

Power and Control

Black people felt powerless in mental health services engendered by insufficient information; a lack of choice or autonomy about care or decisions; and exertion of both implicit and explicit control. The Black community spoke of physical restraint and feeling controlled by their medication.

The sense of a power imbalance in mental health services between professionals and service users due to a lack of information from professionals and an absence of joint decision-making echoes previous literature in the Black community (Keating, 2007) and in broader populations (Wood & Alsawy, 2016; Staniszewska et al., 2019). The findings reinforce that there are several layers of power, both obvious and subtle, which operate unanimously within mental health care (Cutcliffe & Happell, 2009). For Black people however this is only one aspect of power, and it is an extension of other oppressions they experience throughout life (Fernando, 2006; Keating, 2007). Trivedi (2002) termed it a "a spiral of oppression", which leads Black people to fear and mistrust services, and is a cyclical process, and therefore a pertinent discourse to change. Regaining a sense of power and agency over one's life are key features of how Black African and Caribbean men perceive recovery (Keating et al., 2019) and perhaps explains why powerlessness was a dominant feature of participants experiences.

Service-users' inability to be heard within the system is also conceptualised as a demonstration of epistemic injustice, which proposes that a person's capacity as being a 'knower' of their circumstances and experiences is denied by professionals (Fricker, 2008), as they are considered not to have capacity to communicate such 'knowledge' (Fricker, 2007). More specifically, people with mental disorders are considered cognitively unreliable or emotionally unstable and therefore the plausibility of their views are considered unreliable (Carel & Kidd, 2014). Consequently, professionals are considered to hold epistemic privileged in making decisions about care and deciding how much involvement a service-user has within their care (Grim et al., 2019), which service-users across the included studies appear to describe.

Restrictive interventions were experienced negatively and made service users fearful of services, which replicates broader literature (Brady et al., 2017; Staniszewska et al., 2019). Restrictive interventions result in feelings of fear and powerlessness; distress; dehumanisation and re-traumatisation (Strout, 2010; Cusack et al., 2018; Staniszewska et al., 2019; Scholes et al., 2022). Cusack et al., (2018) also found given the retraumatising impact, peoples' recovery was hindered. This is particularly concerning for racially minoritised people, who are more likely to be the subject of restrictive interventions (Mind, 2020; Payne-Gill et al., 2021), and the fear these evoke may explain why Black people are less likely to approach services for help and only attend services at crisis stage (Halvorsrud et al., 2018).

Losses

Research purports people lose aspects of their identity because of their mental health (Wisdom et al., 2012), just as participants in this review depicted. Other literature suggests a lack of independence and disconnect to 'normality' is common for people in inpatient mental health services, like the losses and social disconnect participants in this review expressed (Wyder et al., 2015; Akther et al., 2019).

Identity is a flexible and changeable construct driven by a person's context including perceptions of others and forces around them (Fernando, 2012). For young black men though, mental health and engagement with services is only a part of the challenges and oppressions to their identity, as they experience these broadly in other aspects of life (Khan et al., 2017). Moreover, the multidimensional discrimination to one's identity can have a causal role in mental health thus the process is cyclical (Khan et al., 2017).

Additionally, Black people valued social connection and relationships with others; though they felt there was a tension between their mental health and use of services and maintaining relationships. The importance of maintaining relationships is seen in literature on wider populations (Wood & Alsawy, 2016), and previous research demonstrates social connection is pertinent for recovery for Black African and Caribbean service users (Codjoe et al., 2013).

Therapeutic Needs

Medication was the dominant intervention offered and many expressed they did not have access to talking therapies, which aligns with data and reports (Das-Munshi et al., 2018; McManus et al., 201; Mind, 2018). There was divergence amongst Black service users' views on medication, and many wanted interventions beyond medication. Contrasting and varied views about medication replicate previous findings of racially minoritised groups (Hunt et al., 2013) and broader populations (Wood & Alsawy, 2016). Southby et al., (2021) explored recovery for black African-Caribbean men and found that while people felt medication was beneficial at one point, their aim was to reduce and cease taking it, thus it may be beneficial to afford personal choice and agency to service users.

A research study which reviewed access to and outcomes of psychological therapies for people from different ethnic groups found that Black service-users reported higher rates of distress at pre and post timepoints of psychological therapy compared to white people (Mercer et al., 2018). This is perhaps explained in that psychological therapies in the UK are developed and aligned with Western cultures and may not be accessible or relevant cross culturally (Rathod et al., 2019; Kirmayer & Pederson, 2014). A recent meta-analysis found culturally adapted psychotherapies were more efficacious for racially minoritised populations than control groups (Anik et al., 2021).

Participants valued the therapeutic relationships with professionals, in which important aspects included time to talk to staff, trust and feeling understood as a whole person, which was similarly found for Black American service users (Gaston et al., 2019). Additionally, Codjoe et al., (2013), found black and ethnic minority groups endorsed opportunities to talk through their difficulties and help with making sense of them as a key part of the recovery process.

System Challenges

Participants described services as culturally incompetent, engendered by professionals' difficulty understanding them as a Black person. Cultural insensitivity was also described by Black American and south Asian service users (Gaston et al., 2019; Prajapati & Liebling, 2021); and black and ethnic minority perinatal service-users (Watson et al., 2019). Perceived cultural naivety and insensitivity of healthcare services acts as a barrier for black and ethnic minority groups to accessing services (Memon et al., 2016). The included studies did not strongly advocate for ethnicity specific services or ethnic matching with professionals, which has been debated in literature (Bhui & Sashidharan, 2003; Cabral & Smith, 2011). Instead, Black service users wanted staff to recognise, understand, and respect their personal culture, thus being offered culturally sensitive treatment is deemed more important than professionals' ethnicity (Steinfeldt et al., 2020).

Black service users criticised psychiatry and the medical/biological underpinnings for being limited and narrow in its understandings of mental health. Participants in this review endorsed alternative explanatory models of mental health mainly religious and spiritual, or social perspectives. This replicates a study comparing explanatory models between different ethnic groups which found non-white[8] groups described supernatural or social causes of illness (McCabe & Priebe, 2004). Religious and spiritual needs are important for services to consider for Black and wider populations (King et al., 2009; Wood et al., 2019). This may be interwoven with views of cultural competence, as Black people deem culturally competent care/services to be sensitive to and integrate spirituality (Lewis et al., 2007). Furthermore,

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[8] The author has utilised the terminology of the source paper to correctly cite the findings but acknowledges this centres white ethnicity as the 'norm', and is incorrect.

the debate between biological and social explanations is not new and a social model of mental health has been advocated for some time (Foucault, 1961; Szasz, 1961). Recent research supports this as it found services which address social problems and attend to social, spiritual, and religious needs result in improved engagement, clinical outcomes, and recovery for Black people (Codjoe et al., 2013; Morgan et al., 2017).

People experienced subtle forms of racism during their interactions with services, through differences in treatment to white counterparts, stereotyping, or a lack of awareness of culture. This offers important and contrary evidence to government perspective that institutional racism does not exist (Sewell et al., 2021; White & Cowburn, 2021). Racial discrimination and disadvantage are strongly associated with poorer mental health (Paradies et al., 2015), thus experiencing this in services will have a paradoxical effect on a person's mental health and may explain the higher prevalence rates amongst Black people (Baker, 2021). The subtle forms of racism participants described is characteristic of racial microaggressions, in which racism is likely to be disguised and go unnoticed, which makes it harder to identify and explain whilst still causing considerable harm (Sue et al., 2007).

Critique of Included Studies

Only three studies commented on the relationship between the participants and researchers; and implemented ways to offset biases and beliefs. Reflexivity should be central to qualitative research given that the researcher's world views and personal biases may influence the interpretation of the findings (Flemming & Noyes, 2021). Perhaps reflexivity is more salient for these studies given the possibility of several aspects of power differentials between researchers and participants (e.g., race, education, social status, gender; Dodgson, 2019). Hence, it is a weakness of the other ten studies not to acknowledge this and their findings should be viewed cautiously.

It was a strength that all studies described the data collection methods, and several studies incorporated secondary reviewers during data collection and/or analysis to improve credibility and rigour. However, two studies provided limited participant demographic details which makes it hard to situate the findings within a particular sample (Wagstaff et al., 2018; Pierre, 2000). Additionally, several studies failed to adequately describe ethical considerations (i.e., informed consent, confidentiality, participant welfare), despite protection and safeguarding of participants through ethical procedures being a central role of the researcher (Sutton & Austin, 2015). Given that racially minoritised people are increasingly fearful about participation in research and the unintended adverse impact it may have (George et al., 2014), extra care and attention to ensure ethical practice is imperative.

Many of the themes echo previous literature on wider, predominately white, populations (Wood & Alsawy, 2016; Staniszewska et al., 2019), and only certain themes directly relate to culture and/or race (e.g., cultural competence; racism). The limited distinctive themes for Black people may reflect reality, given the similarities between ethnic groups of overall experiences of services (Boydell et al., 2012). Though it may also reflect biases in the methodology and analysis of the primary studies, as researcher's personal biases and world view may have influenced the questions and interpretations. Sue et al., (2007) highlights that more subtle aspects of race and racial prejudice are often excluded in research.

Limitations of the Review and Future Directions

Thematic synthesis utilises quotations from studies to evidence findings, however, the frequency and data provided by each study varied. Therefore, there was a weighting towards certain studies in this review's findings. Specifically, Pierre (2000) did not include participant quotes, and two studies had limited narratives from Black service-users (Weich et al., 2012; Islam et al., 2015). Therefore, they do not feature heavily in the synthesis and there may be skewness in the findings.

It was a strength of the review to use broad search terms to capture all relevant studies. However, the construct of experience was considered and conceptualised in this review as a broad phenomenon. The review may have inadvertently missed nuanced, indirect, or wider experiences contained within literature which explores experiences less directly (e.g., process of recovery, therapeutic relationships, psychological therapy). Future research could unpack the findings from this review and investigate indirect experiences.

The review did not include grey literature which may have excluded relevant findings and introduced a publication bias in the results. Studies with small sample sizes are less likely to be published. Also, researchers in the UK are predominately white and thus are less likely to conduct and publish research with participants from different ethnic backgrounds, a bias that may be further reinforced by dominance of white journal editors who determine whether research is publishable (Roberts et al., 2020). Future reviews in this area should include grey literature to offset any biases and ensure a more extensive review.

Positively, a quality appraisal was completed and utilised a recognised and endorsed tool, and the reliability of this was improved by a secondary reviewer. However, the tool utilises a limited categorical scoring system, hence it is hard to differentiate between studies or explore quality extensively. The researcher scored ‘yes’ when some aspects of a domain were present but there were vast differences between ‘good enough’ and ‘gold standard’ methodological rigour, which this scoring system failed to represent. The undifferentiated scoring is perhaps evident in the high proportion of high-quality studies and thus quality ratings must be viewed considerate of this. Moreover, the overall quality rating was based on the reviewer’s arbitrary quantification, which aided the description process, but should be viewed tentatively as a formal reflection of study quality. Additionally, the quality assessment was used descriptively as part of the synthesis and all studies were included irrespective of rating, thus one low quality study was included. The review would have been strengthened by conducting a post-hoc sensitivity analysis to determine whether low quality studies affected the findings (Carroll & Booth, 2015).

The author acknowledged their position relative to the participant group and completed reflective comments during the analysis. However, it is unavoidable that the researcher remains an ‘outsider’ to the participant group (Suwanakhong & Liamputting, 2015), there is therefore a possibility that the author may have overlooked, or mis-interpreted people’s experiences given they may be outside their awareness or understanding.

Clinical Implications

Services should be designed, structured, and implemented based on views and needs of racially minoritised people (Bhui et al., 2007), which is beneficial and supports better service user outcomes (Vahdaninia et al., 2020). This QES highlights services need to be culturally competent and actively work to dismantle systemic prejudices towards racially minoritised groups. Acknowledging and understanding racism and oppressive practices exist; and an understanding of how white privilege prevails services is a useful foundation for services to develop cultural competence and safety (McGough et al., 2018; Williams et al., 2022).

Power imbalances in mental health services seems inexorable (Cutcliffe & Happell, 2009), but acknowledging, recognising, and managing it is imperative to dismantling it, hence this should be a professional, organisational and leadership priority. Professionals should be afforded specific time (e.g., supervision, reflective practice) to reflect on their own identity and beliefs; and the manifestation of power both personally and in their relationships with service users, and more specifically the role of race and ethnicity in this (Curtis et al., 2019).

Cultural competence training aimed at increasing understanding and knowledge of cultural beliefs, values, biases, and practices should be implemented and mandated within services (Atewologun et al., 2019). Though learning is a continual, not static process, and Black people are a diverse and varied population, thus a person-centred tailored approach to mental health is advantageous, not ‘one size fits all’ (Fernando, 2003). Professionals working in services should afford dedicated time to get to know service users personally, and be open to learning about people’s culture, beliefs and needs to better attend to them (Race Equality Foundation, 2015).

This review highlights services should utilise a holistic approach to understanding and supporting Black people’s mental health, considering wider factors including social circumstances, relationships, and religious needs. Services should consider frameworks of understanding peoples’ mental health that are not tied to Western psychiatric ideologies, and instead aim to understand a person’s distress on a personal level related to their cultural, social, and environmental context. The “power-threat meaning” framework (PTMF; Johnstone & Boyle, 2018) is one option, which proposes difficulties emerge from social and cultural discourses, belief systems and bodily experiences. People’s distress can be understood from a wider lens, to acknowledge the influence of power both historically and in services, and to collaboratively address the issues most pertinent to the person. This will open space for social injustices operating in a person’s life to be included in formulations of their difficulties, aligned with the community psychology principles (Kagan et al., 2019). Though caution should still be exercised in the use of the PTMF given that the people who developed the PTMF were all white and there was a distinct lack of racial and ethnic diversity amongst the authors (Scheherazade, 2018). Moreover, several assertions made within the framework are criticised for lacking evidence to support these (Salkovskis & Edge, 2018) and there is no evidence reviewing the efficacy or validity of the framework yet (Larkin, 2018). Also, the swap from biological to social determinism proposed by the framework is as equally biased to one end of a paradigm like the medical model it criticises, and hence is still limited in its perspective and cannot account for all distress or difficulties people experience (Larkin, 2018; Seager, 2018).

Services should offer therapeutic interventions beyond medication (Wessely, 2018). Partnership between statutory services and other organisations may be beneficial (Race Equality Foundation, 2015), including religious and faith-based services (Rabiee & Smith, 2013); mental health charities/organisations for Black people (Bhui & Sashidharan, 2003); and social care services (DoH, 2011). This would enable a holistic and joint approach to meet Black people's mental health needs. Moreover, service users value opportunity to explore and discuss their problems and therefore services need to increase access to talking therapies, aligned with other recommendations (Mind, 2013; DHSC, 2021). These should be culturally sensitive and considerate of personal conceptualisations to distress (Loewenthal et al., 2012).

Finally, services should actively seek collaboration and joint service development with racially minoritised groups, to ensure their needs are centralised and offset white bias (Williams et al., 2022). The reverse commissioning approach provides one such framework, which promotes empowering racially minoritised service users to use their knowledge and experience to shape services (Mind, 2013; NHS England, 2017).

Conclusion

The results from this synthesis highlight Black people's diverse experiences of mental health services. Participants felt services held all the power, resulting in participants having a lack of control or agency over their care. Participants feared and described losing themselves and relationships because of their mental health and journey through services. Additionally, Black people within this QES noted medication was the predominate intervention offered, but their views varied on the helpfulness of it. Many wanted services to go beyond medication and offer opportunities to talk about their difficulties. Therapeutic relationships with professionals were important, but Black people felt staff needed to afford sufficient time and space to get to know service users. Finally, the QES found Black people felt services did not understand their culture and associated needs and described implicit racism throughout their interaction with services. Participants also criticised psychiatry for being narrow and non-inclusive of other conceptualisations of mental health. Recommendations of ways in which services could better understand and meet the needs of Black people were identified.

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Appendix A: *SPIDER tool (Cooke et al., 2012).*

SPIDER	
Sample	Adults, of working age (age 18-65), who identify as Black (Black African, Black British, Black Caribbean, Black mixed). Living in the UK
Phenomenon of interest	Secondary mental health services, community or hospital based mental health services.
Design	Gathering qualitative data: Interviews, focus groups
Evaluation	Perceptions, views, experiences, attitudes, thoughts, feelings, opinions
Research type	Qualitative studies, thematic analysis, grounded theory, discourse analysis, interpretative phenomenological analysis

Appendix B: *MeSH terms*

Construct	MeSH Term
Adults, from black African/Caribbean/British backgrounds	exp Blacks/ or black African.mp.; exp Blacks/ or african caribbean.mp.; black caribbean.mp.; (black and ethnic minority).mp.; (black and ethnic minorities).mp.; exp; afro-caribbean.mp BME.mp. or exp Ethnic Identity "Racial and Ethnic Groups"/ or exp Minority Groups/ or BAME.mp.; black west Indian.mp.
Secondary mental health services	mental health services.mp. or exp Mental Health Services/; community mental health services.mp. or exp Community Mental Health Services/; exp Mental Health/ or secondary mental health.mp.; exp Psychiatric Units/ or exp Mental Health Services/ or exp Psychiatric Hospitalization/ or exp Psychiatric Patients/ or exp Hospitalized Patients/ or inpatient mental health.mp.; exp Assertive Community Treatment/ or assertive outreach.mp.; exp Crisis Intervention Services/ or home treatment.mp.;crisis resolution.mp.; early intervention.mp. or exp Early Intervention/; exp Mental Health/ or secondary mental health.mp.; exp Psychosis/ or exp Acute Psychosis/ or early intervention psychosis.mp.; exp Psychiatric Hospitalization/ or psychiatric ward.mp.; psychiatric liaison.mp.; psychology service.mp.; therapy service.mp.
Experiences/ view	experience.mp.; review.mp.; exp Attitudes/ or exp Client Attitudes/ or attitude.mp. or exp Adult Attitudes/; exp Satisfaction/ or exp Client Satisfaction/ or satisfaction.mp.; perspective.mp.; perception.mp. or exp Perception/; exp Expectations/ or expectations.mp.; exp Patient Reported Outcome Measures/ or outcome.mp.; opinion.mp. or exp Attitudes/; understanding.mp.; description.mp.
Qualitative research	exp Qualitative Methods/ or exp Qualitative Measures/ or qualitative.mp.; exp Interviews/ or interviews.mp.; focus groups.mp. or exp Focus Group/; exp Thematic Analysis/ or thematic analysis.mp.; exp Discourse Analysis/; exp Phenomenology/ or exp Interpretative Phenomenological Analysis/ or interpretative phenomenological.mp.; ethnograph.mp.; ethnography.mp. or exp Ethnography/; grounded theory.mp. or exp Grounded Theory/

Appendix C: Examples of reflective notes

1. It feels like they have no voice, like they just ‘wouldn’t say anything’, but then I think is it wouldn’t, couldn’t or shouldn’t? Because that is different. I notice I initially thought wouldn’t, like it was their choice not to. I should read the paper again and watch for this interpretation.

2. It is like people have fought for so long to be heard, in services and life generally and got nowhere and now they have just resigned to the fact that services are in charge. That must feel so horrible, like you have no chance of being heard so save yourself the effort. Like they are self-preserving or biding time in services.

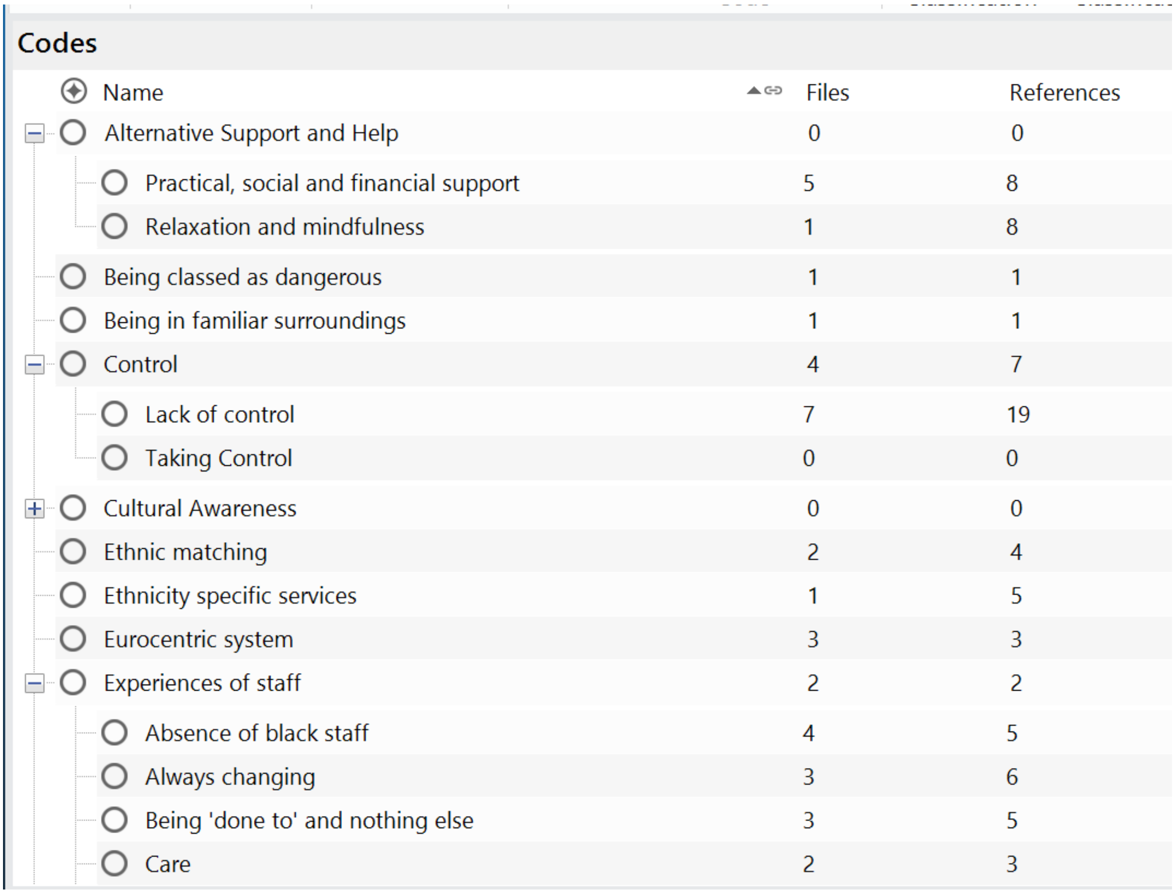
3. The phrase “hold all the cards” is interesting, it makes me think that services are both in charge and like it’s a secret, making it doubly powerful?

4. Reading the paper made me feel so sad, to me, people feel alone. Because of their race, their mental health, being in services, all of it. They just feel so alone. I have always felt homesick, when I moved to University, I struggled so much, and I wanted to be there, but I missed my home, I missed being around people who knew and loved me. Then I think how it must feel when you are somewhere you don’t want to be. I think this is what makes me feel sad when I read that paper, and people describe nobody understanding them, or wanting to get to know them as people. Family and friends are a huge part of my life, and I feel safe around them, I know that no matter what they will care for me, probably why I feel homesick a lot. I wonder if people didn’t feel safe or cared for because they had nobody? Then is it nobody who cares or nobody who gets them as a Black person, or both. I have never considered race in my feeling of ‘belonging’, need to hold that in mind.

<u>Implications on my clinical practice</u>

- It really struck me how people felt they could not say anything about their care, in my clinical practice now, I am more explicit in asking the people I work with their views and opinions on a plan about their care, especially given the debate of whether it is people “wouldn’t or couldn’t” give their opinions. Reflecting on the papers made me think, I assumed I was inviting people’s opinions and voice, but I am much more explicit in this and active in my efforts to do this.
- I have spoken a lot in supervision about what we do and do not tell the people we work with. I discussed that as a service we do not share the waiting times for psychological therapy for example, and how this does not allow people the right to make the decision of whether they wait or seek alternative support. I am mindful of how power operates in my clinical practice and consider more openly what is important to share and challenge the narrative in services that things must be kept confidential from service users where possible. I have discussed in my clinical session’s the options available to people, and offered them a choice, to make the decision make process more transparent and collaborative.
- Although I do not work in inpatient mental health services, I have considered belonging much more broadly. I have always considered group belonging within sessions but in future sessions I will consider this related to race and culture as well, bringing this aspect of a person’s identity to the discussions as it is important and something I was not as mindful of before.

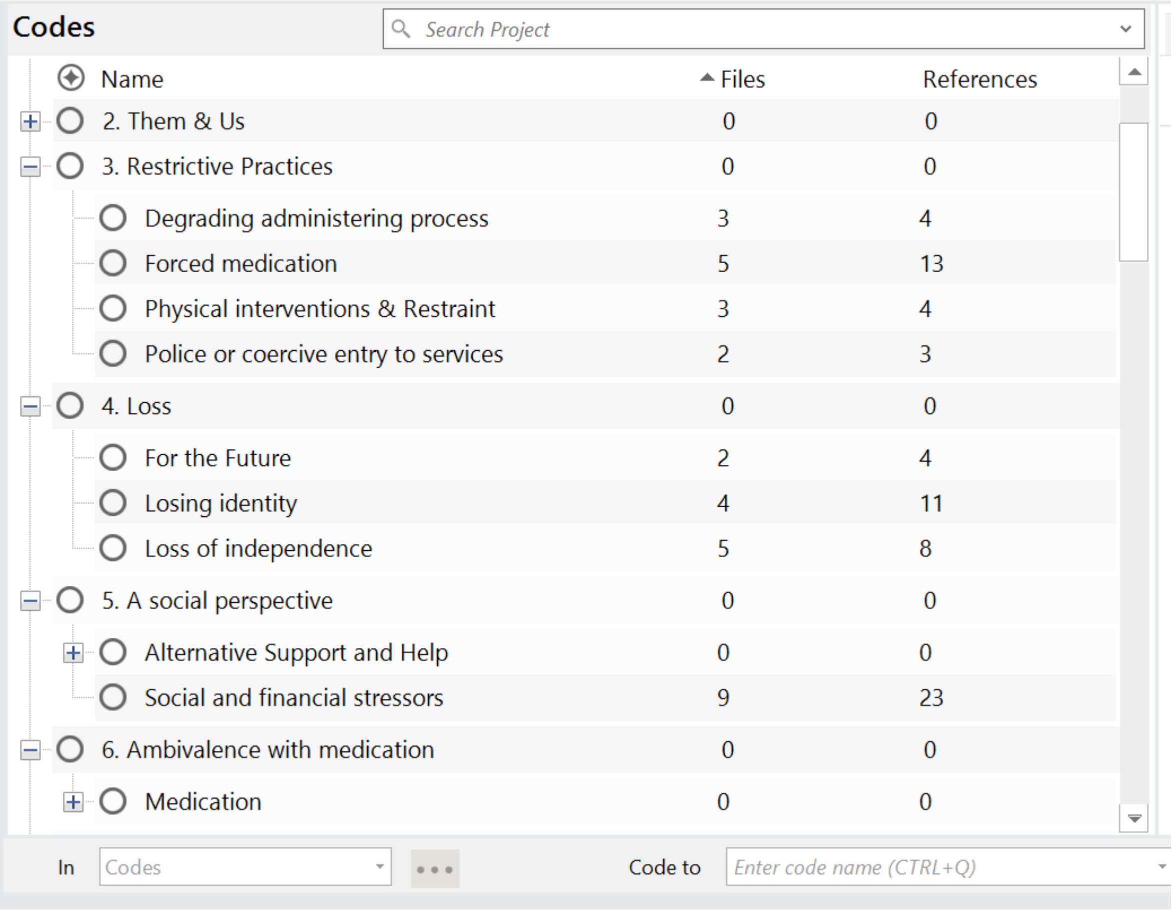
Appendix D: *Descriptive Themes and Code Development.*



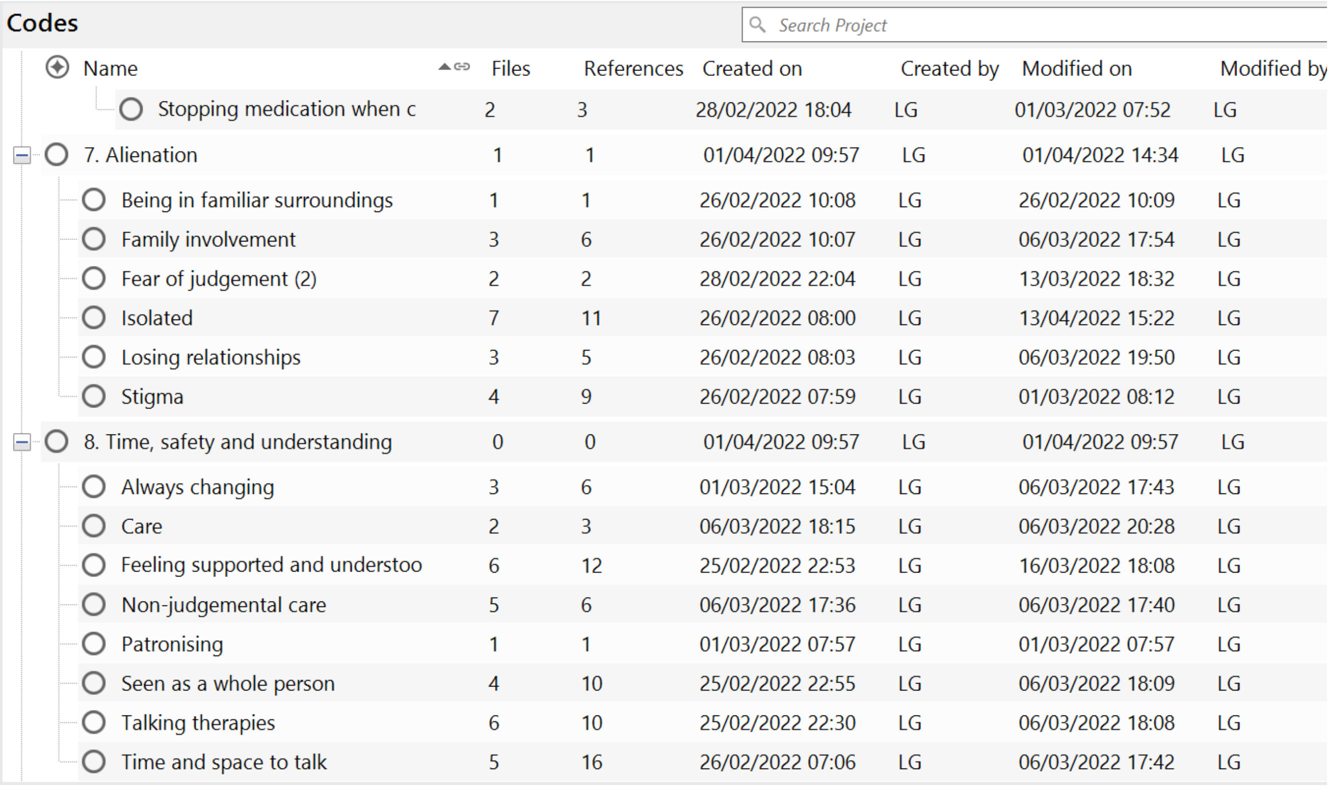
Codes

Name	Files	References
Alternative Support and Help	0	0
Practical, social and financial support	5	8
Relaxation and mindfulness	1	8
Being classed as dangerous	1	1
Being in familiar surroundings	1	1
Control	4	7
Lack of control	7	19
Taking Control	0	0
Cultural Awareness	0	0
Ethnic matching	2	4
Ethnicity specific services	1	5
Eurocentric system	3	3
Experiences of staff	2	2
Absence of black staff	4	5
Always changing	3	6
Being 'done to' and nothing else	3	5
Care	2	3

Appendix E: *Analytical theme development*

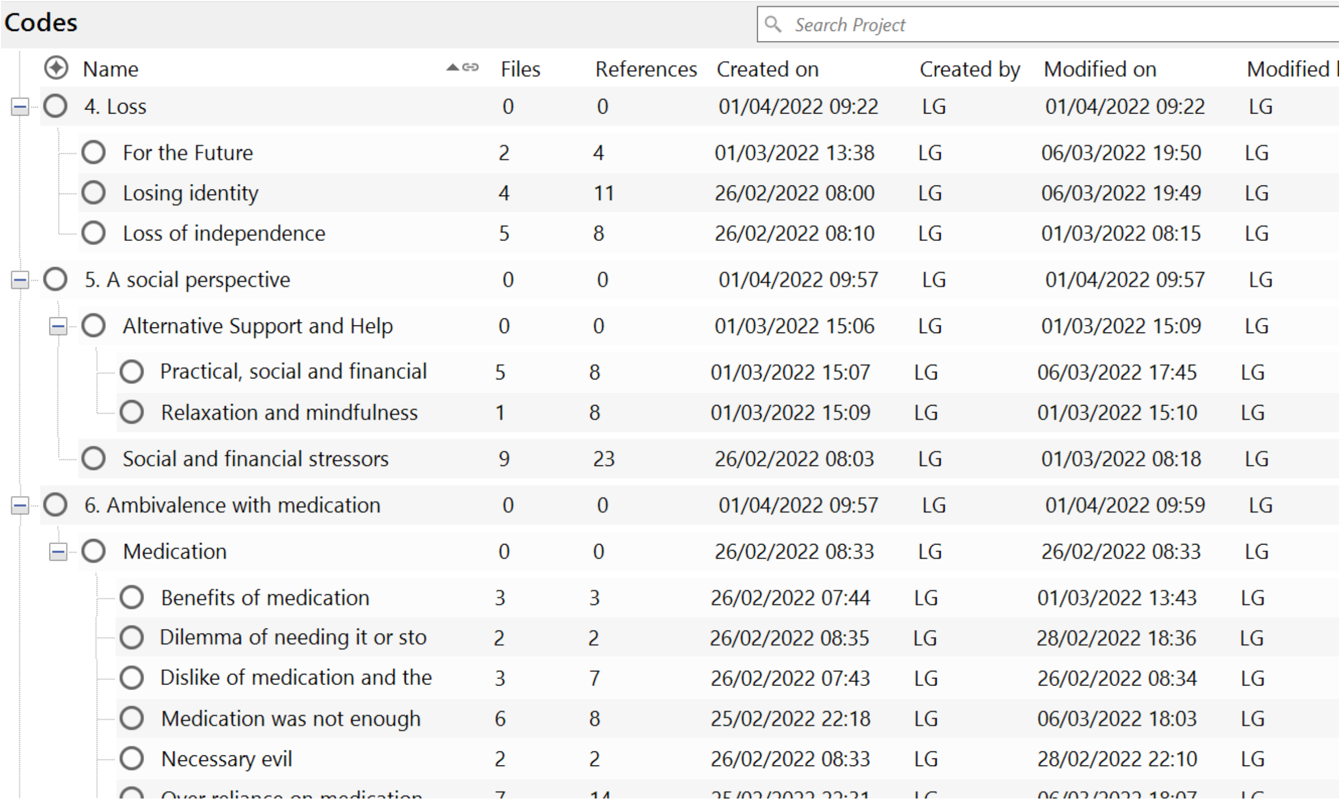


Name	Files	References
2. Them & Us	0	0
3. Restrictive Practices	0	0
Degrading administering process	3	4
Forced medication	5	13
Physical interventions & Restraint	3	4
Police or coercive entry to services	2	3
4. Loss	0	0
For the Future	2	4
Losing identity	4	11
Loss of independence	5	8
5. A social perspective	0	0
Alternative Support and Help	0	0
Social and financial stressors	9	23
6. Ambivalence with medication	0	0
Medication	0	0



Codes

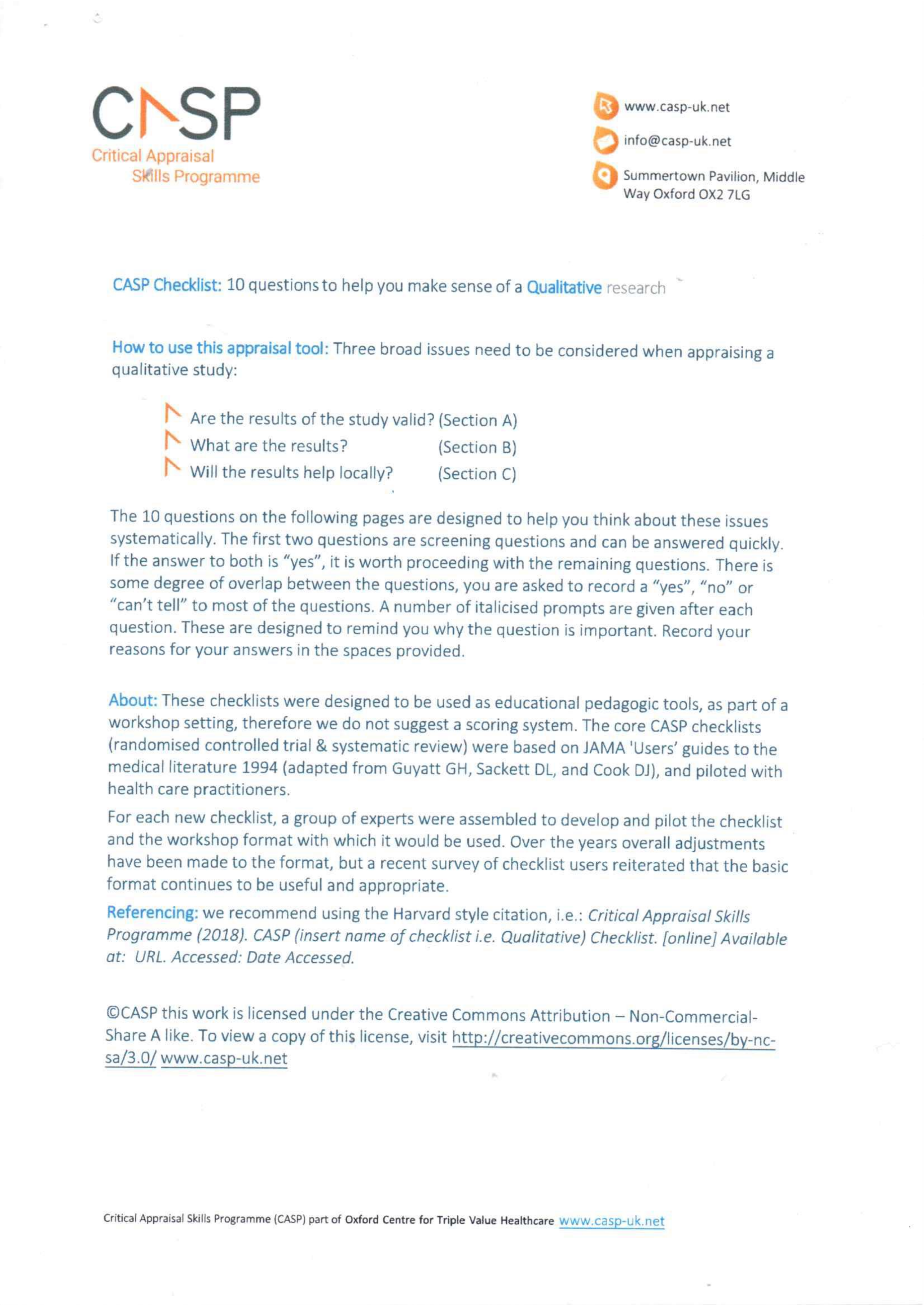
Name	Files	References	Created on	Created by	Modified on	Modified by
Stopping medication when c	2	3	28/02/2022 18:04	LG	01/03/2022 07:52	LG
7. Alienation	1	1	01/04/2022 09:57	LG	01/04/2022 14:34	LG
Being in familiar surroundings	1	1	26/02/2022 10:08	LG	26/02/2022 10:09	LG
Family involvement	3	6	26/02/2022 10:07	LG	06/03/2022 17:54	LG
Fear of judgement (2)	2	2	28/02/2022 22:04	LG	13/03/2022 18:32	LG
Isolated	7	11	26/02/2022 08:00	LG	13/04/2022 15:22	LG
Losing relationships	3	5	26/02/2022 08:03	LG	06/03/2022 19:50	LG
Stigma	4	9	26/02/2022 07:59	LG	01/03/2022 08:12	LG
8. Time, safety and understanding	0	0	01/04/2022 09:57	LG	01/04/2022 09:57	LG
Always changing	3	6	01/03/2022 15:04	LG	06/03/2022 17:43	LG
Care	2	3	06/03/2022 18:15	LG	06/03/2022 20:28	LG
Feeling supported and understoo	6	12	25/02/2022 22:53	LG	16/03/2022 18:08	LG
Non-judgemental care	5	6	06/03/2022 17:36	LG	06/03/2022 17:40	LG
Patronising	1	1	01/03/2022 07:57	LG	01/03/2022 07:57	LG
Seen as a whole person	4	10	25/02/2022 22:55	LG	06/03/2022 18:09	LG
Talking therapies	6	10	25/02/2022 22:30	LG	06/03/2022 18:08	LG
Time and space to talk	5	16	26/02/2022 07:06	LG	06/03/2022 17:42	LG



Codes

Name	Files	References	Created on	Created by	Modified on	Modified l
4. Loss	0	0	01/04/2022 09:22	LG	01/04/2022 09:22	LG
For the Future	2	4	01/03/2022 13:38	LG	06/03/2022 19:50	LG
Losing identity	4	11	26/02/2022 08:00	LG	06/03/2022 19:49	LG
Loss of independence	5	8	26/02/2022 08:10	LG	01/03/2022 08:15	LG
5. A social perspective	0	0	01/04/2022 09:57	LG	01/04/2022 09:57	LG
Alternative Support and Help	0	0	01/03/2022 15:06	LG	01/03/2022 15:09	LG
Practical, social and financial	5	8	01/03/2022 15:07	LG	06/03/2022 17:45	LG
Relaxation and mindfulness	1	8	01/03/2022 15:09	LG	01/03/2022 15:10	LG
Social and financial stressors	9	23	26/02/2022 08:03	LG	01/03/2022 08:18	LG
6. Ambivalence with medication	0	0	01/04/2022 09:57	LG	01/04/2022 09:59	LG
Medication	0	0	26/02/2022 08:33	LG	26/02/2022 08:33	LG
Benefits of medication	3	3	26/02/2022 07:44	LG	01/03/2022 13:43	LG
Dilemma of needing it or sto	2	2	26/02/2022 08:35	LG	28/02/2022 18:36	LG
Dislike of medication and the	3	7	26/02/2022 07:43	LG	26/02/2022 08:34	LG
Medication was not enough	6	8	25/02/2022 22:18	LG	06/03/2022 18:03	LG
Necessary evil	2	2	26/02/2022 08:33	LG	28/02/2022 22:10	LG

Appendix F: *CASP appraisal tool*



CASP
Critical Appraisal
Skills Programme

www.casp-uk.net
info@casp-uk.net
Summertown Pavilion, Middle
Way Oxford OX2 7LG

CASP Checklist: 10 questions to help you make sense of a **Qualitative** research

How to use this appraisal tool: Three broad issues need to be considered when appraising a qualitative study:

- Are the results of the study valid? (Section A)
- What are the results? (Section B)
- Will the results help locally? (Section C)

The 10 questions on the following pages are designed to help you think about these issues systematically. The first two questions are screening questions and can be answered quickly. If the answer to both is "yes", it is worth proceeding with the remaining questions. There is some degree of overlap between the questions, you are asked to record a "yes", "no" or "can't tell" to most of the questions. A number of italicised prompts are given after each question. These are designed to remind you why the question is important. Record your reasons for your answers in the spaces provided.

About: These checklists were designed to be used as educational pedagogic tools, as part of a workshop setting, therefore we do not suggest a scoring system. The core CASP checklists (randomised controlled trial & systematic review) were based on JAMA 'Users' guides to the medical literature 1994 (adapted from Guyatt GH, Sackett DL, and Cook DJ), and piloted with health care practitioners.

For each new checklist, a group of experts were assembled to develop and pilot the checklist and the workshop format with which it would be used. Over the years overall adjustments have been made to the format, but a recent survey of checklist users reiterated that the basic format continues to be useful and appropriate.

Referencing: we recommend using the Harvard style citation, i.e.: *Critical Appraisal Skills Programme (2018). CASP (insert name of checklist i.e. Qualitative) Checklist. [online] Available at: URL. Accessed: Date Accessed.*

Paper for appraisal and reference:

Section A: Are the results valid?

1. Was there a clear statement of the aims of the research?	Yes ☐ Can't Tell ☐ No ☐	HINT: Consider • what was the goal of the research • why it was thought important • its relevance

Comments:

2. Is a qualitative methodology appropriate?	Yes ☐ Can't Tell ☐ No ☐	HINT: Consider • If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants • Is qualitative research the right methodology for addressing the research goal

Comments:

Is it worth continuing?

3. Was the research design appropriate to address the aims of the research?	Yes ☐ Can't Tell ☐ No ☐	HINT: Consider • if the researcher has justified the research design (e.g. have they discussed how they decided which method to use)

Comments:

4. Was the recruitment strategy appropriate to the aims of the research?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If the researcher has explained how the participants were selected
- If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study
- If there are any discussions around recruitment (e.g. why some people chose not to take part)

Comments:

5. Was the data collected in a way that addressed the research issue?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If the setting for the data collection was justified
- If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)
- If the researcher has justified the methods chosen
- If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews are conducted, or did they use a topic guide)
- If methods were modified during the study. If so, has the researcher explained how and why
- If the form of data is clear (e.g. tape recordings, video material, notes etc.)
- If the researcher has discussed saturation of data

Comments:

6. Has the relationship between researcher and participants been adequately considered?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider

- If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location
- How the researcher responded to events during the study and whether they considered the implications of any changes in the research design

Comments:

Section B: What are the results?

7. Have ethical issues been taken into consideration?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider

- If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained
- If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)
- If approval has been sought from the ethics committee

Comments:

8. Was the data analysis sufficiently rigorous?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If there is an in-depth description of the analysis process
- If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data
- Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process
- If sufficient data are presented to support the findings
- To what extent contradictory data are taken into account
- Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation

Comments:

9. Is there a clear statement of findings?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider whether
- If the findings are explicit
- If there is adequate discussion of the evidence both for and against the researcher's arguments
- If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)
- If the findings are discussed in relation to the original research question

Comments:

Section C: Will the results help locally?

10. How valuable is the research?

HINT: Consider

- If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g. do they consider the findings in relation to current practice or policy, or relevant research-based literature
- If they identify new areas where research is necessary
- If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used

Comments:

Appendix G: *Quality assessment results*

Author(s) (year)	1. Clear statement of aims	2. Qualitative methodology	3. Research design	4.Recruitment strategy	5. Data collection	6. Relationship between researcher and participant	7. Ethical issues	8. Rigorous data analysis	Clear statement of findings	10. How valuable is the research?	Quality Rating
Islam et al., (2015)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Findings were discussed in relation to previous research. Limitations discussed. Further research areas were not discussed. Clinical Implications were discussed with minimal detail	High
Keating and Robertson (2004).	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Findings were discussed in relation to previous research. Limitations were not discussed; neither was further research areas. Clinical implications were discussed.	High
Lawrence et al., (2021a)	Yes	Yes	Yes	Can't tell	Yes	Yes	Yes	Yes	Yes	Findings were discussed in relation to previous research. Limitations discussed. Further research areas were not discussed. Clinical Implications were discussed.	High
Lawrence et al., (2021b)	Yes	Yes	Yes	Can't tell	Yes	Yes	Yes	Yes	Yes	Findings were discussed in relation to previous research. Limitations discussed. Further research areas were not discussed. Clinical Implications were discussed.	High
Mclean et al., (2003)	Yes	Yes	No	Can't tell	Yes	No	No	No	Yes	Findings were discussed in relation to some previous research. Limitations were not discussed; neither were further research areas. The implications of the research were discussed with minimal detail.	Moderate
Pierre (2000)	Yes	Yes	No	Can't tell	Yes	No	No	No	No	Findings were not discussed in relation to previous research. Limitations were discussed, as were future research ideas. Clinical Implications were discussed.	Low
Priebe et al., (2005)	Yes	Yes	No	Yes	Yes	No	No	Yes	Yes	Findings were discussed in relation to previous research. Limitations were discussed. Future research areas were	Moderate

									identified. Clinical implications were discussed in brief detail.	
Rabiee and Smith (2013)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Findings were discussed in relation to previous research and policies. Limitations were not discussed. Clinical implications were not discussed; neither were future research ideas.	High
Rabiee and Smith (2014)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Findings were discussed in relation to previous research and policies. Strengths and limitations were discussed. Some future research areas were identified. Clinical implications were discussed related to findings.	High
Secker and Harding (2002)	Yes	Yes	No	Yes	Yes	No	Yes	Yes	Yes	Findings were discussed in relation to previous research and policies. Limitations were discussed. Future research ideas were not identified. Clinical implications were discussed.	High
Wagstaff et al., (2018)	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Findings were discussed in relation to previous research. Limitations were discussed. Future research areas were not identified. Clinical implications were not explicitly discussed	High
Watts and Priebe (2002)	No	Yes	Yes	Yes	Yes	No	Yes	No	Yes	Findings were discussed in relation to previous research. Limitations were not discussed; neither was further research areas. Clinical implications were not discussed.	Moderate
Weich et al., (2012)	Yes	Yes	No	Yes	Yes	No	Yes	Yes	Yes	Findings were discussed in relation to previous research. Limitations were discussed, as were future research ideas. Clinical implications were not discussed explicitly.	High

Note. The research implemented a scoring template. Scoring strategy: ‘No’ = 0; ‘can’t tell’ = 0; ‘yes’ = 1. Total score ratings: <3, poor quality; 4-6, moderate quality; ‘yes’, high quality.

Appendix H: Examples of additional quotes for each theme

Super-ordinate theme	**Subtheme**	**Quotes**
Power and control	Powerlessness	*I can't remember, they did various things like blood samples, swabs and urine tests, I think they did all of that, and they said that the way they analysed me was that I had schizophrenia, because I'd been smoking cannabis, and I had a nervous disorder, because I'd become nervous, that's what they said. Interviewer: And what do you think, do you think you have schizophrenia? That's what they say, I don't know, I don't really know, I'm not really trained to say if I have or I haven't, but that's what they say. (Lawrence et al., 2021b; p.4).* *"When you are on the ward, you get staff that think it's a prison or something. And that you've done something and they try and boss you around. Control you, control you" (Watts & Priebe, 2002)* *"I wasn't doing anything as far as I know, but they just decided to put me in the lockup and that made me even worse, you know. Not understanding why they're taking me and putting me into the lock up. And I was in there for some time, when they could have kept me on the ward …" (Keating & Robertson, 2004)*
	Restrictive Practices	*"Sticking the needle and dropping my trousers and looking at my arsehole and all that" (Wagstaff et al., 2018).* *"I did not like it one bit, they treat you bad and they hold you down on the floor and they inject you…they lock you in your room, you can't go outside, it was horrible" (Priebe et al., 2005)* *"There is no redress to the medication. I have to take the medication that they give me. And, you know, when I was taken away the first time and injected and damaged…" (Secker & Harding, 2002)*

Disconnection	Personal Losses	*“It had taken years to separate herself from this identity, “If you’re told enough times you believe it.” (Lawrence et al., 2021b)* *“I had feelings of hopelessness … feelings of fear in terms of: Can I be like everyone else? Can I pay my bills? Would I be able to have enough money to live on? Such feelings of helplessness of not knowing if I’d be able to do all that …” (Keating & Robertson, 2004)* *“Coming to mental health services was like the last straw … You come to services dis-empowered already, they strip you of your dignity … You become the dregs of society …” (Keating & Robertson, 2004)*
	Social isolation	*“There are lots of outings to the cinema. That stops the isolation . . . keeps up communication” (Watts & Priebe, 2002)* *“I feel that because of the stigma, er … the stigma, I have not told my mates, they don’t know that I am schizophrenic because if you do something a bit peculiar, then they’ll think, ‘Oh, mentally ill, it must be an illness somewhere …’ So you carry it around with you and you don’t really like anyone to know” (Keating & Robertson, 2004)* *“By not being in an environment I knew, understood, I had never been in hospital before, I felt completely alienated from everyone, from society” (Priebe et al., 2005)*
Therapeutic needs	Beyond medication	*. . I want the cure you know, we want the cure you know” (Islam et al., 2015)* *“Sometimes you get a number of . . . urgent problems . . . in that kind of situation I need someone to talk to more than anything else. You can take tablets but the tablets kind of just dampen you down so that you can’t deal with any of the things that are causing the problems in the first place” (Rabiee & Smith, 2013)* *“I stopped hearing voices but the side-effects were so bad I’d prefer to hear voices” (Priebe et al., 2005)*

	Therapeutic relationships	*“Not being able to see the same doctor…having to repeatedly ‘to re-live the traumatic experience’ when describing it to a new doctor” (Rabiee et al., 2014)* *“It was awful, there was very few people who actually cared in there, I mean to be in such an environment where people don’t care, and they hold all the cards, and you have absolutely no rights and you have, you know, there’s no respect, I mean it was…a nightmare” (Lawerence et al., 2021a)* *“I had that with my social worker named Lucy. She was . . . something else. That time I was very, very sick and I was trying to tell her my situation and she said I look very confident, `you should be able to cope with this', you know what I mean? I was thinking `what's wrong with this lady. Can't she understand I need help?” (Watts & Priebe, 2002)* *“They talk about day-to-day stuff with me you know. It’s interesting really, they take an interest in my life” (Priebe et al., 2005)*
System Challenges	Cultural incompetence	*Even through some of the black staff, sometimes I felt that they weren’t caring enough about my condition and my well-being, um, as being a black, a black member, a . . . a black person in the, in the . . . from a black background with a good upbringing. Um, I felt that they could’ve been a little bit more sympathetic (Secker & Harding, 2002).* *“I’m not racist or anything, as regarding white or Asian, but I think at the end of the day I think that black doctors have been under- unrepresented in the mental health system.” (Rabiee & Smith, 2013)* *“I like James’s [pseudonym, chair of local African-Caribbean community development voluntary organisation] idea because James is sorting out that they should cook Caribbean food in the hospitals and serve them to the patients. If they had more people like James that got together and sorted out these things, then the black people wouldn’t have that problem” (McClean et al., 2003)*

Explanatory models	*“There was this ongoing conflict between am I crazy or am I not and I decided no I’m not, I’m going to do without this I’m going to get by without it, I’m not taking tablets because there’s nothing wrong with me” (Lawrence et al., 2021b)* *I had my benefit book, which was due, and I didn't know. . . . I was looking at it the wrong way, I was walking around broke, and my book became battered and torn, and I lost quite a bit of money then . . . and I thought it was another month” (Watts & Priebe, 2002)* *“You’ve got to realise that apart from being sick, you’ve got your financial life as well which is different from your medication, you know, because social security tend to mess you around. You need someone to stand up for you, give you your giro” (Priebe et al., 2005)* *“If you are lonely you have depress [depression] and stress. When I come here and my family were there and there was fighting there, you feel crying inside, sadness, you remember where you used to be and you can’t be with family, you are here. When I was in Somalia, I had a lot of friends, especially on Friday, I go to the beach. ... I don’t know how to work this country” (Rabiee & Smith, 2014).*
Implicit racism	*“I know from, you know, my brother that works for an organisation and he, before…he worked for somebody who dealt with mental health and that’s what they dealt with was you know people of colour being put into mental health, being wrongly diagnosed, totally drugged up. I was just, I was terrified” (Lawrence et al., 2021a)* *“Asian women sometimes get a bit of support especially if they’ve got an Asian doctor, an Asian psychiatrist. They get more help to cope and then their family would be counselled as well, the whole family. But black people, you know, it’s either hospital or prison” (Rabiee et al., 2013)* *“I do get depressed easily because of my circumstances and the way people in the community sometimes ignore you and all that, they just, you know I mean, because you’re black. I get all that, you know.” (Secker & Harding, 2002)*

Section Two: Research Report

Exploring Black peoples' experiences of acute inpatient mental health services and their perceptions of therapeutic needs: An interpretative phenomenological study.

Abstract

Objectives

Inpatient mental health services need to improve the quality and therapeutic benefit of care for Black people. This study aimed to explore Black peoples' experiences of. inpatient mental health services and their views on therapeutic needs.

Design and Method

Purposive sampling was utilised to find adults who identified as Black and had been admitted to an inpatient mental health service within the past 5 years. Six people took part in a semi-structured interview. Data was analysed using Interpretative Phenomenological Analysis methods.

Results

Three themes were reported: "importance of identity", "working together", and "connection with community". Participants wanted staff and services to recognise and understand their personal and cultural needs. Participants wanted information and involvement in decisions about their care and more opportunities to understand their mental health. Maintaining connection with family and aspects of cultural community was eminent to Black service-users.

Conclusion

Participants valued connection to staff, their family, and their culture, which they wanted inpatient mental health services to better cultivate. Collaborative care and respecting individuality were identified as important to Black people.

Practitioner Points

- Individual and cultural needs of Black people should be recognised and attended to within inpatient services.

- Service-users should be provided with information and psychoeducation regarding their mental health and included in decisions about their care.
- Services should support Black people to maintain connections with family and religion.
- Services need to recognise systemic racism and operate a strong stance against direct and indirect racism.

Keywords: Black people, inpatient mental health services, interpretative phenomenological analysis, qualitative.

Introduction

Reducing admissions to and improving the quality of acute inpatient mental health services is a current political priority, most specifically for racially minoritised populations (NHS England, 2016; Department of Health and Social Care [DHSC], 2021). For decades, data has presented significant disparities in inpatient care for Black people[9] (Barnett et al., 2019). Black people are four times more likely to be admitted to inpatient services than white people and are more likely to have repeated and longer detentions (NHS Digital, 2021). Furthermore, Black people are more likely to be compulsorily admitted; enter via 'negative' routes e.g., criminal justice system; be administered medication; placed in seclusion, and physically restrained than other service-users (Morgan et al., 2005; Care Quality Commission [CQC], 2011; Barnett et al., 2019).

An independent review of acute inpatient care (Crisp et al., 2016) found "a long list of problems" (p.13) and in particular a failure of services in understanding the differing needs of black and ethnic minority service-users. Following this, a review of the Mental Health Act (MHA; 1983) reinforced that the rates of detention were disproportionately high for Black people; and they had excessively poorer views and outcomes from, and an extreme fear of inpatient services (Wessely, 2018).

Focus groups with Black people were conducted as a part of Wessely's (2018) review to elicit their views and experiences of the MHA. Findings suggested Black people were concerned about race-based discrimination, staff's failure to protect them from abuse, an overuse of restrictive practices, and feeling unsafe. Black people wanted more collaboration when planning discharge, improvements to cultural competence, increased cultural diversity in workforce, and services to actively address racism and determinants of mental health

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[9] Data referring to Black people includes individuals who identify as Black African, Black Caribbean, Black British, Black mixed background, Black other or Black unspecified (Barnett et al., 2019; NHS Digital, 2019; 2020).

(Wessely, 2018). Overall, the review highlighted a need for services to better consider individual and cultural needs of racially minoritised groups (Wessely, 2018); reinforcing the longstanding call for services to become more culturally competent (Bhui et al., 2007).

Culture is the shared values, beliefs, practices, products, and norms of social groups (Cruz & Sonn, 2011). Literature proposed mental health conceptualisations; definitions of ‘abnormality’; causal reasons; help seeking behaviours; perceptions of helpful and unhelpful support; and identification of solutions are embedded within cultural constructions (James & Prilleltensky, 2002; Fernando, 2003).

Improving cultural competence is not bound to increasing staff diversity or implementing training programmes. Rather it is a multifaceted individual, organisational and systemic approach demonstrating a willingness to learn from service users from all cultures to design, develop, and implement services according to their needs (Bhui et al., 2007; Hernandez et al., 2009; Kirmayer, 2012). Capturing service user experiences can be useful to improving and delivering high quality mental health services (Chaplin, 2019), and is a research priority specifically for racially minoritised groups (Wessely, 2018).

Keating et al., (2002) conducted interviews and focus groups as part of a review of Black African and Caribbean peoples’ views of mental health services. The findings suggested inpatient services were most feared, viewed most negatively; and described as impersonal, autocratic, unresponsive to need and lacking structure (Keating et al., 2002).

A qualitative research study of Black African and Caribbean people’s experiences of inpatient mental health services found similar findings (Secker & Harding, 2002). Black people’s time on the wards were characterized by feeling powerless, with a lack of access to psychological treatments; experiences of overt and covert racism; and an overuse of medication. Participants also identified relationships with staff as a central facet to positive experiences of services, although good relationships with staff were rare. People wanted more time with staff to enable them to build relationships and for staff to help them with their difficulties (Secker & Harding, 2002).

There is a paucity of further research beyond these findings with regards to Black people's experiences of inpatient services, which contrasts to the wealth of research exploring the experiences of other populations (Cutcliffe et al., 2015; Tingleff et al., 2017; Eldal et al., 2019). Two recent systematic reviews synthesized the literature on experiences of inpatient services (Wood & Alsawy, 2016; Staniszewska et al., 2019) and found there was a dominance of white participants across the evidence base and a notable absence of research with racially minoritised populations.

The need for inpatient mental health services to provide a therapeutic environment and benefit for service users is well established (Crisp et al., 2016; Wessely, 2018); and hence is a central tenet of the political endeavors to reform the MHA (NHS, 2016; DHSC, 2021). Psychiatry standards for inpatient mental health services proposes a similar perspective and outlines that care, and treatment should be considered broadly (Chaplin, 2019). The guidelines suggest several aspects under the umbrella of 'care and treatment' including medication, psychological therapies, occupational therapy, creative therapies, collaboration on care plans, psychoeducation, written information about treatment, time to talk to staff, faith-based support and access to outdoor spaces (Chaplin, 2019).

Carey (2016) advocates for service user perspectives to be central to guiding what is considered therapeutic or helpful rather than being defined by services. Wood et al., (2019b) conducted a qualitative study to explore therapeutic needs of inpatient service users, which found people wanted services to consider their wider and social contexts; help with managing acute distress; and more collaborative care. Further research utilising content analysis explored what is deemed therapeutic more broadly and reviewed inpatient service users' views on 'beneficial moments' (Locher et al., 2020). Service-users reported education groups, exercise, authentic therapeutic relationships, engagement with nature, tranquil ward environments, spirituality, and talking with family were important to their care (Locher et al., 2020).

As proposed earlier, the perceptions of a person's mental health, help-seeking behaviours, and the judgement on what is helpful and unhelpful support is grounded in a person's views and beliefs shaped by their culture (Fernando, 2003; Bhui et al., 2018). For example, in some cultural groups, talking about painful events within talking therapies is not considered therapeutic or helpful (Lustig et al., 2003; Hague, 2010); and others consider mental health distress a religious rite of passage which must be endured not cured hence do not seek treatments aimed at curing it (Fernando, 2003).

Inpatient services' therapeutic provision and efforts should therefore be sensitive and responsive to a person's cultural context and needs (Mantovani et al., 2016). However, research exploring and commenting upon therapeutic needs have predominately described the views of white service users and did not directly explore views of ethnically diverse groups (Wood et al., 2019b; Locher et al., 2020). Thus, the findings may be limited in cross-cultural application to racially minoritised populations.

Research Aims

There is an evident need for inpatient mental health services to better meet the needs of and improve therapeutic care for Black people, who are significantly over-represented in inpatient services (NHS Digital, 2021; Wessely, 2018). Utilising Black people's experiences and views are crucial in achieving this (Wessely, 2018). However, published research exploring Black peoples' experiences of services is limited and is now 20 years old (Secker & Harding, 2002); and no study to date has explored Black peoples' perceptions on their therapeutic needs.

Hence, this research study aims to address these gaps in the literature. Adopting a qualitative design enables a rich and in-depth understanding of a personal perspective

(Pietkiewicz & Smith, 2014) and helps empower the ‘hidden’ voices of racially minoritised people (Bhui et al., 2018).

The aim of this study was to explore Black peoples’ experiences of acute inpatient mental health services and their views on their therapeutic needs.

Research Questions

(i) What are Black peoples’ experiences of inpatient mental health services?

(ii) What do Black people consider to be their therapeutic needs when accessing inpatient mental health services?

Method

Design

The study aims assumed people held a personal meaning about their life experiences and had a subjective way of making sense of them. This position is aligned with the underpinnings of Interpretative Phenomenological Analysis (IPA), which aims to explore lived experience*.* This idiographic approach, contrary to more nomothetic approaches, aims to understand a particular phenomenon at an individual level.

IPA is situated in the continuum between phenomenology (description of a person’s experience; Husserl, 1927) and hermeneutics (interpretation, which gives meaning to a person’s experiences; Heidegger, 1962). Firstly, participants make sense of and describe their experiences, following which researchers interpret, make sense, and formulate meaning of these experiences (Pietkiewicz & Smith, 2014); referred to as the double hermeneutic process (Smith & Osborne, 2003). The double hermeneutic process allows for experiences to be shared and phenomenon to be seen, where the purpose of the methodology is to ‘give voice’ to specific experiences (Larkin et al., 2006; Smith et al., 2009). Moreover, the value of using IPA in psychological research of cultural perspectives is recognised (Pietkiewicz & Smith, 2014). IPA was therefore selected as the most appropriate method for this research study (Smith et al., 2009; Harper, 2012).

Other qualitative analysis methods were considered but ruled out. Grounded theory (Glaser & Strauss, 1967), underpinned by a realist perspective, aims to develop theory to explain behaviours. This method did not align with the philosophical position from which this study is based, an exploration of subjective experience, and thus was not deemed suitable. Discourse Analysis explores the use of language to identify and investigate narratives of life experiences (Potter & Wetherell, 1995). However, this study was less interested in *how* service-users describe their experience and understandings, rather the experience and understanding themselves.

Reflexivity

Within IPA, the researcher is a central analytic instrument as they co-construct meaning of the participant's experiences through their interpretations of the data (Smith et al., 2009). However, the researcher exists within their own context influenced by personal beliefs, history, and culture, thus interpretation can never be without presupposition (Heidegger, 2010). Hence, the researcher must identify, acknowledge, and explore their own perspectives, influences, and biases through reflexivity to consider the influence these may have on the research (Berger, 2015).

The researcher identifies as a white British woman, raised around white norms. They work as a trainee Clinical Psychologist and have not accessed inpatient mental health services. The researcher reflects further on their personal position and the differences they have to the participant group in a reflexive statement (appendix A). The researcher also kept a reflective diary to consider beliefs, assumptions, thoughts, and emotional responses during the data collection and analysis stages (Horsburgh, 2003; appendix B).

Patient and Public Involvement

Research should be done 'with' and 'by' members of the public, rather than to them, through patient and public involvement (National Institute of Health Research, 2019). This was particularly important in this study given the recognised cultural, racial, and lived experience differences between the researcher and participants.

The researcher sought consultation from public and professionals, relevant to the study population. The aim was to ensure the study was sensitive, appropriate, and relevant to the participants, and to enhance the research methodology and study materials. Three people made up the advisory group: one Black adult who had experience of inpatient mental health services previously; one Black male clinical psychologist who had worked in inpatient mental health services; and one Black female forensic psychologist, with experience of qualitative research and working in forensic inpatient mental health services. Moreover, one Black female adult who had experience of mental health services completed a pilot interview and provided feedback. The contributions, recommendations and amendments made are outlined in appendix C.

Ethics

Ethical approval was obtained via the Integrated Research Application System (IRAS, 293712) following full Research Ethics Committee review and Health and Research Authority approval. Approval was also granted from the NHS Foundation Trust for governance. Substantial time was afforded to consideration of ethical issues for the research (appendix D). All ethics approval documentation is contained in appendix G-J.

Recruitment and Participants

Small and reasonably homogeneous samples are appropriate for IPA research as the focus is upon the richness and depth of personal account (Smith et al., 2009). Purposive sampling was used to recruit a sample which allowed for exploration of the identified phenomenon, experience of inpatient services, at an individual level within a specific population, Black people. Participants were identified across several inpatient and community mental health services within one NHS mental health trust in England, according to the study's inclusion criteria, shown in Table 1.

Table 1.

Inclusion and exclusion criteria

Inclusion Criteria	Exclusion Criteria
Adults (Age 18-65 years)	Individuals experiencing ongoing significant distress, as assessed by clinical team
Any gender	Individuals who had only accessed forensic inpatient mental health services
Self-identified as Black[10] (Including people who identified as mixed Black ethnicity)	Individuals who were unable to provide informed consent.
Currently or previously (in the past 5 years) been admitted to an acute inpatient mental health service/ward, under any section of the Mental Health Act.	
Spoke English	

Note. The criteria were adapted during the research process, following feedback from potential participants, and recruiting clinicians. Changes outlined in appendix E. This table describes the final criteria.

Posters outlining the research study were placed in visible areas around each service (appendix K, L). Clinicians within each team identified people who met the inclusion criteria and spoke to them to provide a brief overview of the research and answered initial questions. If individuals were interested, they were provided with a participant information sheet (appendix M) and consent was sought for the researcher to contact them. The researcher contacted consenting individuals and offered them opportunity to meet, discuss the research

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[10] During research development the researcher proposed inclusion criteria would be people who identify as Black African or Caribbean. However, on further reading and conversations with PPI, this did not allow people to define their own ethnicity, thus the use of the term Black ensured this was broad and allowed for personal ethnic identification.

study and ask any questions. If participants were happy to proceed, an interview time was booked.

Six participants took part in the study which is in line with recommendations for IPA research studies of between four and ten for doctoral studies (Smith et al., 2009). Six interviews were considered adequate for the research aims, as the comprehensive dialogue within each interview and the exploration of an under-researched area of a particular experience within a specific population provided sufficient information power (Malterud et al., 2016). Participant demographic details are displayed in Table 3.

Data from recruiting clinicians demonstrated 45 people were directly invited to take part and therefore the participation rate was estimated to be 13.3%. People were not required to give a reason why they did not want to take part, but of those that did, they typically cited that their focus was on community discharge, they did not want to discuss their experiences, or they had other life stressors at the time.

Two participants consented to taking part but withdrew before their interview; one participant consented to take part but withdrew 10 minutes into the interview as they were feeling too tired, their data was securely discarded.

Data Collection

Participants could opt to complete the interview in person (n=4), via video call (n=1) or telephone (n=1). Before the interview, the aims and outline of the research were repeated, and further questions were answered. Once the participant had no further questions and if they were happy to take part, informed consent was gained and recorded (appendix N). Participants then completed a demographic information sheet (appendix O) and the interview.

The interview schedule (appendix P) was developed in line with guidance (Smith et al., 2009; Pietkiewicz & Smith, 2014) and in collaboration with the advisory group. The interview schedule was a loose guide, and open to flexibility to move to what participants wanted to discuss and important aspects to them. Questions involved an initial question with follow-up prompts dependant on the participant's answer. Interviews were audio-recorded using an encrypted digital recorder. Interviews lasted between 38 and 85 minutes (mean=59 minutes). Participants wellbeing was considered throughout the interview (appendix F), and they were offered a debrief at the end to review their wellbeing; reminded of their right to withdraw the data; and given a debrief form (appendix Q).

Quality and Rigour

The researcher adhered to the different aspects of quality control outlined in Elliot et al., (1999) quality standard guidelines, as outlined in Table 2.

Table 2.

Quality control

Guideline	Application to current study
Owning one's perspective	The researcher acknowledged and considered their own position, biases, assumptions, and thoughts during the research. These were identified in a reflexive statement (appendix A) and within reflexive diary entries maintained during the research study (appendix B).
Situating the sample	Demographic data for all participants is provided to help situate the findings, whilst balancing the need to protect participants identity. The sample are recruited from one city within the North of England which has a small ethnically and racially diverse population, although remains a predominately White population. The participant sample will vary from that which is recruited from other areas within the UK and internationally due to demographic differences including wealth, access to education, healthcare provisions, and ethnic diversity amongst population.
Grounding in examples	Quotes from the interviews, considered 'raw data' are included in the results section to evidence the themes.
Credibility checks	One transcript was co-analysed by the researcher's supervisor[a]. They then met with the researcher to discuss their analysis and identify similarities and discrepancies, considered a 'verification step'. The author also discussed the final themes with an independent colleague[b].

	Participants were asked whether they wished to take part in member checking, as a part of the credibility checks. However, no participant wanted to. The author acknowledges the weakness of this study in not completing member checking with participants or PPI representatives.
Coherence	Analysis methods are outlined clearly, and the development of the themes is demonstrated (appendix R). Results section provides a succinct and clear summary of the findings. Themes are organised in a table for ease of the reader.
Accomplishing general vs. specific research tasks	The participant sample is small, and the focus was upon gathering a homogenous sample. The findings therefore represent the views of a small group of Black people who have utilised inpatient services. The researcher does not proclaim the findings represent the views of all Black people and/or inpatient mental health users and discusses this further in the limitations section.
Resonating with readers	The researcher has carefully balanced the interpretation aspects of IPA methodology with ensuring the findings remain close to the participants experiences. The findings are presented in a coherent way that centralises people's experiences.

[a] Lecturer in Clinical Psychologist, with experience of qualitative research

[b] Trainee Clinical Psychologist, with experience of qualitative research

Analysis

The analysis followed the stepped method outlined by Smith et al., (2009), which depicts an iterative and inductive process. Firstly, the researcher became immersed in the data by listening to the interview once, listening again during the transcription phase; and reading each transcript. Next, the researcher made line-by-line comments about things they noticed as they read each transcript. The comments were colour coded to identify descriptive, linguistic, and conceptual aspects of the data. Then the researcher moved towards the interpretive analysis. The researcher noted emergent codes from the comments, moving towards their interpretations but ensuring these remained grounded in the participants experiences.

Codes for each transcript were then ordered chronologically and grouped into how the researcher viewed they fitted together to develop themes. Next, the researcher compared themes across transcripts, to look for convergent and divergent themes, and final superordinate and subthemes were refined. Examples of each analysis stage are presented in appendix R.

Results

Data analysis revealed three superordinate themes, with several subordinate themes (Table 4). The themes are discussed with illustrative participant quotes (additional quotes, appendix S). Participants’ contributions to each theme are presented in Table 5. Themes do not represent an exhaustive account of participants’ experiences, rather an interpreted account of prominent discourses. Some aspects of experience overlap themes.

Table 3.

Participant demographic information

Participant	Gender	Age	Country of birth	Ethnicity[a]	Number of admissions to inpatient wards	Length of most recent admission	Time since most recent discharge
1	Male	40-49	England	African-Caribbean	>10	>30 days	Inpatient
2	Female	21-29	England	Mixed Black Caribbean – White English	5-10	> 30 days	Inpatient
3	Male	40-49	England	Black Caribbean (British Status)	<5	22-30 days	Inpatient
4	Female	40-49	England	Black Caribbean (British Status)	<5	>30 days	7-12 months
5	Male	30-39	West African	Black African	>10	>30 days	7-12 months
6	Male	21-29	South African	Black African - British	<5	>30 days	7-12 months

[a] Each participant has defined their own ethnicity, and this is reported here verbatim.

Table 4.

Superordinate and subordinate themes

Superordinate themes	Subordinate themes
Importance of Identity	Wanting to Feel Understood
	Becoming Aware of Mental Health Problems
	Overt and Covert Racism
Working together	Safety and Containment
	“Where is the Collaboration?”
	Meaningful Activity
Connection with community	Significance of Food
	Attention to Religion and Spirituality
	Maintaining a Connection with Home

Table 5.

Participants contributions to themes

Superordinate and subthemes	**Participants**					
	1	**2**	**3**	**4**	**5**	**6**
Importance of Identity						
Wanting to Feel Understood	✓	✓	✓	✓	✓	✓
Becoming Aware of Mental Health Problems		✓	✓	✓	✓	✓
Overt and Covert Racism	✓	✓	✓	✓	✓	✓
Working Together						
Safety and Containment	✓	✓		✓	✓	✓
“Where’s the Collaboration?”	✓	✓	✓	✓	✓	✓
Meaningful Activity	✓	✓	✓	✓	✓	✓
Connection with community						
Significance of Food	✓		✓	✓	✓	✓
Attention to Religion and Spirituality	✓		✓		✓	✓
Maintaining a Connection with Home		✓	✓	✓		✓

Importance of Identity

This theme encapsulates recognition, understanding and responsiveness of services to service users' individuality and needs. Identity is related not just to mental health needs but needs as a Black person, though many felt discriminated against whilst on the ward.

Wanting to Feel Understood

Participants wanted to be seen, understood, and treated as an individual by staff, which helped them to feel cared for. Some found it helpful that "staff understand what's going on for me" (P1), with regards to their mental health and difficulties. Others valued staff getting to know their life context, histories, and stories more broadly, as these were important parts of who they were and contributed to what they needed.

> *"It's nice to just speak to people and know that people do care about who they are looking after…That's really reassuring… I do think they do know a lot about me now, and probably too much" (P.2).*

> *"Whenever I've been on the ward, I've always been cared for, the people help me, they really do" (P5).*

However, others felt "they miss the personal bits" (p.4), and they presented a sense of them feeling 'invisible' or dehumanisation on the ward, which contributed to negative experiences of the ward.

> *The staff didn't offer me any sort of…anything…they're was in the office quite a lot of the time. On the ward were some care workers, but they, they didn't even know my names. They didn't really care. They didn't talk to you, they didn't have a conversation. (P4).*

> *“They [staff] need to speak to their patients more and find out if there is anything they can do for them and if there is anything they need…Like when you get sectioned you just get sectioned, you just get admitted and then they leave you” (P6)*

People’s need to be understood and respected extended to their identity as a Black person. Some participants felt services were “outta touch with Black people” (P6), and so their preferences, nuances, and needs were ignored. Though the discrete times when these were recognised, had a big impact on people feeling ‘seen’ as a Black person.

> *“…they [staff] selected a Bob Marley track, I felt like, they support…There were all different types of music, but she did include a little bit of reggae. So, I thought yeah, see they can, it’s not that difficult” (P.4).*

Becoming Aware of Mental Health Problems

Several participants described being admitted to the ward enabled them to recognise, “ahhh, I’m ill, it’s an illness” (P4), and begin their emotional recovery journey. Participants conveyed moving from a “psychotic cloud” (P5); “manic state” (P2); “midst of a psychotic breakdown” (P4) to being more aware, in control and ‘well’. Although there was a stark contrast in participant three’s narrative who disagreed with the view that they were unwell.

> *“…When in hospital realised, I really have bipolar…I’m not saying it was a good time, it was a terrible terrible time, upsetting time, a traumatic times” (P2).*

> *I always said that there is nothing wrong with me, and I believe there is nothing wrong with me now. But they saying I am better, better from what?” (P3)*

Participants shared their hope that the ward would offer opportunity for them to learn more about their mental health, though their experiences of being offered this varied. Participants wanted to know/learn about the causes, symptoms, likely impact, and coping strategies; some specifically identified Psychology sessions as the place where they would gain this understanding. Participants conveyed a view that knowing more would help them better manage their difficulties and bolstered their hope, "that there is light at the end of the tunnel" (P6).

> *"I have had sessions with the Psychologist…I have liked having a place to talk about, life and the things I wanted to…Learning about how I got here, or how it was, what triggered it, like I learnt about that which have helped me get it" (P.2)*
>
> *"I thought they would be more things in place to like, educate you on it. Like teach you like the best ways to cope with it, like what coping mechanisms to do…It's the psychologist thing, that's probably the most important thing" (P.6).*

Notably though, participant one offered a contrasting perspective, in that too much focus was given to Psychology.

> *"Rather than just…kinda, constantly trying to delve into your head, and solve everything through Psychology and medication." (P.1).*

Overt and Covert Racism

Experiences of racism or discrimination were present across all participants narratives. Some participants described unintentional acts or interactions, which they felt were not set out to be racist, but inadvertently were experienced as discriminatory. Other narratives suggested there was an implicit, but noticeable, bias within the system which resulted in the unequivocal treatment of Black people, "like the system is not for us, it is not designed for me" (P5).

> *“People from Jamaican backgrounds get racism from Asian and English people…Its very subjective, like, when you are on section for a very long time. Or not being given very much leave. Or being on a section for longer than you need to be on a section” (P.1).*

> *“It is just something I’ve noticed and picked up, like women of colour, like women who aren’t white basically, they, we get told that we dress really inappropriate…and I’ve just noticed like if a white woman, like a white woman goes in and wears the same thing, they won’t be told in the same way” (P.2).*

Other accounts described more direct interactions, remarks, or comments, experienced as racism, mostly from other service users. Three participants conveyed this was an inevitable and regular occurrence on the wards, which made one person in particular “hate” (P4) being there.

> *“I had my hair in twists…they’d [service users] sing, ‘buffalo soldier, dreadlock rasta, say aye, aye’…And they was just going on, on, repeatedly” (P.4).*

> *“Being black in the ward is difficult, because racism is something we encounter by looks. You know, you don’t have to say a word, for me to feel it. Or for me to think, this people probably don’t want me standing around here, so I might as well just walk about” (P.5)*

> *“A few inpatients might have niggle, but that’s inpatients. But might be, but might be a few offensive words, but, not more than that.” (P.3).*

Racism felt difficult to challenge, particularly that perpetrated by other service-users. Participants felt it was not their job to address other service-users and were mindful that other service-users may be racist within the context of being unwell.

Hence people often relied on staff to address racism; some felt this was managed well but some felt disappointed with staff’s stance against racism.

> *“They [staff] need make it clear that racism on the ward is not, is not acceptable. Make it clear that in any shape form or whatever, racism is not acceptable.” (P.4).*

Working Together

This theme covers people’s narratives of their relationships and engagement with staff, and the wards generally. Participants wanted service users and professionals to work together, to create a safe, therapeutic, and engaging ward to help their mental health.

Safety and Containment

Participants reflected on their sense of safety, in which divergent narratives appeared. For some, the ward was “a place of safety” (P5), that offered them containment. Two participants reflected on the plethora of life stressors they were enduring prior to their admission, and the ward relinquished them of such pressures, a sanctuary, which allowed them opportunity to focus on their wellbeing.

> *“You get to relax, you get to wind down…you get to think about your next step forward and to think about what you want to do…To have time away from it all, and time to rest and time to heal” (P1)*

However, other participants described feeling “scared” on the wards. Some people felt scared because of their mental health and being ‘placed’ on the ward without knowing why. Additionally, people felt the wards were unsafe and described them as scary characterised by a loud environment; witnessing other service users in distress or fighting; lack of privacy; and lack of trust in staff. Participants also utilised metaphors to describe the environment, referring to the ward as a “prison” (p4) and “being released” on leave (p6), suggesting it felt controlling or restrictive, rather than helpfully containing.

> *“I thought if I just stay in my room, nothing will happen. I will be safe in my room. It was about safety, cos I didn’t feel safe at all whilst I was in…Like I didn’t, like there were some patients, there were some patients that were fighting and stuff, and difficult to handle, just seeing them…” (P.6).*

“Where’s the Collaboration?”

Collaborative care for participants was that in which professionals provided clear and extensive information and ensured joint decision making about service users’ care/treatment; this was considered a basic requirement of the wards. Though this was often lacking, and participants described “things were going on that I don’t know about” (P1), insinuating a view that services held the power.

An absence of information meant people felt in the dark about their detention, care plan, diagnosis, and medication. Moreover, people felt they were ‘done to’ rather than ‘with’ in respect to their care and treatment.

> *“Your care plan is supposed to be a collaborative thing. And like this care plan, I was like I’ve not had these words, these aren’t what I’ve said, where’s the collaboration…I can speak, you know” (P4)*

> *“They came in and just said you are taking this medication and forced me down, put a needle in my right butt, and I took the medication. Now, I still have a right to say yeah or no” (P3)*

The lack of collaboration appeared not for service users want for trying, as participants often attempted to have their voices heard with respect to their care and treatment. Though participants portrayed a view that they were unheard or dismissed, “it’s quite hard to be listened to when you’re unwell” (P2); further perpetuating their powerlessness.

> *“…on the ward I was asking for it [to attend MDT meetings], but never got it. And even now, with, the CBT, I am still waiting. So, like I’ve not had any involvement” (P6).*

Additionally, participants found it impossible to challenge the system or professionals and resigned to notions that staff made the decisions and instead focussed on ‘getting out’.

> *“I feel treated unfairly here, who do I speak to about it? You know, I speak to somebody about it, and they like okay we will see what we can do about it. But nothing ever gets done. And this is what keeps repeating itself over and over” (P5).*

> *“I really do not want to think or talk about it if I am honest. It’s, it’s sorted now. I know I am leaving now. And I will have a different consultant” (P2).*

Meaningful Activity

All participants described doing interesting activities and occupational therapy sessions on the ward, which were noted as the most offered intervention/sessions after medication. Participants unanimously spoke positively about these sessions and conveyed a sense of the therapeutic benefit they had more broadly. Sessions helped participants to keep busy; to cope with being on a busy ward; to connect and build relationships with staff and other service users; to feel safe; to learn something new; and improve their mental health.

> *"I like doing the OT sessions, like pottery or art or things like that. Keeping busy is good for me…" (P2)*
>
> *"Pottery, I thought it was just to pass time, but it probably did help me, come back to being lucid kinda thing." (P4)*

Connection with Community

Participants wanted to maintain a connection and engagement with the aspects of their life and culture that they valued whilst on the ward. To participants, maintaining connection to 'their community' was therapeutic and helped their mental health.

Significance of Food

The significance of food was evident across all participants narratives. Some participants conveyed an appreciation for just having food, proposing it was "nice to have a meal, food was good" (P1). This conveyed the view that participants access to regular foods/meals in life outside of the ward is vastly different, and meeting this need was beneficial to their wellbeing and mental health.

> *"When I'm in the ward…I would have breakfast, have lunch, you know, I would have supper, all the things that help me…to get better" (P5)*

For others, the importance was not on the availability of food, rather the type that was important. Participants wanted African or Caribbean foods, referred to as "supper", as these were the foods they enjoyed, preferred, needed or were familiar with. Again, highlighting participants' wish to be 'seen' as a Black person, and for services to show more consideration to what foods they might need consequently.

Food had a significant role in people’s mental health and general wellbeing, and on top of services not attending to these needs, efforts by service users and families to meet their own needs were also denied.

> *“I don’t eat what you eat for supper. But I ate it, but…I’d like some Caribbean food for supper.” (P3).*

> *“I’m used to like African food…like more time I couldn’t eat. When like my mum would try and bring me food in…weren’t, wasn’t allowed so what could you do? ... With my illness, meals they are important to me. Like if I have eaten, I feel ten times better” (P6).*

Though the lack of availability of culturally appropriate foods was not the problem, services did offer individualised menus. However, participants reflected on finding out coincidently, rather than from professionals.

> *“I’ve seen that Rasta [service user] got curried goat and he goes, oh you can ask the, you can ask for food… for the Caribbean meal. I was like, how can I’ve been here for 3 weeks, or whatever it was, I didn’t know” (P4).*

Attention to Religion and Spirituality

Religion was important to some participants, and they wanted services to recognise and attend to aspects of this within their care on the ward. Though generally participants felt “nothing was discussed about my religious needs or anything like that” (P6). Consequently, attention to and practices aligned with a person’s religion was left to service-users themselves to do or individual staff members who shared similar religious values.

> *"They had a chaplain in…that's helped, in some way but…I feel, they're doctors and they're struggling to understand certain points of aspects of my religion" (P3).*

> *"For her [staff member] to just come and be like can I pray for you, and I thought like, that was one of the nicest things anyone did for me on that ward."* (P6)

Two other participants described their spiritual connection and perspectives particularly in relation to their mental health. Similarly, participants wanted services to appreciate and provide support aligned to their values.

> *"I want to do more of the spiritual. You know, like more of the meditation, yoga, kung-fu, karate, more of the spiritual aspects of Kung-fu." (P1).*

Maintaining a Connection with Home

Family was important to participants, and subsequently they wanted to maintain close connections with them throughout their admission to hospital, to provide a source of familiarity and safety for people especially when distressed. Despite separation from family, participants articulated that they were still integral to them becoming well. Moreover, participants also described their family offering advice or acting as their advocate to ensure their voices were heard either via complaints or conversations with staff.

> *"…She [mum] would get on the phone, she would say to me you need to take your medication, and I was like why, I don't need drugs they trying to force me. But my mum was like you need to take your medication, it will help you to feel better or it will be enforced, kinda thing…so I took it…My mum was a big part of me getting well" (P4)*

> *"That [seeing family] would have helped me with comfort and trust. And, that I was in a safe place, and recognising the people that I familiarise myself with and the surroundings. It would have been so much easier if my family had been around. I don't think I would have, stayed at the ward as long" (P6).*

Home visits, telephone calls and family visits to the ward were crucial for participants to help maintain a connection with home, though many participants felt the ward could still do more to facilitate this further.

> *"I miss home, I miss home comforts, I am going home today. That's, that's the comforting thing. Just being in my own home. Getting in my own bath, getting in my shower, eating at home, talking to my family" (P3).*

Discussion

This study aimed to explore Black people's experiences of inpatient mental health services and their views on therapeutic needs. Three themes were identified: *"importance of identity*", *"working together",* and *"connection with community*".

Importance of Identity

Feeling recognised as a person and understood on an individual level was important to participants, and meant they felt cared for by staff, which replicates previous inpatient research with Black people (Secker & Harding, 2002), and wider populations (Eldal et al., 2019; Staniszewska et al., 2019). Being afforded time by staff and opportunity to talk, helped service-users to be better understood (Koivisto et al., 2004). Qualitative research suggests nursing staff similarly value time spent with service-users (McAllister et al., 2021) and endorse the principles of person-centred and therapeutic care in inpatient services (Wyder et al., 2017), although systemic barriers (e.g., low staff levels, risk management, increased role complexity) meant nurses had to focus on procedural rather than therapeutic tasks (Totman et al., 2011; Wyder et al., 2017). Participants wanted to be ‘seen’ as a Black person, in which aspects of their culture (i.e., music, food) would be recognised. Rabiee et al., (2013) similarly found that Black service users wanted to feel understood on a cultural level, but white professionals are often fearful about asking about culture for fear of ‘getting it wrong’ or being politically incorrect (Rathod et al., 2010).

Participants use of diagnostic conceptualisations of their difficulties is contrary to previous findings which suggested Black people were less likely to hold biological explanatory models of mental health (McCabe & Priebe, 2004). Participants wanted, but were afforded inconsistent, opportunities to talk about and better understand their mental health, which replicates previous research (Secker & Harding, 2002). Moreover, previous research replicates participants’ view in that joint sense making of difficulties in Psychology sessions was valuable to developing personal awareness and understanding (Small et al., 2018). For racially minoritised people, understanding the diagnosis, implications, and coping strategies (Islam et al., 2015); and making sense of personal difficulties are important for coping with mental health problems and working towards ‘wellness’ (Codjoe et al., 2013).

Participants described direct and indirect racism from other service-users, professionals, and the system generally, which echoes research outlining Black people’s experiences of inpatient (Secker & Harding, 2002) and other mental health services (Priebe et al., 2005; Keating & Robertson, 2004). Sue et al., (2007) provides an overview of different forms of racism which are commonplace in clinical practice. These include direct racist abuse, termed ‘micro-assaults’, and less obvious, yet still prejudicial, forms of racism called “microaggressions” which can be intentional or unintentional, perpetrated by a person, environment, or system (Sue et al., 2007).

Such microaggressions, that are often hard to identify, manifest in mental health services as systemic bias (Sue et al., 2007) or ‘institutional racism[11]’; which some propose is evident in the significant inequalities in admissions and treatment in inpatient services for Black people (Sashidharan, 2003).

Working Together

The ward offered a safe space away from life stressors for some participants. A place of safety without social pressures, termed ‘safe spaces’, is a key aspect of mental health recovery for Black men (Keating et al., 2019). Conversely, others felt scared on the ward, due to concerns about their mental health or because the ward felt unsafe and restrictive; the multi-layered fear in inpatient services has been demonstrated in research (Sweeney et al., 2015). The findings also replicate Keating et al., (2002) review, which found Black people feared inpatient services due to wards being loud, unpredictable, and hostile.

Participants wanted information about their mental health and treatment, and to have a voice in the decisions made about their care; factors which help improve engagement with mental health services for Black people (Priebe et al., 2005). Previous literature has indicated lack of communication and joint decision making contributes to feelings of powerlessness in inpatient mental health services for Black people (Keating, 2007) and in broader populations (Wood & Alsawy, 2016; Staniszewska et al., 2019). Providing service-users psychoeducation about their mental health and treatment information reduces relapses, admission time, and

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[11] “The collective failure of an organisation to provide appropriate and professional service to people because of their colour, culture, or ethnic origin. It can be seen or detected in processes, attitudes and behaviours which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness, and racist stereotyping which disadvantage minority people” (Macpherson 1999, p.49).

readmission rates; and improves treatment compliance and social functioning (Xia et al., 2011).

Activities and occupational therapy sessions on the ward were unanimously valued by participants, as they relieved boredom, offered distraction, and/or directly helped improve wellbeing. High levels of boredom on inpatient wards are associated with negative experiences of the wards (Chevalier et al., 2018), while a comprehensive activity programme is associated with reduced levels of restraint (Wilson et al., 2018) and has a positive impact on psychological wellbeing, social connectedness, and recovery (Foye et al., 2020; Stickley et al., 2018).

Connection With Community

Participants described the importance of maintaining connection to their culture and community whilst in inpatient services, which research supports and suggests is crucial for recovery in racially minoritised populations (Kang & Moran, 2020). African and Caribbean cultures are collectivist which centralises group identity, solidarity, and a co-dependence on each other (Chioneso, 2008), which may explain the importance of maintaining cultural connections.

More specifically, the significance of food was recognised. Firstly, participants depicted adequate access to food had a positive impact on their wellbeing, which is an established link (Mind, 2017) and recognised as a ‘basic need’ (Maslow, 1943). Other people wanted culturally appropriate foods, which literature suggests helps people to feel a belongness to African culture (Airhihenbuwa et al., 1996) and maintain self-identity (Burrowes, 2004). Introduction of Caribbean food to inpatient services previously was felt to indicate a small shift towards cultural competence as services recognised and respected Black people’s culture (McClean et al., 2003).

Participants described their spiritual and religious needs were not sufficiently met. Previous literature equally evidences the importance of religion and spirituality in the process of recovery for racially minoritised people (Leamy et al., 2011), but that these were often not met in inpatient services (Kang & Moran, 2020). Moreover, the value of spiritual or alternative therapies (e.g., yoga) was similarly found by Locher et al., (2020). Research proposes staff may miss religious and spiritual needs as they assume service users will raise them (Foskett et al., 2004); lack of confidence about discussing them (Kang & Moran, 2020); or these are not included within assessment frameworks (McSherry & Ross, 2002).

Finally, participants valued seeing and maintaining relationships with family; the therapeutic benefit of family involvement in mental health care for Black people is evidenced (Keating et al., 2002). Kang and Moran (2020) highlights family for racially minoritised service users are effective in communicating a person's difficulties to professionals; helping service users understand their difficulties; encouraging engagement with interventions; and being service users' advocates to raise concerns.

Strengths, Limitations, and Future Directions

This research study addressed a gap in the literature of Black people's experiences of inpatient mental health services and their perceptions of their therapeutic needs. This provides an update to Secker and Harding (2002) study and goes someway in readdressing the underrepresentation of racially minoritised populations in research (Redwood & Gill, 2013). Moreover, the research offered participants a platform in which to have their voices heard. Two participants specifically noted this was the first time they had been asked, and they valued the opportunity to 'share' and 'offload' their thoughts.

The researcher, as a white woman, acknowledged the ‘outsider’ position from which they conducted the research. As such, consultation with an advisory panel was integral to the study, and the researcher implemented recommendations from this. However, inevitably the researcher will still have ‘blind spots’ which, most pertinently, may have impacted the interpretation of participant’s experiences (Suwanakhong & Liamputting, 2015). The inclusion of a co-researcher from the Black population would have been advantageous and offered helpful collaboration.

The participation rate was lower than expected which may be reflective of some methodological limitations of the study. Recruiting through NHS services helped recruit a homogenous sample aligned with IPA methodology. However, services and clinicians were then the gatekeepers for people’s recruitment/participation. People who had a fractious relationship with, sporadic engagement, or lacked trust in services or professionals were probably less likely to participate or may not have been approached by clinicians. This may have introduced a bias in the results, as people who were not asked or declined to take part may have had different experiences to those who took part. Additionally, people who have accessed inpatient services but are not currently engaged with statutory mental health services may offer another perspective, which this study did not aim to explore, but future research should address this gap.

The researcher was independent from the recruiting NHS services. This distance aimed to position the researcher as separate from participants’ care, to dismantle power imbalances and create a safe space for participants to share honest experiences. However, this may also have caused difficulties in recruitment, as service-users did not know the researcher and did not have a foundation of trust and safety which may have made people fearful about taking part. Difficulties with recruiting people from racially minoritised groups is recognised (Rugkasa & Canvin, 2011), in which mistrust in research and healthcare services, and fear about participation were found to be the key barriers for Black people (Scharff et al., 2010).

Moreover, it is possible that the researcher was never fully considered a ‘neutral’ person and was still positioned as a part of the staff team. Especially given the researcher adopted the same confidentiality protocol as staff and was afforded the same rights to access staff offices and keys. Hence participants may have felt uncomfortable or reserved about discussing their ‘true’ experiences, which may have been further heightened by the researcher’s difference in culture and race.

Finally, Black people are not a homogenous group, and this broad categorisation as an inclusion criterion, still ignored intra-ethic or cultural differences (Owusu-Kwarteng, 2017) and the influence of other aspects of intersectionality including disability, gender, physical health, and country of birth. Future research would benefit from considering different aspects of diversity and explore Black people’s experiences on a more individual and specific level.

Implications

Many of the findings replicate those reported by Secker and Harding (2002), suggesting Black people’s experiences remain consistent, despite efforts to improve services (DoH, 2005). Moreover, this demonstrates a gap in that previous findings did not transfer to clinical changes within services for Black people and hence it is pertinent the findings from this study are utilised to guide action and change within health services (Coutler et al., 2014).

Person-centred care principles outline the importance of staff spending time with service-users in formal and informal ways to develop relationships (Kitson et al., 2013). Staff working in inpatient services should increase time spent with service-users on the ward, focussed on relational and interpersonal aspects rather than procedural or process tasks (Myklebust & Bjorkly, 2019). More formally, staff should provide every service-user with daily protected time, of up to one hour, to talk individually about care, treatment, and pertinent issues for service-users (NICE, 2011). This will need organisational as well as service-level support however, as increased nurse-patient time requires services to operate with “effective” or ‘therapeutic’ staffing levels, as opposed to ‘safe’ (NHS England, 2014; Helm & Bungeroth, 2017; Gilburt, 2018). Additionally, service-users should be afforded adequate information about their rights and care; and invited to be an active part of decisions made about their treatment and care plan in multi-disciplinary meetings (NHS, 2019). This ensures care is shaped around individual needs aligned with person-centred care principles (DHSC, 2021).

Professionals working with Black people need to actively learn about and understand a person’s culture through conversations with them to build ‘partnerships’ (Gopalkrishnan, 2018). Professionals should cultivate ‘cultural humility’ (Hook et al., 2013; Mosher et al., 2017) in which they bracket off personal beliefs and assumptions and adopt an open and curious stance in conversations, to understand service-users’ culture. The cultural formulation template outlined in the DSM-V (American Psychiatric Association, 2013; p.723) provides a useful framework as a foundation to facilitating this approach and to support staff to have these conversations (Lewis-Fernandez et al., 2015). Moreover, Psychologists in acute settings can support staff teams to develop a holistic formulation for service-users, to help staff to identify factors related to admission, understand service users’ difficulties, and centralise individual needs, including cultural aspects, within a plan for care (British Psychological Society [BPS], 2019).

Professionals should help maintain service-users' connection to family by ensuring adequate telephone access, sufficient visiting hours/rooms, and home visits (Leggatt, 2002; Cheng et al., 2018); and involving family in discussions and decisions about their care (NICE, 2016; Dirik et al., 2017). Additionally, incorporation of a spiritual needs assessment (Nissen et al., 2021) during admission stages would ensure services identify Black service-users' spiritual and religious needs, and these can then be incorporated into their inpatient care (Mohr et al., 2010). Moreover, services should also incorporate questions about food needs and preferences into admission assessment frameworks, and include culturally appropriate meals as standard on menus, to ensure easy access (Siegel et al., 2011).

Inpatient services should provide information and opportunities for Black service users to develop an awareness and understanding of their mental health through psychoeducation sessions (NICE, 2011). Psychology sessions focussed on developing a co-constructed formulation of a person's difficulties would help people to make sense of their mental health and feel more involved in their care (Small et al., 2018). Thus, aligned with guidelines, all service-users should be afforded Psychology sessions, which will need further provision and funding (BPS, 2012; 2019). Psychologists could also offer staff training and supervision to enable them to support service-users to increase understanding of their difficulties within other one-to-one spaces on the ward (BPS, 2019).

Addressing systemic racism is more than vocalised efforts to treat people fairly. The first important step is for services to recognise and understand how racial prejudice on both micro- and macro-levels has permeated society and mental health services (Sue et al., 2007; Williams et al., 2022). Then a concerted effort to stand up for racial prejudice should be adopted by services, by having a clear and transparent anti-racism policy in place which staff can follow to ensure a strong stance against inter-service-user racism is maintained.

This study highlighted divergence amongst Black people's experiences and their perceptions of therapeutic needs, guided by personal contexts and values. This reinforces the need for person-orientated care in inpatient services (DHSC, 2021). The implementation of the implications however is dependent on organisational and political factors. Changes within services to better meet the needs of Black people will require investment of additional funding, resources and staffing, which services are already depleted of (Mind, 2017; Gilburt, 2019; NHS providers, 2020).

Conclusion

Black people wanted inpatient services to cultivate a caring and therapeutic approach in which professionals recognised, understood, and attended to their individual and cultural needs. Providing adequate information and opportunity to discuss their mental health may help Black people to understand and manage their difficulties better. Inpatient services should work together with service-users to support them in a way that is meaningful to them, embedding a person-centred approach to services.

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Appendix A: Reflexive statement

Reflexive statement

The researcher identifies as a white British female, in her thirties. Her family were all born in the U.K. and remain residents here. She grew up in a working-class family, within and around British and white norms. She considers herself a family person, who has strong ties to her immediate and extended family, as well as to close friends. These people play a large part in the researcher's life across life events and situations, to celebrate or support through them. The researcher and those around her have no specific religious beliefs or affiliations to a faith or religion.

Professionally, the researcher is a trainee clinical psychologist with experience of working in mental health services in the NHS, private sector, and charity organisations. The researcher has also worked specifically within a long-term inpatient mental health service, a forensic inpatient mental health hospital and in a prison based mental health service. The researcher was always struck by the disproportionately high numbers of Black people who were admitted to inpatient or forensic settings. This was further highlighted when she moved to work in the community, and there was a significant lack of Black people in community mental health services. This triggered an interest in understanding 'why' this was, and thus the researcher begun to explore the evidence base for Black people and inpatient services, where it quickly became apparent it is quite limited. The researcher was interested in pursuing research to address this gap and to find out more about Black people's experience of services.

The researcher aligns with the social constructionist position, in that there is few, if any, objective 'truths' and people's views and beliefs are borne out of their own experiences which are their own reality. She believes her experiences as a white woman will inevitably shape her views of the world and her interactions within it. The researcher has always been interested in qualitative research as it aligns with this world view, and aims to find out the more exploratory questions, from personal perspective. The researcher was drawn to IPA as a methodology for its focus of understanding what the experience is like for *this* person and what sense *this* person makes of it, especially when thinking about Black people's experiences, and making sure the findings are focussed on vocalising their personal perspectives. Additionally, the researcher draws upon different therapeutic approaches in her clinical work, but values mostly compassion focussed models and systemic ideas. The researcher as a professional is interested in the influence of wider systems, for example mental health services, political agendas, societal biases, have on a person and their wellbeing. The researcher has taken an interest in community Psychology across their training.

The research was completed during a unique context and political time period. The research was carried out throughout the global Covid-19 pandemic, which highlighted significant social and health inequalities for people from minority ethnic groups, who were disproportionality impacted by the coronavirus disease. Moreover, the 'Black Lives Matter' movement had gained significant momentum as the research commenced following the murder of George Floyd. Though not a new message, it was amplified, that the Black community were cruelly treated by people in power, including by the police, professionals, services. The movement shone a light on institutional racism and was starting to give a voice to the people it affected. The researcher is mindful of how the current political landscape impacts the participants and people related to this study. The hope was that Black people in inpatient services would have their voices heard as part of this larger movement; their voices were always there - it was the researcher's aim for the research world to hear them.

Appendix B: Example excerpt from the researcher’s reflexive diary log

I really enjoyed this interview, and found the conversation flowed really well, probably felt more like a conversation, and they were comfortable with talking through their experiences. It was a much longer interview than the rest, and I wondered whether this was because they felt comfortable talking or whether I kept talking because I found it interesting.

I felt a real warmth towards them, maybe because we are roughly the same age or because I found them charismatic, they were so friendly and chatty. I like people like that, maybe because that’s how I like to be, so this is why I connected to them more. I noticed some shared similarities in the things we liked, opinions and mannerisms. I will need to be mindful of this during analysis, to step outside of my opinions and remain true to their account.

This was the first time during an interview someone became visibly upset, we spent some time discussing how they felt and checking they were happy to continue. For them, they said it was part of the reason they wanted to take part was to share the parts that had been hard. I noticed my uncomfortableness with my research causing someone to feel upset. I also felt connected to the world of ‘professionals’ that they had said were so dismissive, and I really wanted to distance myself from that and position myself as this ‘outsider’ to the world of mental health professionals, but I couldn’t, I was acutely aware I was one, I am one. I wondered whether I had not fully appreciated how upsetting it would be for people. I had considered it in all my planning and documentation, maybe I was thinking about it procedurally or on an intellectual level, and not on an emotional level. It was so powerful in the room, and I felt this real responsibility to change services for Black people, if I was a part of this group of professionals, I had to be a voice. I think this left me feeling empowered after the interview to do people's accounts and experience justice, to make sure these are heard.

I was really struck by their story that staff on the ward did not know their name. I was really shocked to be honest, that feels horrible, to be admitted to hospital and someone not know who you are? I really had to monitor my response to this, as I found myself really shocked and quite angry about it. I really wanted to validate that this was wrong and should never have happened, again I think I wanted to position myself as a 'good professional' and reassure her that this was okay to be upset about. These are important things to notice, and I will continue to monitor and look for my own reactions and pulls in interviews.

Implications on my clinical practice

- Conducting this interview and hearing the person's experiences made me recognise my uncomfortableness with being considered a 'bad' professional. Though I appreciate there may be times when I do not get it right as a professional. I make an active effort to invite people's feedback during and after our work together, to ensure that people feel empowered to share their opinions on my practice and encourage feedback that may improve my clinical practice and support of that person.
- The importance of understanding someone as a person – knowing what matters to them and the things they valued was really clear in this interview and others. Within my clinical practice since this time and going forward, I afford good time at the beginning of working with someone to get to know them as a person, without specific questions or areas that I am interested in influencing this. I open

discussions with people to invite them to share aspects of themselves that are important for me to know about and consider in our work together – be it their racial identity, their cultural interests, their social circumstances, their religious beliefs, their hobbies/interests – whatever may be important to them.

- I actively encourage conversations about race and ethnicity in mine and other's clinical practice. As a white woman, I undoubtedly will not know aspects of Black culture or identity that are important to Black people. I ask, I acknowledge my blind spots and demonstrate my willingness to learn and how this is important to include in our work together.

Appendix C: Consultation with PPI panel.

Research Stage	Role and Involvement	Feedback and recommendations
Design	One hour meeting with the EbE and clinical psychologist	• The research is exceptionally valuable (EbE and professional feedback). • Be mindful of professional jargon and using technical language when discussing research, need to make it accessible to people (Professional feedback). Recommend defining what interpretative phenomenological analysis means on materials. • Consider whether to use Black African/Caribbean as inclusion criteria – some people might identify as Black but of mixed background, and may be excluded or not invited if it looks too narrow (Professional feedback) • Important to share results with the black community, tell them what you found, keep them involved (EbE feedback).
Recruitment	One hour meeting with the EbE and clinical psychologist	• Important to go out and meet black people where they are, do not expect people to come to you (EbE feedback). • Black people struggle to talk about how they feel, even with family. May be suspicious about speaking to someone never met before. EbE feedback to allow time for someone to get to know the researcher before interview. Subsequently, people were offered a pre-meeting before interview to meet the researcher and ask questions, to ease feelings of suspicion before they decided if they want to participate. • Utilise African, Caribbean or African-Caribbean to describe a person’s heritage but do not use word “Afro-Caribbean” (EbE feedback). All documentation adhered to this.
Interview	One hour meeting with the EbE	• Discussing experiences may be emotive and/or take people back to a traumatic place (EbE and professional feedback). Suggested need to consider this in interview. Created ways to manage this: o Included an introductory part to interview which acknowledged this. o Offered breaks regularly throughout interview

		o Purposeful check ins were included during all interviews to review if they needed any support or wanted to stop interview. • When transcribing interviews, notice the sounds and noises the person makes. People may sigh or tut in places for example, these have meaning and may be important. Enquire with the person during the interview what they mean to them (EbE feedback). Noted on transcripts.
Materials	Time to review materials broadly	• Identified appropriate services to signpost people to within debrief forms (professional feedback). Included organisations for black community. • Reviewed and amended wording in all documents to make accessible and appropriate.
Materials	Development of interview schedule. Two separate meetings with the forensic psychologist and EbE	• ADD: questions at the start to find out about people’s context before hospital (professional feedback) • ADD: small introduction to say all experiences are welcome and create space for issues related to race to be heard. Need to show that researcher is willing to hear these. Added in introduction (professional feedback). • REMOVE: some questions, too many. Use broad opening questions and can always follow up with more specific questions afterwards (professional feedback) • CHANGE: professional jargon (EbE feedback), Using words such as “therapeutic interventions” – either explain this, or change to more accessible language “talking sessions” • CHANGE: wording from “tell me about” to “could you describe your”, to soften the language (EbE and professional feedback) • CHANGE: Questioning style – be direct, too vague e.g., do services understand your needs, how did you find talking to staff. Need to specifically ask about the areas that the research is interested in i.e., culture and experiences of mental health services. Ask directly about experience, for example, did you experience any racism, how did staff understand you as a black person, what was it like talking to white staff members (professional feedback).
Pilot interview	One hour pilot interview with EbE.	• Important research. Interview style was warm and helped person to speak freely. • ADD: can add more follow up questions or check person has nothing further to add, before moving to next question.

	• ADD: Add questions in to ask how participants feel rather than just “what it was like”, helps expand from description.

Appendix D: Ethical considerations

Ethical Issue	Measures taken and implemented to address issue
Participation and right to withdraw	Clear and written information. Participants were approached by a clinician within the team to determine interest before being contacted by the researcher. They were provided brief overview and poster before full information sheet. Participants could ask the clinician questions and given time to read the full participant information sheet before being asked consent for researcher to contact. Consent was gain at various points: before researcher contacted person, during discussions about research and booking interview and before interview started. Participation was voluntary and participants could withdraw from the research after their interview (up to 2 weeks after). Informed consent was gained prior to the interview – documented on form (appendix N). People were not asked for a reason if they did not want to take part or if they wanted to withdraw. There wellbeing was checked if there were concerns it related to this. Participants were aware that their choice to participate or withdraw would not affect their care or service offered by any NHS services (included in information sheet).
Confidentiality	Anonymity was extremely important due to the sensitive nature of the interviews. Consideration was given to the demographic details written in the report to ensure people were not identifiable. All interviews were transcribed by the researcher and no personal identifiable information (names, locations, hospitals) were transcribed or included in this report. Data was recorded on an encrypted Dictaphone and transferred securely for transcription. Once transcribed, the recording was deleted.
Disclosures	Participants were informed prior to the interview (written and verbal communication) that in the instance of them disclosing issues of risk (to self, to others or from others), then the researcher would need to share this information and they would be informed about this. The researcher would then follow the relevant NHS Trust safeguarding policy procedure.
Emotional Distress	It was possible that interview topics may have been emotive, the researcher developed a distress protocol to outline the steps taken to safeguard against potential distress (appendix F). This included options for participants

	to take breaks, stop the interview, and use of open questions in which responses could be guided by the participant and what felt comfortable to them. Participants were provided with a debrief period after their interview, used to check in with how they were. Provided with debrief form which outlined services available for support and contact details for researcher if they wanted to withdraw. All participants were offered opportunity to discuss anything that came up for them during the interviews with a member of the clinical team after the interviews.

Appendix E: Changes to inclusion criteria during research study

Change	Inclusion criteria	Reason for change
Original	Current inpatient on an acute inpatient mental health ward, under any section	N/A
1	Current inpatient on an acute inpatient mental health ward Or has been an inpatient on an acute inpatient mental health ward within the past 3 months	People's admissions were often short, and they were quickly discharged once they appeared 'well'. To allow time for recruiting clinician to approach the person and for the interview to be set up, including people who were discharged allowed for this.
2	Current inpatient on an acute inpatient mental health ward Or has been an inpatient on an acute inpatient mental health ward within the past 12 months	Feedback from potential participants was they wanted to focus on getting out from the ward and resettling into the community before taking part. Increased timeframe following discharge to allow for this reintegration period.
3	Current inpatient on an acute inpatient mental health ward Or has been an inpatient on an acute inpatient mental health ward within the past 5 years	Feedback from potential participants was they were focussed on their mental health and getting better, with community services. They needed to focus on this, before taking part in research about experiences on the ward.

Appendix F: Distress protocol

The
University
Of
Sheffield.

Department Of Psychology.
Clinical Psychology Unit.

Doctor of Clinical Psychology (DClin Psy) Programme
Clinical supervision training and NHS research training & consultancy.
Telephone: 0114 2226650
Email: a.sinha@sheffield.ac.uk

Study IRAS ID: 293712

Clinical Psychology Unit
Department of Psychology
University of Sheffield
Floor F, Cathedral Court
1 Vicar Lane
Sheffield
S1 2LT

Distress Protocol

Project title: Understanding the experiences and therapeutic needs of Black people accessing acute inpatient services: A phenomenological study.

It is possible that interview topics may be emotive so the following steps will be taken to safeguard against potential distress:

1. Using a semi-structured interview method consists of open-ended questions, enabling participants to choose the experiences they would like to talk about and the level of detail they wish to describe them in.

2. The researcher will state clearly before starting the interview and ensure participants are aware that they can decline to answer any questions during the interview.

3. The research will state clearly before starting the interview and ensure participants are aware they can withdraw from or stop the interview at any point during this.

    i. For face-to-face interviews, the recording device will be placed in the middle of the room for participants to stop this if they wish.
    ii. For remote/telephone interviews, participants will be informed about the recording device, and a withdrawal plan will be agreed with the participant prior to commencing the interview. Participants will be informed that if they hang the telephone up or the call unexpectedly ends during the appointment, the researcher will make one attempt to call them back in case of a lost connection but if they fail to pick this call up, the researcher will assume they wished to end the interview and the recording will be stopped. The researcher will retain the recording for 24 hours before deleting this, and assume the participant no longer wants to participate.

4. Participants will be offered opportunity to take a break at their discretion. The researcher will ask at frequent intervals whether they wish to take one.

5. The student researcher is trained in communicating with individuals during times of distress and will use these skills throughout the interview.

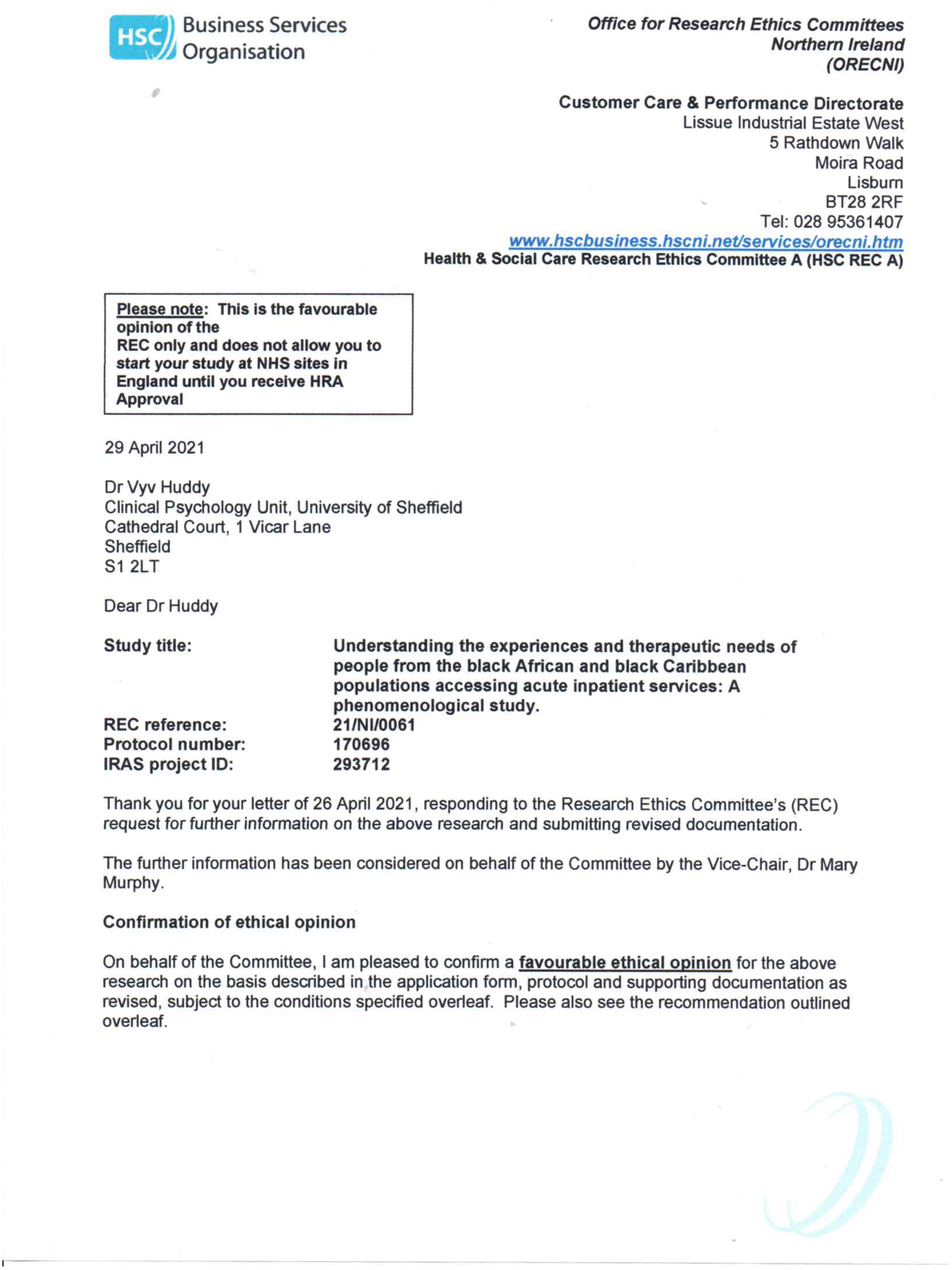
6. The student researcher will assess and monitor participant distress levels base do verbal and non-verbal clues during interviews and use their support and communication skills to help participants feel at ease.

7. Direct questions about wellbeing. Regular explicit checks will be completed by the researcher (interviewer) throughout the interview, asking specifically how the interviewee is feeling and offering the opportunity for a break if required. These will be asked more frequently during remote interviews given the increased difficulty in assessing a person's wellbeing.

8. If a participant appears distressed or concerned about the process at any point as assessed by the researcher (interviewer) or if stated by the participant, the interview will be paused by the researcher to explore this, and if felt appropriate the researcher will offer the participant to take a break and/or will stop the interview to protect the wellbeing of participants.

9. End of interview debrief, participants will be afforded time to ask questions or discuss any concerns they have following the interview with the researcher. The participant's wellbeing will then be reviewed explicitly by the researcher. This will entail two specific questions asking participants if anything distressing arose because of taking part in the interview.
    i. Participants currently on the ward will be offered support from the ward staff and/or Psychology team on the ward.
    ii. Participants in the community will be invited to discuss with the researcher and signposted to support organisations, encouraged to contact their GP or community mental health services. This information is also identified on the debrief forms.

Appendix G: Research Ethics Committee (REC) approval letter



HSC Business Services Organisation

Office for Research Ethics Committees
Northern Ireland
(ORECNI)

Customer Care & Performance Directorate
Lissue Industrial Estate West
5 Rathdown Walk
Moira Road
Lisburn
BT28 2RF
Tel: 028 95361407
www.hscbusiness.hscni.net/services/orecni.htm
Health & Social Care Research Ethics Committee A (HSC REC A)

Please note: This is the favourable opinion of the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval

29 April 2021

Dr Vyv Huddy
Clinical Psychology Unit, University of Sheffield
Cathedral Court, 1 Vicar Lane
Sheffield
S1 2LT

Dear Dr Huddy

Study title:	**Understanding the experiences and therapeutic needs of people from the black African and black Caribbean populations accessing acute inpatient services: A phenomenological study.**
REC reference:	**21/NI/0061**
Protocol number:	**170696**
IRAS project ID:	**293712**

Thank you for your letter of 26 April 2021, responding to the Research Ethics Committee's (REC) request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Vice-Chair, Dr Mary Murphy.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a **favourable ethical opinion** for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified overleaf. Please also see the recommendation outlined overleaf.

Good practice principles and responsibilities

The UK Policy Framework for Health and Social Care Research sets out principles of good practice in the management and conduct of health and social care research. It also outlines the responsibilities of individuals and organisations, including those related to the four elements of research transparency:

1. registering research studies
2. reporting results
3. informing participants
4. sharing study data and tissue

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Confirmation of Capacity and Capability (in England, Northern Ireland and Wales) or NHS management permission (in Scotland) should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for HRA and HCRW Approval (England and Wales)/ NHS permission for research is available in the Integrated Research Application System.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations

Registration of Clinical Trials

All research should be registered in a publicly accessible database and we expect all researchers, research sponsors and others to meet this fundamental best practice standard.

It is a condition of the REC favourable opinion that **all clinical trials are registered** on a publicly accessible database within six weeks of recruiting the first research participant. For this purpose, 'clinical trials' are defined as the first four project categories in IRAS project filter question 2. Failure to register a clinical trial is a breach of these approval conditions, unless a deferral has been agreed by or on behalf of the Research Ethics Committee (see here for more information on requesting a deferral: https://www.hra.nhs.uk/planning-and-improving-research/research-planning/research-registration-research-project-identifiers/.

If you have not already included registration details in your IRAS application form, you should notify the REC of the registration details as soon as possible.

Further guidance on registration is available at: https://www.hra.nhs.uk/planning-and-improving-research/research-planning/transparency-responsibilities/.

Publication of Your Research Summary

We will publish your research summary for the above study on the research summaries section of our website, together with your contact details, no earlier than three months from the date of this favourable opinion letter.

Should you wish to provide a substitute contact point, make a request to defer, or require further information, please visit: https://www.hra.nhs.uk/planning-and-improving-research/application-summaries/research-summaries/.

N.B. If your study is related to COVID-19 we will aim to publish your research summary within 3 days rather than three months.

During this public health emergency, it is vital that everyone can promptly identify all relevant research related to COVID-19 that is taking place globally. If you haven't already done so, please register your study on a public registry as soon as possible and provide the REC with the registration detail, which will be posted alongside other information relating to your project. We are also asking sponsors not to request deferral of publication of research summary for any projects relating to COVID-19. In addition, to facilitate finding and extracting studies related to COVID-19 from public databases, please enter the WHO official acronym for the coronavirus disease (COVID-19) in the full title of your study. Approved COVID-19 studies can be found at: https://www.hra.nhs.uk/covid-19-research/approved-covid-19-research/.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

REC Recommendation:

1. Thank you for providing evidence Good Clinical Practice (GCP) training undertaken by you (chief investigator) on 7 July 2015. However, as this training has expired, it is recommended that this is completed again and evidence of more recent GCP training is provided for file.

After ethical review: Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study, including early termination of the study
- Final report
- Reporting results

The latest guidance on these topics can be found at https://www.hra.nhs.uk/approvals-amendments/managing-your-approval/.

Ethical review of research sites

NHS/HSC sites

The favourable opinion applies to all NHS/HSC sites taking part in the study, subject to confirmation of Capacity and Capability (in England, Northern Ireland and Wales) or management permission (in Scotland) being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS/HSC sites

I am pleased to confirm that the favourable opinion applies to any non-NHS/HSC sites listed in the application, subject to site management permission being obtained prior to the start of the study at the site.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	**Version**	**Date**
Cover Letter [Cover Email - Provisional Opinion Response Table]		26 April 2021
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Sponsor Insurance Certificate]		24 February 2021
Interview schedules or topic guides for participants [Interview Schedule]		26 February 2021
IRAS Application Form [IRAS_Form_08032021]		08 March 2021
IRAS Checklist XML [Checklist_08032021]		08 March 2021
IRAS Checklist XML [Checklist_26042021]		26 April 2021
Letter from sponsor [Letter from Sponsor]		04 March 2021
Non-validated questionnaire [Demographic Questionnaire]		26 February 2021
Other [Participant Debrief Form 1]	1	26 February 2021
Other [Participant Debrief Form 2]	1	26 February 2021
Other [Distress Protocol]	1	22 April 2021
Other [Good Clinical Practice Certificate Chief Investigator]		07 July 2015
Other [Good Clinical Practice Certificate Principal Investigator]		26 April 2021
Participant consent form [Participant Consent Form]	2	22 April 2021
Participant information sheet (PIS) [Participant Information Sheet]	2	26 April 2021
Research protocol or project proposal [Research Protocol]	4	22 April 2021
Summary CV for Chief Investigator (CI) [CV Chief Investigator Vyv HUDDY]	1	08 March 2021
Summary CV for student [Student/Academic Researcher CV]	1	08 March 2021
Summary CV for supervisor (student research) [CV for supervisor]	1	08 March 2021

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/.

HRA Learning

We are pleased to welcome researchers and research staff to our HRA Learning Events and online learning opportunities– see details at: https://www.hra.nhs.uk/planning-and-improving-research/learning/.

IRAS project ID: 293712   Please quote this number on all correspondence

With the Committee's best wishes for the success of this project.

Yours sincerely

Tamla Ervine

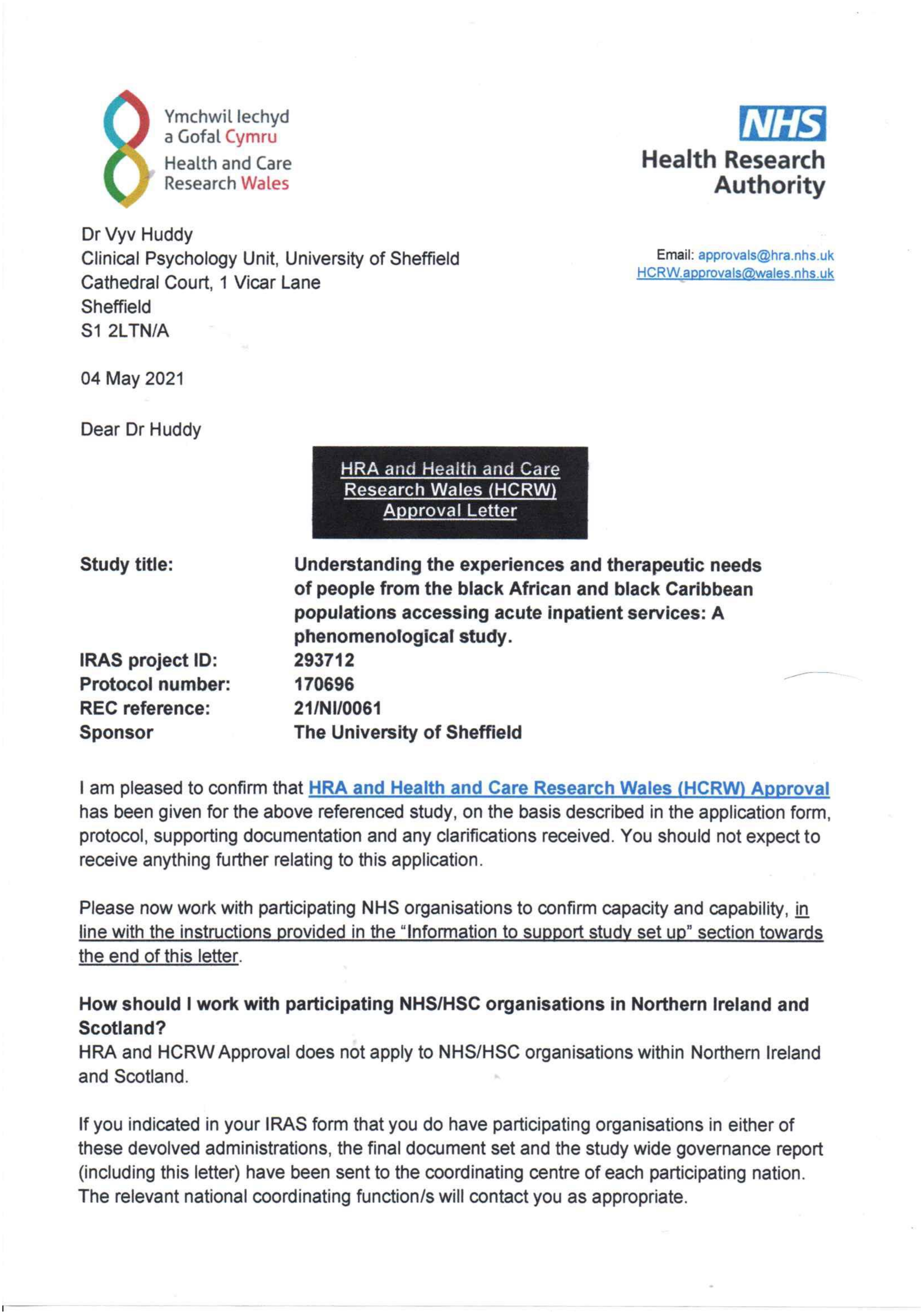
pp Dr Mary Murphy
Vice-Chair (Chair of Meeting 23 March 2021)

Email: RECA@hscni.net

Enclosure: After ethical review – guidance for researchers

Copy to: Mr Jamie Delgadillo, University of Sheffield (Sponsor)
Miss Laura Gillies, University of Sheffield (PhD Student)
Health Research Authority (HRA) approvals@hra.nhs.uk

Appendix H: Health Research Authority (HRA) ethical approval form



Ymchwil Iechyd
a Gofal Cymru
Health and Care
Research Wales

NHS
Health Research
Authority

Dr Vyv Huddy
Clinical Psychology Unit, University of Sheffield
Cathedral Court, 1 Vicar Lane
Sheffield
S1 2LTN/A

Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

04 May 2021

Dear Dr Huddy

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Understanding the experiences and therapeutic needs of people from the black African and black Caribbean populations accessing acute inpatient services: A phenomenological study.**
IRAS project ID:	**293712**
Protocol number:	**170696**
REC reference:	**21/NI/0061**
Sponsor	**The University of Sheffield**

I am pleased to confirm that HRA and Health and Care Research Wales (HCRW) Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?

HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The standard conditions document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **293712**. Please quote this on all correspondence.

Yours sincerely,
Nabeela Gaulton (nee Iqbal)
Approval Specialist

Email: approvals@hra.nhs.uk

Copy to: *Jaime Delgadillo, The University of Sheffield*

List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	*Version*	*Date*
Cover Letter [Cover Email - Provisional Opinion Response Table]		26 April 2021
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Sponsor Insurance Certificate]		24 February 2021
Interview schedules or topic guides for participants [Interview Schedule]		26 February 2021
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Participant information sheet (PIS) [Participant Information Sheet]	2	26 April 2021
Research protocol or project proposal [Research Protocol]	4	22 April 2021
Schedule of Events or SoECAT [Schedule of Events]	1	04 March 2021
Summary CV for Chief Investigator (CI) [CV Chief Investigator Vyv HUDDY]	1	08 March 2021
Summary CV for student [Student/Academic Researcher CV]		04 March 2021
Summary CV for student [Student/Academic Researcher CV]	1	08 March 2021
Summary CV for supervisor (student research) [CV for supervisor]	1	08 March 2021

Information to support study set up

The below provides all parties with information to support the arranging and confirming of capacity and capability with participating NHS organisations in England and Wales. This is intended to be an accurate reflection of the study at the time of issue of this letter.

Types of participating NHS organisation	Expectations related to confirmation of capacity and capability	Agreement to be used	Funding arrangements	Oversight expectations	HR Good Practice Resource Pack expectations
Single site type.	Research activities should not commence at participating NHS organisations in England or Wales prior to their formal confirmation of capacity and capability to deliver the study.	An Organisation Information Document has been submitted and the sponsor is not requesting and does not expect any other site agreement to be used.	Appendix 2 of the OID states no funding will be available to sites.	A local collaborator would be expected at site.	No Honorary Research Contracts, Letters of Access or pre-engagement checks are expected for local staff employed by the participating NHS organisations. Where arrangements are not already in place, research staff not employed by the NHS host organisation undertaking any of the research activities listed in the research application would be expected to obtaina Letter of Access based on standard DBS checks and occupational health clearance.

Other information to aid study set-up and delivery

This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales in study set-up.

Appendix I: Scientific Approval Letter issued by The University of Sheffield

The University Of Sheffield.

Department Of Psychology.
Clinical Psychology Unit.

Doctor of Clinical Psychology (DClin Psy) Programme
Clinical supervision training and NHS research training & consultancy.

Clinical Psychology Unit
Department of Psychology
University of Sheffield
Floor F, Cathedral Court
1 Vicar Lane
Sheffield
S1 2LT

Dr A R Thompson, Clinical Training Research Director
Please address any correspondence to Amrit Sinha
Research Support Officer
Telephone: 0114 2226650
Email: a.sinha@sheffield.ac.uk

6th January 2020

To: Research Governance Office

Dear Sir/Madam,

RE: Confirmation of Scientific Approval and indemnity of enclosed Research Project

Project title: Understanding the experiences and therapeutic needs of people from the black African and black Caribbean populations accessing acute inpatient services: A phenomenological study

Investigators: Laura Gillies (DClin Psy Trainee, University of Sheffield); Dr Vyv Huddy (Academic Supervisors University of Sheffield)

I write to confirm that the enclosed proposal forms part of the educational requirements for the Doctoral Clinical Psychology Qualification (DClin Psy) run by the Clinical Psychology Unit, University of Sheffield.

Three independent scientific reviewers usually drawn from academic staff within the Psychology Department have reviewed the proposal. Review includes appraisal of the proposed statistical analysis conducted by a statistical expert based in the School of Health and Related Research (ScHARR). Where appropriate an expert in qualitative methods is also appointed to review proposals.

I can confirm that approval of a proposal is dependent upon all necessary amendments having been made to the satisfaction of the reviewers and I can confirm that in this case the reviewers are content that the above study is of sound scientific quality. Consequently, the University will if necessary indemnify the study and act as sponsor.

Given the above, I would remind you that the Department already has an agreement with your office to exempt this proposal from further scientific review. However, if you require any further information, please do not hesitate to contact me.

Yours sincerely

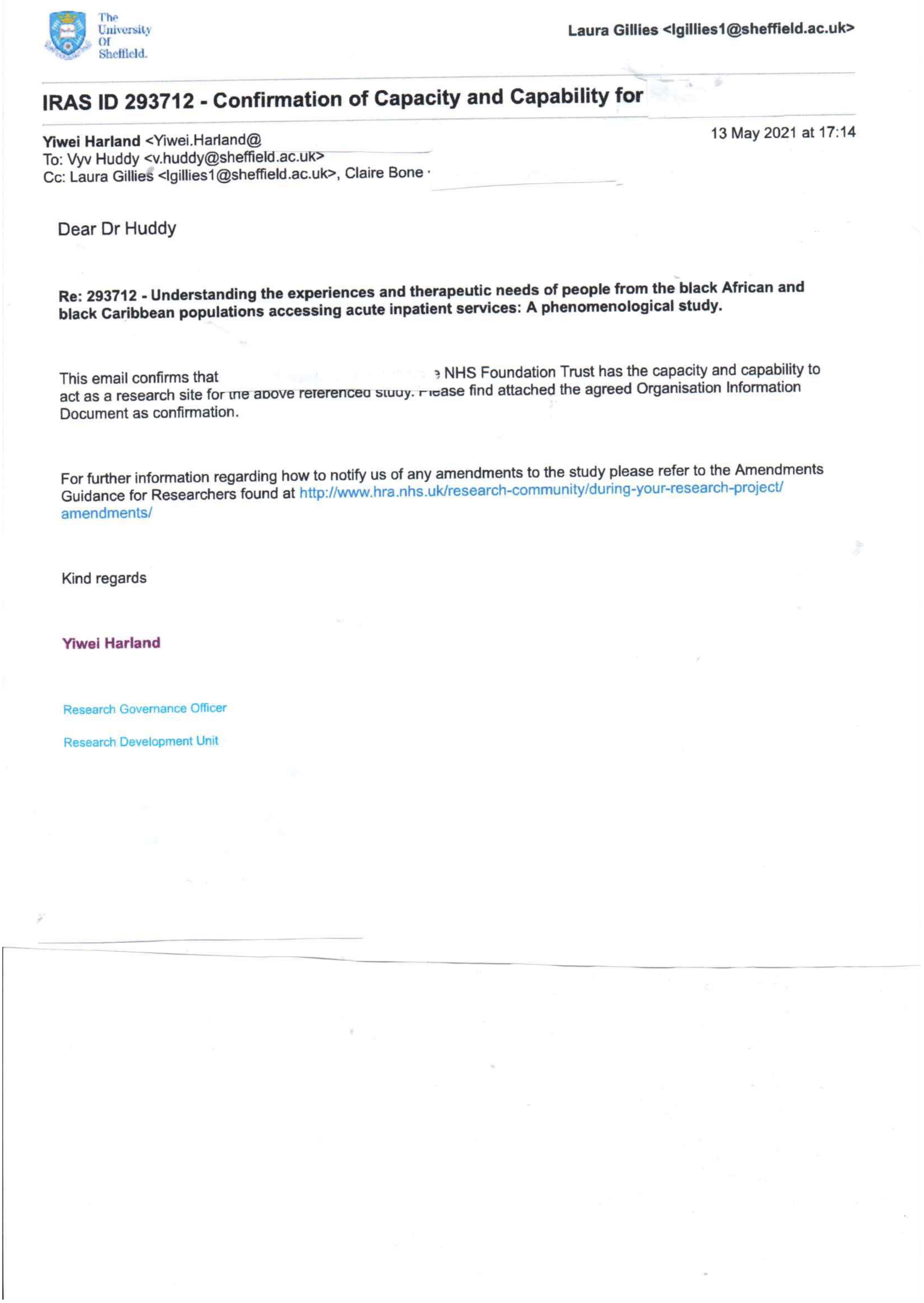
Jaime Delgadillo

Dr Jaime Delgadillo

Director of Research Training, Clinical Psychology Unit

Cc. Laura Gillies, Vyv Huddy

Appendix J: Confirmation of capability for NHS Trust to act as research site



The University Of Sheffield.

Laura Gillies <lgillies1@sheffield.ac.uk>

IRAS ID 293712 - Confirmation of Capacity and Capability for [redacted]

Yiwei Harland <Yiwei.Harland@[redacted]
To: Vyv Huddy <v.huddy@sheffield.ac.uk>
Cc: Laura Gillies <lgillies1@sheffield.ac.uk>, Claire Bone [redacted]

13 May 2021 at 17:14

Dear Dr Huddy

Re: 293712 - Understanding the experiences and therapeutic needs of people from the black African and black Caribbean populations accessing acute inpatient services: A phenomenological study.

This email confirms that [redacted] NHS Foundation Trust has the capacity and capability to act as a research site for the above referenced study. Please find attached the agreed Organisation Information Document as confirmation.

For further information regarding how to notify us of any amendments to the study please refer to the Amendments Guidance for Researchers found at http://www.hra.nhs.uk/research-community/during-your-research-project/amendments/

Kind regards

Yiwei Harland

Research Governance Officer

Research Development Unit

Appendix K: Information poster about research study for clinical team members

The
University
Of
Sheffield.

Research Study

Understanding the experiences and therapeutic needs of patients who identify as Black, accessing acute inpatient services.

Why is this research being done?

Detention rates to inpatient mental health services are four times higher for people from Black backgrounds, and they often experience repeated admissions. Yet little is known about their experiences and what they need from inpatient mental health services, this research aims to find this out.

Who can take part?

Anyone who is:

- Between 18 and 65 years old and speaks English.
- Currently detained under the MHA (any section) on an inpatient mental health ward or has been discharged from an inpatient ward in the last 5 years.
- Identifies as being from a Black background (e.g., African and/or black Caribbean; based on the person's self-identification).
- Not currently experiencing ongoing increased acute distress

What they will be asked to do?

Complete a one-hour interview with Laura, either in an interview room on the ward/in the service building or on the telephone. During the interview participants will be asked questions about their experiences of inpatient services, how it made them feel and their opinions on what they consider as beneficial and helpful for their mental health whilst in inpatient services.

Everything the participants say in the interview will be confidential, unless there are issues related to risk which will be shared with staff on the ward. Patients can opt out at any point, and taking part is voluntary

How can staff help?

If you think someone on the ward/in the service would like to take part, or if a patient has said they are interested, please speak to the Clinical Psychologist working on the ward/in the service who can speak to the patient about taking part and discuss with Laura who is completing the study.

Who can tell you more about the research?

Name (Clinical Psychologist on the ward/in the service)

Laura Gillies (Trainee Clinical Psychologist, University of Sheffield)

Contact details inserted here.

Ethical Approval.

This study has been checked and approved by Health and Social Care Research Ethics Committee A (HSC REC A). Study IRAS ID: 293712

Appendix L: Information poster about research study for potential participants

The
University
Of
Sheffield.

Study IRAS ID: 293712

Research Study

For Black people who are currently or have recently been admitted to an acute inpatient ward.

Why is this research being done?

Mental health services, including inpatient services, are always looking for new ways to improve the care, treatment and service they offer to people. This study would like to find out how services can support individuals from black African/Caribbean backgrounds better in the future.

Can I take part?

You can take part if you would like to, and you are:

- Between 18 and 65 years old and speak English.
- Currently detained on an inpatient mental health ward or have been discharged from an inpatient mental health ward in the last 5 years .
- Identify as being from a Black background (e.g., Black African, Caribbean).
- Not currently experiencing ongoing increased distress

Taking part is voluntary, meaning it is your choice whether to take part or not.

What would you need to do?

Complete a one-hour interview with Laura (the researcher), either in an interview room on the ward/in the service building or on the telephone.

During the interview you will be asked questions about your experience of inpatient services, how it made you feel and your opinions on what you consider as beneficial and helpful for your mental health whilst in inpatient services.

Everything you say in the interview will be confidential, unless there are issues related to risk which will be shared with staff on the ward, but you would be informed about this.

The interview will be audio (sound only) recorded. This recording is only used by the research team and nobody else will have access to this. The research will not identify you or your identity. We will not record your name, and everything will be anonymised so you cannot be identified.

Who can tell you more about the research?

Name (Clinical Psychologist on the ward/in the service)

Laura Gillies (Trainee Clinical Psychologist, University of Sheffield).

Ethical Approval.

This study has been checked and approved by Health and Social Care Research Ethics Committee A (HSC REC A). Study IRAS ID: 293712

Appendix M: Participant Information Sheet

The University Of Sheffield.

Department Of Psychology.
Clinical Psychology Unit.

Doctor of Clinical Psychology (DClin Psy) Programme
Clinical supervision training and NHS research training & consultancy.
Telephone: 0114 2226650
Email: a.sinha@sheffield.ac.uk

Clinical Psychology Unit
Department of Psychology
University of Sheffield
Floor F, Cathedral Court
1 Vicar Lane
Sheffield
S1 2LT

Study IRAS ID: 293712

Participant information sheet

Project title: Understanding the experiences and therapeutic needs of Black people accessing acute inpatient services: A phenomenological[12] study.

You are being invited to take part in a research study. This information sheet tells you why we are doing this research and what you will be asked to do if you take part. Please take your time to read the following information. You can discuss it with other people if you want. If anything is unclear, or if you would like more information, please ask the member of the Psychology team who will come back to speak to you soon.

This study has been checked and approved by Health and Social Care Research Ethics Committee A (HSC REC A).

Why are we doing this research?

Inpatient services are a part of the mental health system. Mental health services are always looking for new ways to improve the care, treatment and service they offer.

Currently, there is not very much research telling us about the experiences of people from black African or black Caribbean backgrounds in inpatient mental health services. There is also no research exploring what people from these backgrounds need from services to make services feel more therapeutic and helpful.

This study would like to find out how services can support individuals from these backgrounds better in the future.

---

[12] A study that will ask people about their personal experiences

Why have I been asked to take part?

You have been invited to take part in this research because you are currently or have recently been admitted to an inpatient ward (within the last 5 years) and you are from a black African, black Caribbean or black African-Caribbean background.

Do I have to take part?

Participation is completely voluntary. You choose whether you want to take part or you do not want to take part. You can change your mind and stop taking part at any point without giving us a reason.

Please note: Your decision will not affect the care and treatment you receive during or after your admission to the ward.

What happens if I choose to take part?

- The research study needs participants to take part in one interview with the researcher, Laura Gillies.
- During the interview you will be asked questions about your experience of inpatient services, how it made you feel and your opinions on what you consider as beneficial and helpful for your mental health whilst in inpatient services.
- **Please note:** this interview is not a Psychology therapy session.
- The interview will be audio (sound only) recorded. This recording is only used by the research team and nobody else will have access to this.
- This interview will be private and confidential between you and the research team.
- The research will not identify you or your identity. We will not record your name, and everything will be anonymised so you cannot be identified.
- Before the interview you will be asked some information about yourself including age and place of birth. You do not have to answer these questions and can still take part without answering them. These questions are asked so we have some background information about who took part. If you do answer these questions, they will also be anonymous and will not include your name or any other information that would identify you.
- After the interview you will be asked if you want to be contacted at a later date, to discuss the results of the research. Laura wants to make sure that the findings from the research make sense and reflect what people talked about.

How and when would the interview happen?

- The researcher will find a time to suit you between the hours of 9am – 5pm. The interview will take approximately one hour. You will be given time to ask the researcher any questions you have about the research study or the interview.
- The interview may take place in a private interview room near the ward you are currently on, e.g., the room where you see the ward Psychologist, or where you have meetings with staff on the ward. Or, if you are living in the community, the interview can take place in a private room at the community mental health

service you are working with e.g., where you meet with you the Psychologist or care coordinator. Or, if you would prefer the interview can be done on the telephone or via a video call.

- If you are admitted to an inpatient service currently, you can also choose whether you want the interview to be completed during your admission or you can wait until you are discharged. For all options, the interview will still be audio recorded.
- If you agree to take part and then you are discharged before the interview, Laura Gillies as the researcher will contact you by telephone and ask if you would still like to take part. If you do still want to take part, you can do the interview on the telephone or via a video call, or you can come back to the hospital and you can do the interview in a private room. All interviews will be audio recorded.

You will be paid for any travel costs that you need as part of completing this research. You will also be offered a £10 Tesco voucher as a thank-you for your time.

Confidentiality

- The staff on the ward or within the community mental health service will know you are taking part in the research study as they will have invited you to take part and you will be in the interview for an hour, but they will not come to the interview with you.
- Everything you say in the interview will be kept private (confidential) between yourself and the research team.
- Just like when you talk to other healthcare professionals, , the only time this may change is if you said something that suggested you or someone else was at risk.
- The researcher may have to report this to the staff on the ward or within the service to look after your wellbeing. The researcher would talk to you about this. Only the information related to risk would be shared, everything else would remain private.
- If there are no changes or concerns about risk, the staff on the ward will not know anything you say during the interview.

What will happen to the information I share in the interview and the results of the research study?

The audio recordings of the interviews will be listened to, and the words will be typed up so the researcher can read all the interviews of the people who took part. The recordings will be listened to and typed up by either the researcher or somebody employed to do this (3rd party), both people will follow confidentiality guidelines and sign a confidentiality agreement to maintain your privacy.

When your interview is typed up, your name and any details that would identify you will be removed. This means if you spoke about your age, where you live or the hospital or service name, all of this information will be deleted. The researcher will read all the interviews and they will look for things that more than one person talks about. These are called themes. These themes will be written up into a report. Some anonymous quotes from the interviews may be used to explain a theme or an idea. Anonymous quotes mean there will be no way of identifying that it was you who said this statement. The audio recording of your interview will then be deleted.

The report is part of the training programme for the Doctorate in Clinical Psychology programme at the University of Sheffield. Your name will not be identified in any report. If you do not want any of your quotes from your interview to be included in the report, please let the researcher know.

The researcher plans to publish the results of the study so that other people can read them. This means that people who manage mental health services can use the results to improve patient care. No information will identify you as a participant.

You can have a copy of the research results. The researcher will ask you if you would like this after the interview.

What happens if I don't want to discuss something during the interview?
It is up to you what you talk about, and you can refuse to discuss anything when you do not feel comfortable.

What are the possible benefits of you taking part?
The research will ask about your experiences and your views on your therapeutic needs, the things you consider as helpful or beneficial for your mental health, whilst accessing inpatient services. It is hoped that this will be meaningful for you and allow you some time to talk about what is important for you. We also hope this will improve the knowledge and understanding to support service users from black African and black Caribbean backgrounds better.

What are the possible risks/disadvantages?
The researcher does not expect there to be any significant risks to you for taking part in this study. It might be upsetting to talk about some of your experiences of inpatient mental health services. We will support you during and after the interview if this is the case for you. You can talk about as much or as little as you want, depending how comfortable you feel. You will be given time before and after the interview to ask the researcher any questions. Support is also available after the interviews from the researcher or from clinical staff on the ward.

What happens to my information once the research has finished?
Your contact details (telephone number or email address) will be deleted after they have been used. If you would like a copy of the results, the researcher will save your contact details to be able to send you this at the end of the research. Once the results are sent these details will be deleted.

The written version of your interview will have all personal details removed and this is saved as a number, that does not identify you. This anonymous and unidentifiable document is saved on a secure and protected computer at the University of Sheffield for 5 years. It is then deleted. Your signed consent form will be securely destroyed when the research is finished (September 2022).

What do I do if I want to make a complaint?

If you would like to make a complaint about this project, you can contact any member of the research team.

Research team

- **Laura Gillies,** Principle researcher, Trainee Clinical Psychologist, The University of Sheffield. Email: XXX
- **Dr Vyv Huddy,** Principle Researcher and Research supervisor. Clinical Psychologist and Lecturer at the University of Sheffield. Email: XXX
- **Dr Claire Bone,** Supervisor, Clinical Psychologist, email: XXX
- **Amrit Sinha**, Research Support Officer, The University of Sheffield. Telephone: 0114 222 6650, email: XXX

University of Sheffield complaints team

- **Professor Elizabeth Milne,** Head of Psychology Department, The University of Sheffield. Email: XXX
- **Dr Robert Schmidt & Dr Jilly Gibson-Miller**, Joint chairs of the Department Ethics Subcommittee, The University of Sheffield. Email: XXX

Appendix N: Informed consent form

The University Of Sheffield.

Department Of Psychology.
Clinical Psychology Unit.

Doctor of Clinical Psychology (DClin Psy) Programme
Clinical supervision training and NHS research training & consultancy.
Telephone: 0114 2226650
Email: a.sinha@sheffield.ac.uk

Study IRAS Number: 293712

Clinical Psychology Unit
Department of Psychology
University of Sheffield
Floor F, Cathedral Court
1 Vicar Lane
Sheffield
S1 2LT

Consent Form

Project title: Understanding the experiences and therapeutic needs of Black people accessing acute inpatient services: A phenomenological study

If you are happy with the information you have received and you have no further questions at this point, please read the following statements and tick the box if you agree, before signing your name at the bottom.

If you have any questions whilst reading this form please ask the researcher.

I confirm that I have read the information sheet for the above study. I have had the opportunity to consider the information, ask questions and these have been answered well enough.	
I understand it is my choice to take part and that I am free to change my mind at any point without giving a reason and without my care and treatment being affected. I understand I can withdraw my interview up to 2 weeks after the date of my interview.	
I understand the limits of confidentiality: everything I say in the interview will be kept private between myself and the research team, unless I say anything that suggests I or someone else may be at risk. In the event of this, the researcher will discuss with staff on the ward.	
I understand staff on the ward know I am taking part, but they will not know the content of the conversation unless I or someone else is at risk.	
I agree that an audio (sound) recording can be made of the interview. These recordings will be listened to and the content written up word-for-word to complete the analysis.	

I agree for anonymous quotes to be used for the report, publications, teaching, and presentation of the results.	
I agree to take part in the above study	

Written Consent

Name of participant: ……………………………………………………………………

Date: ………………………………………………………………………………………..

Signature:……………………………………………………………………………………..

Name of researcher: ……………………………………………………………………

Date: ………………………………………………………………………………………..

Signature:……………………………………………………………………………………..

Verbal Consent

Name of participant: ……………………………………………………………………

Date: ………………………………………………………………………………………..

Gained verbally via (circle response): Telephone Remote Video

Name of researcher: ……………………………………………………………………

Date: ………………………………………………………………………………………..

Signature:……………………………………………………………………………………..

……………………………………………………………………………………………………..

PLANNING IN CASE OF DISCHARGE

If I am discharged between now and the interview, the researcher would like to contact you to still complete the interview.

I consent to the researcher contacting me if I am discharged between now and the time of my interview	Contact telephone number: …………………………………

I do not consent to the researcher contacting me if I am discharged between now and the time of my interview. If I am discharged, I no longer wish to take part.	

……………………………………………………………………………………………………..

AT TIME OF THE INTERVIEW

- ☐ Consent reviewed and maintained.
- ☐ Consent revoked.

Date of interview: ………………………………………………………………………….

……………………………………………………………………………………………………..

FOR COMPLETION AFTER INTERVIEW

	Please circle your response	
I would like to be contacted at a later date to look at the findings from this research and to share my feedback on these	Yes	No
I would like to receive a summary of the findings or a copy of the full research report from this research study when it is finished (delete as appropriate)	Yes ☐ A Summary ☐ A copy of the full report	No

Preferred method of contact

- Email, please supply an email address:

……………………………………………………………………………………………………..

- Phone, please supply a telephone number:

……………………………………………………………………………………………………..

- Letter, please supply an address:

……………………………………………………………………………………………………..

……………………………………………………………………………………………………..

FOR USE BY RESEARCHER

Participant identification number: ……………………………………………………………..

Date of interview: ………………………………………………………………………….

Appendix O: Demographic questionnaire

The
University
Of
Sheffield.

Department Of Psychology.
Clinical Psychology Unit.

Doctor of Clinical Psychology (DClin Psy) Programme
Clinical supervision training and NHS research training & consultancy.
Telephone: 0114 2226650
Email: a.sinha@sheffield.ac.uk

Clinical Psychology Unit
Department of Psychology
University of Sheffield
Floor F, Cathedral Court
1 Vicar Lane
Sheffield
S1 2LT

Study IRAS Number: 293712

Demographic information sheet

For this study, it would be helpful to find out some information about you. As with the interviews, this will remain confidential and anonymised. If you have any questions or you need some help with this form, please ask the interviewer.

Please answer the following questions by either selecting the response that best suits you or writing your answer in the space provided.

1. How old are you?
   - ☐ 20 or under
   - ☐ 21-29
   - ☐ 30-39
   - ☐ 40-49
   - ☐ 50-59
   - ☐ 60 or over
   - ☐ I prefer not to say

2. Country of birth
…………………………………………………………………………..
   - ☐ I prefer not to say

3. The cultural background do you identify as being from
……………………………………………………………….
   - ☐ I prefer not to say

4. If any, what mental health diagnosis(es) do you have?

………………………………………………………………………………………………
………………………………………………………………………………

- ☐ I prefer not to say

5. Number of inpatient admissions (including this one/the most recent one)

- ☐ 2-4
- ☐ 5-7
- ☐ 8-10
- ☐ 11-13
- ☐ 14+
- ☐ I prefer not to say

6. If discharged, how long has it been since you were discharged?

- ☐ Less than a month
- ☐ 1-3 months
- ☐ 4-6 months
- ☐ 7-12 months
- ☐ Over 12 months

7. Length of this (your most recent) admission

- ☐ 7-14 days
- ☐ 15-21 days
- ☐ 22-30 days
- ☐ Over 30 days
- ☐ I prefer not to say

7. What mental health section are you currently under (were you most recently under)?

- ☐ Section 2
- ☐ Section 3
- ☐ Section 37
- ☐ Section 5
- ☐ I do not know
- ☐ I prefer not to say

8. During this (your recent) inpatient admission, have you experienced any restrictive interventions (e.g. seclusion, restraint, injection). Please tick all answers which apply.

- ☐ Physical Restraint
- ☐ Seclusion
- ☐ Injection of Medicine
- ☐ I prefer not to say

9. During previous inpatient admissions, have you experienced any restrictive interventions (e.g. seclusion, restraint, injection). Please tick all answers which apply.

- ☐ Physical Restraint

☐ Seclusion
☐ Injection of Medicine
☐ Not Applicable
☐ I prefer not to say

Appendix P: Interview schedule

Topic	Questions	Prompts/Follow ups
General Introduction	What country were you born in? What country were you raised in? Prior to your admission to inpatient services where and who did you live with? What cultural background do you identify with?	What does your cultural background mean to you?
Mental health services	How would you describe your overall experience of inpatient mental health services? How do your beliefs or views about your mental health compare to how your mental health has been viewed or explained by the clinical team on the ward? Do you feel inpatient mental health services understand the mental health difficulties of people from black African, black Caribbean or black African-Caribbean backgrounds?	What has it been like to be admitted to this ward? Can you describe your time on the ward? How have you found your time on the ward? Have the inpatient mental health service defined/understood your mental health in similar ways or differing ways to you? How do you think the mental health system generally understands mental health? Did you feel you experienced any racism, or discrimination of any other kind while on the ward? How did these things make you feel?
Relationships	Can you describe your experiences of and relationships with the staff working in the inpatient service? What were the cultural backgrounds of the staff members? How do you feel staff understood and supported your needs specific to your cultural background?	Can you describe your relationship with staff? Can you discuss how staff impacted your time on the inpatient ward? Did staff know what it was you wanted or needed from a cultural perspective? Did staff discuss or explore with you, what you needed to meet your cultural needs? How did this feel?

Therapeutic care and treatment	What kinds of treatments or support were you offered whilst on the ward? What was your experience of this treatment or support that you were offered whilst on the ward? How did the care and support you received fit with your cultural background? What would good or appropriate treatment and support whilst accessing inpatient mental health services look like for you?	Were you offered medication, talking therapies, occupational life skills? Any restrictive interventions e.g. seclusion, restraint? Did the care and support you received feel appropriate for you? What role did culture have on this? How did the care, support, and treatment you received compare to other people on the ward or other services where you have received care? Do you feel other people were treated the same or differently?
Psychology and psychological support	Were you offered any support or time to speak with a psychologist whilst on the ward? How did you and the Psychologist use this time together?	Can you tell me about your experience of this? In what ways were the meetings with the psychologist helpful or unhelpful for you?
Changes	What do you think could be done to make inpatient mental health services feel more supportive or helpful for people from black African, black Caribbean or black African-Caribbean backgrounds?	Can you tell me from your perspective what you would like to see more or less of within inpatient services to support people from black African, black Caribbean or black African-Caribbean backgrounds?

Appendix Q: Debrief form

The University Of Sheffield.

Department Of Psychology.
Clinical Psychology Unit.

Doctor of Clinical Psychology (DClin Psy) Programme
Clinical supervision training and NHS research training & consultancy.
Telephone: 0114 2226650
Email: a.sinha@sheffield.ac.uk

Clinical Psychology Unit
Department of Psychology
University of Sheffield
Floor F, Cathedral Court
1 Vicar Lane
Sheffield
S1 2LT

Study IRAS ID: 293712

Debrief form

Project title: Understanding the experiences and therapeutic needs of people from the black African and black Caribbean populations accessing acute inpatient services: A phenomenological study.

Thank-you for taking part in the research. It is hoped this research will provide services with a better understanding of how people from black African or black Caribbean backgrounds experience acute inpatient mental health services, and to help improve the service offered to better support and meet the needs for these people.

The researcher will be in touch again if you have agreed to look at and offer feedback on the research findings or if you have requested a copy of the results of this research.

Hopefully, you have found taking part interesting and valuable and this interview has not caused you any distress. If you feel it has, and would like to talk to someone, please discuss this now with Laura Gillies, the researcher. Alternatively, please speak to a member of the ward team who can either offer support or seek additional support from the Psychology team. Listed here are also a number of other services you can access, either if you feel you would like support now or in the future.

Sources of support
Sheffield based mental health charity organisations supporting people from black African or black Caribbean backgrounds:

- Adira, website: https://www.adira.org.uk/ ; email: info@adira.org.uk; telephone: 07761925938
- SACMHA, website: www.sachma.org.uk; telephone: 0114 272 6393; email: admin@sacmha.org.uk

Sheffield based charity organisations supporting people from the Somali community:

- MAAN, email: admin.maan@tiscali.co.uk; telephone: 0114 275 8556 / 07960 128 582

Sheffield based general support charity organisation support people from the black African Caribbean community:

- SADACCA, website: https://www.sadacca.co.uk; telephone: 0114 275 3479; email: admin@sadacca.co.uk

National Mental Health organisations:
Samaritans: 116 123 (free to phone, 24 hours a day)
Mind: 0300 123 3393 (Mon-Fri, 9am-6pm)
Shout: text “shout” to 85258 (free conversation, 24 hours a day)

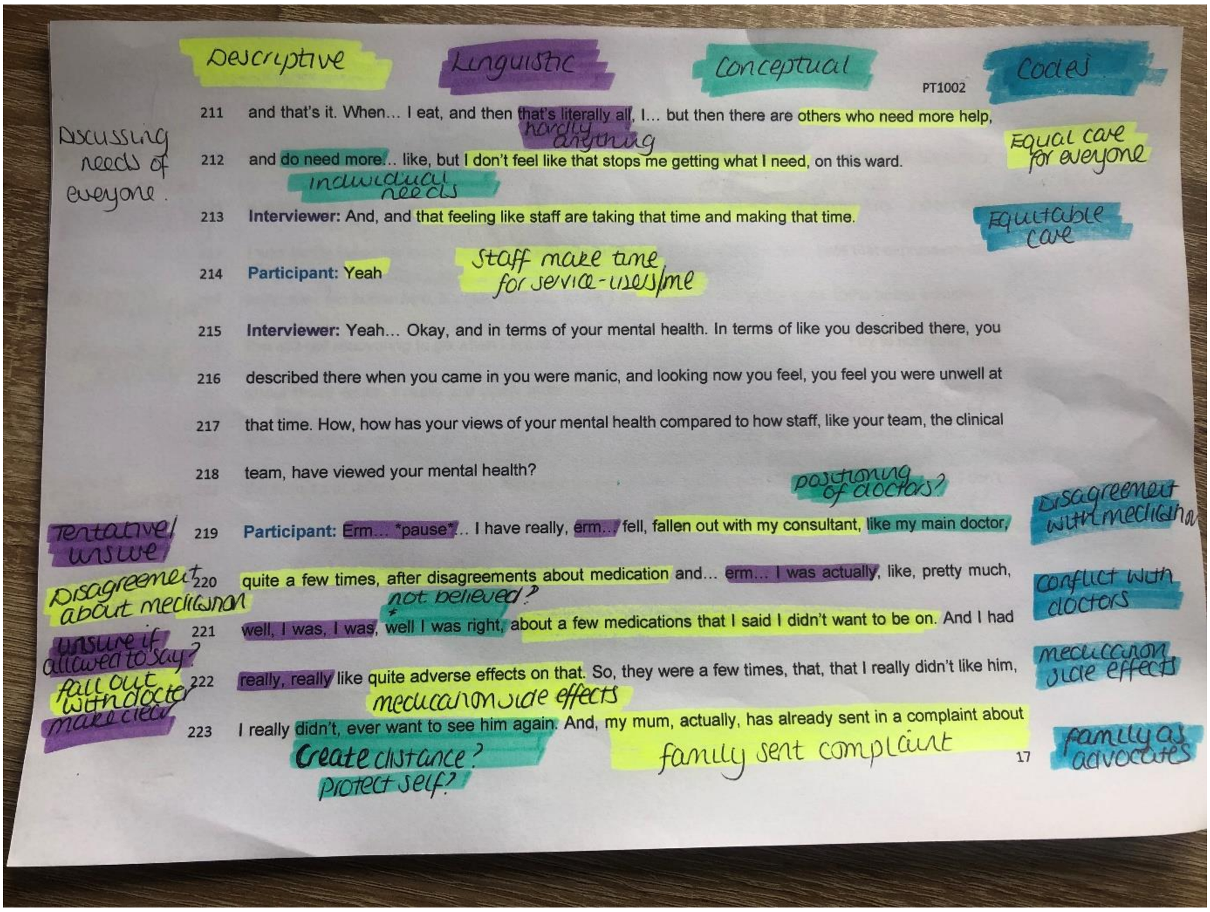
If you would like to withdraw your interview from the research, you can do so anytime from today up until 2 weeks after this date. You do not need to provide a reason why and this will not affect the care and treatment you receive. To do so, please contact Laura Gillies, the researcher, using the details below.

Thank-you again for your time and sharing your experiences for this research, it is appreciated.

Laura Gillies
Lead Researcher
lgillies1@sheffield.ac.uk

Appendix R: Analysis Evidence/Audit

Example transcript with notes and coding



PT1002

and that's it. When… I eat, and then that's literally all, I… but then there are others who need more help, and do need more… like, but I don't feel like that stops me getting what I need, on this ward.

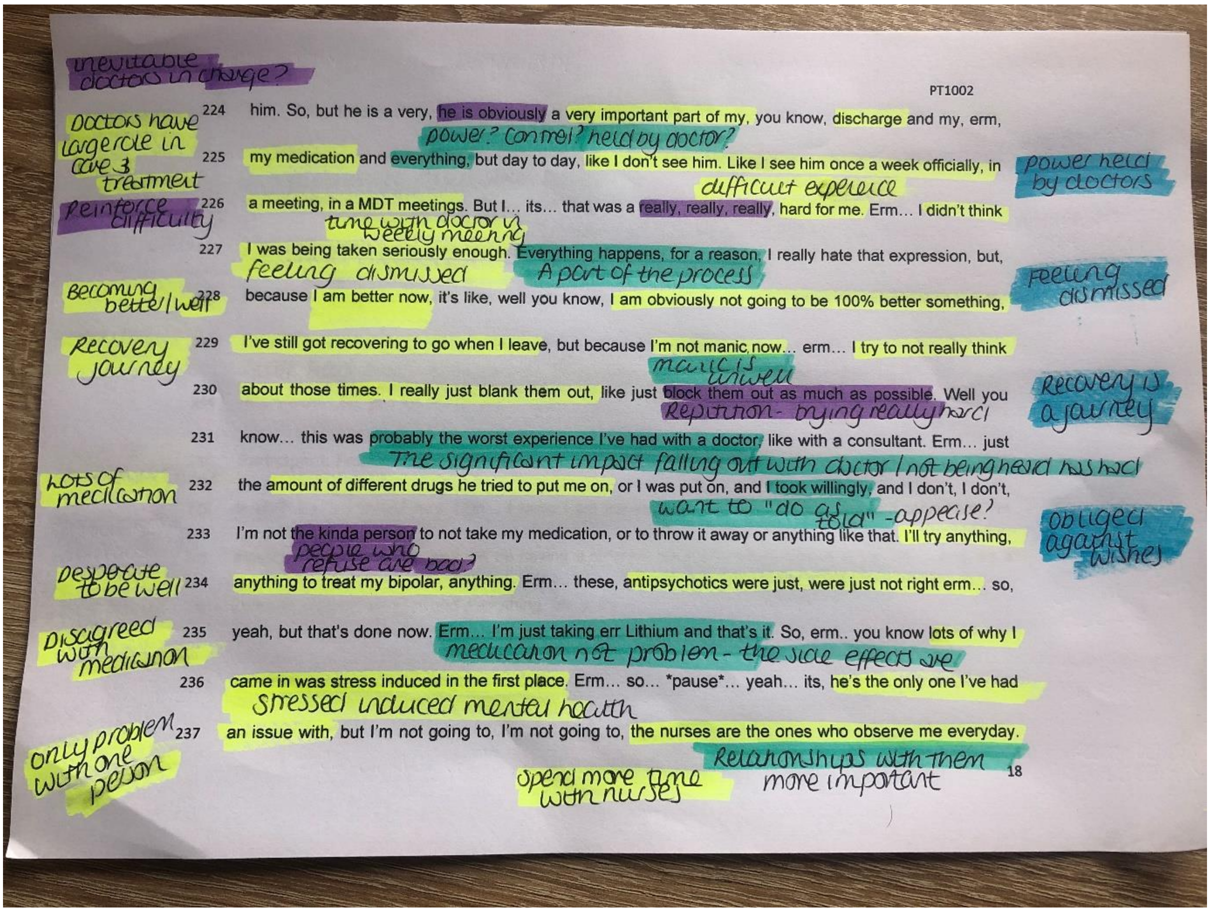
Interviewer: And, and that feeling like staff are taking that time and making that time.

Participant: Yeah

Interviewer: Yeah… Okay, and in terms of your mental health. In terms of like you described there, you described there when you came in you were manic, and looking now you feel, you feel you were unwell at that time. How, how has your views of your mental health compared to how staff, like your team, the clinical team, have viewed your mental health?

Participant: Erm… *pause*… I have really, erm… fell, fallen out with my consultant, like my main doctor, quite a few times, after disagreements about medication and… erm… I was actually, like, pretty much, well, I was, I was, well I was right, about a few medications that I said I didn't want to be on. And I had really, really like quite adverse effects on that. So, they were a few times, that, that I really didn't like him, I really didn't, ever want to see him again. And, my mum, actually, has already sent in a complaint about

17



inevitable doctors in charge?

PT1002

him. So, but he is a very, he is obviously a very important part of my, you know, discharge and my, erm, my medication and everything, but day to day, like I don't see him. Like I see him once a week officially, in a meeting, in a MDT meetings. But I… its… that was a really, really, really, hard for me. Erm… I didn't think I was being taken seriously enough. Everything happens, for a reason, I really hate that expression, but, because I am better now, it's like, well you know, I am obviously not going to be 100% better something, I've still got recovering to go when I leave, but because I'm not manic now… erm… I try to not really think about those times. I really just blank them out, like just block them out as much as possible. Well you know… this was probably the worst experience I've had with a doctor, like with a consultant. Erm… just the amount of different drugs he tried to put me on, or I was put on, and I took willingly, and I don't, I don't, I'm not the kinda person to not take my medication, or to throw it away or anything like that. I'll try anything, anything to treat my bipolar, anything. Erm… these, antipsychotics were just, were just not right erm… so, yeah, but that's done now. Erm… I'm just taking err Lithium and that's it. So, erm.. you know lots of why I came in was stress induced in the first place. Erm… so… *pause*… yeah… its, he's the only one I've had an issue with, but I'm not going to, I'm not going to, the nurses are the ones who observe me everyday.

Doctors have largerole in care & treatment

power? Control? held by doctor?

Power held by doctors

difficult experience

Reinforce difficulty

time with doctor in weekly meeting

feeling dismissed

A part of the process

Feeling dismissed

Becoming better/well

Recovery journey

manic is unwell

Recovery is a journey

Repitition - trying really hard

The significant impact falling out with doctor / not being heard has had

Lots of medication

want to "do as told" - appease?

Obliged against wishes

people who refuse are bad?

Desperate to be well

Disagreed with medication

medication not problem - the side effects are

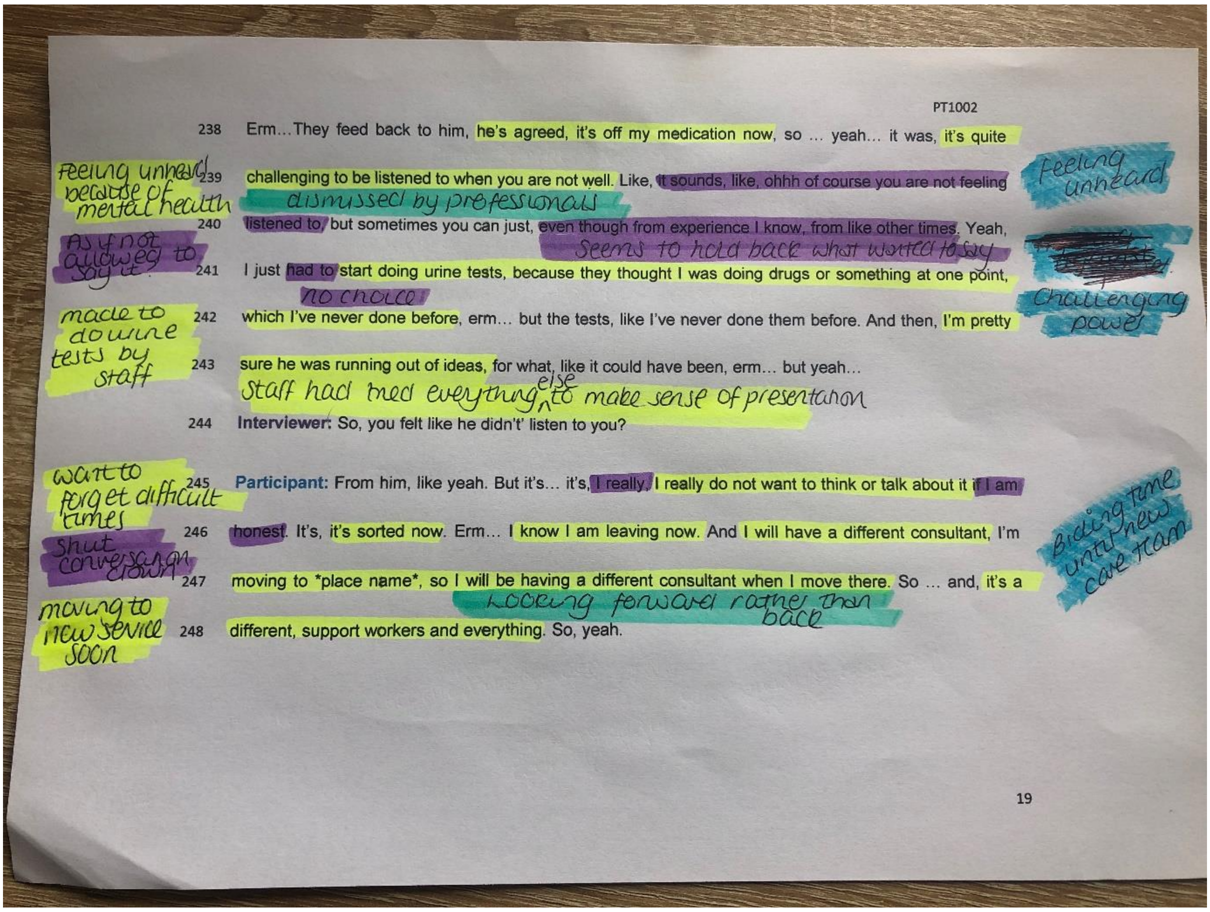
Stressed induced mental health

Only problem with one person

Relationships with them more important

Spend more time with nurses

18



PT1002

Erm…They feed back to him, he's agreed, it's off my medication now, so … yeah… it was, it's quite challenging to be listened to when you are not well. Like, it sounds, like, ohhh of course you are not feeling listened to, but sometimes you can just, even though from experience I know, from like other times. Yeah, I just had to start doing urine tests, because they thought I was doing drugs or something at one point, which I've never done before, erm… but the tests, like I've never done them before. And then, I'm pretty sure he was running out of ideas, for what, like it could have been, erm… but yeah…

dismissed by professionals

Seems to hold back what wanted to say

no choice

staff had tried everything else to make sense of presentation

Interviewer: So, you felt like he didn't't' listen to you?

Participant: From him, like yeah. But it's… it's, I really, I really do not want to think or talk about it if I am honest. It's, it's sorted now. Erm… I know I am leaving now. And I will have a different consultant, I'm moving to *place name*, so I will be having a different consultant when I move there. So … and, it's a different, support workers and everything. So, yeah.

Looking forward rather than back

Feeling unheard because of mental health

As if not allowed to say it

made to do urine tests by staff

want to forget difficult times

Shut conversation down

moving to new service soon

Feeling unheard

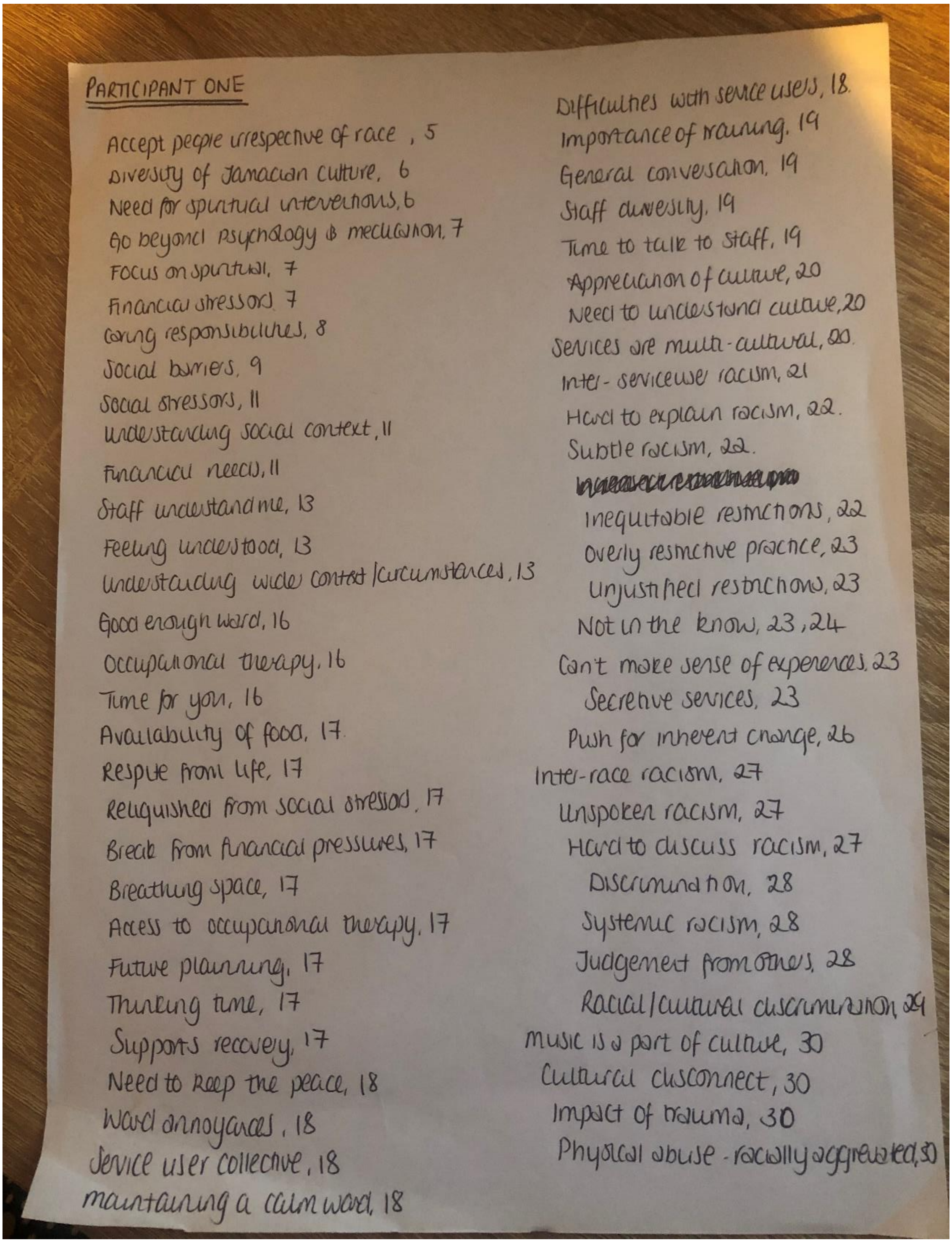
~~[illegible]~~

Challenging power

Biding time until new care team

19

Example of all themes for one participant transcript



PARTICIPANT ONE

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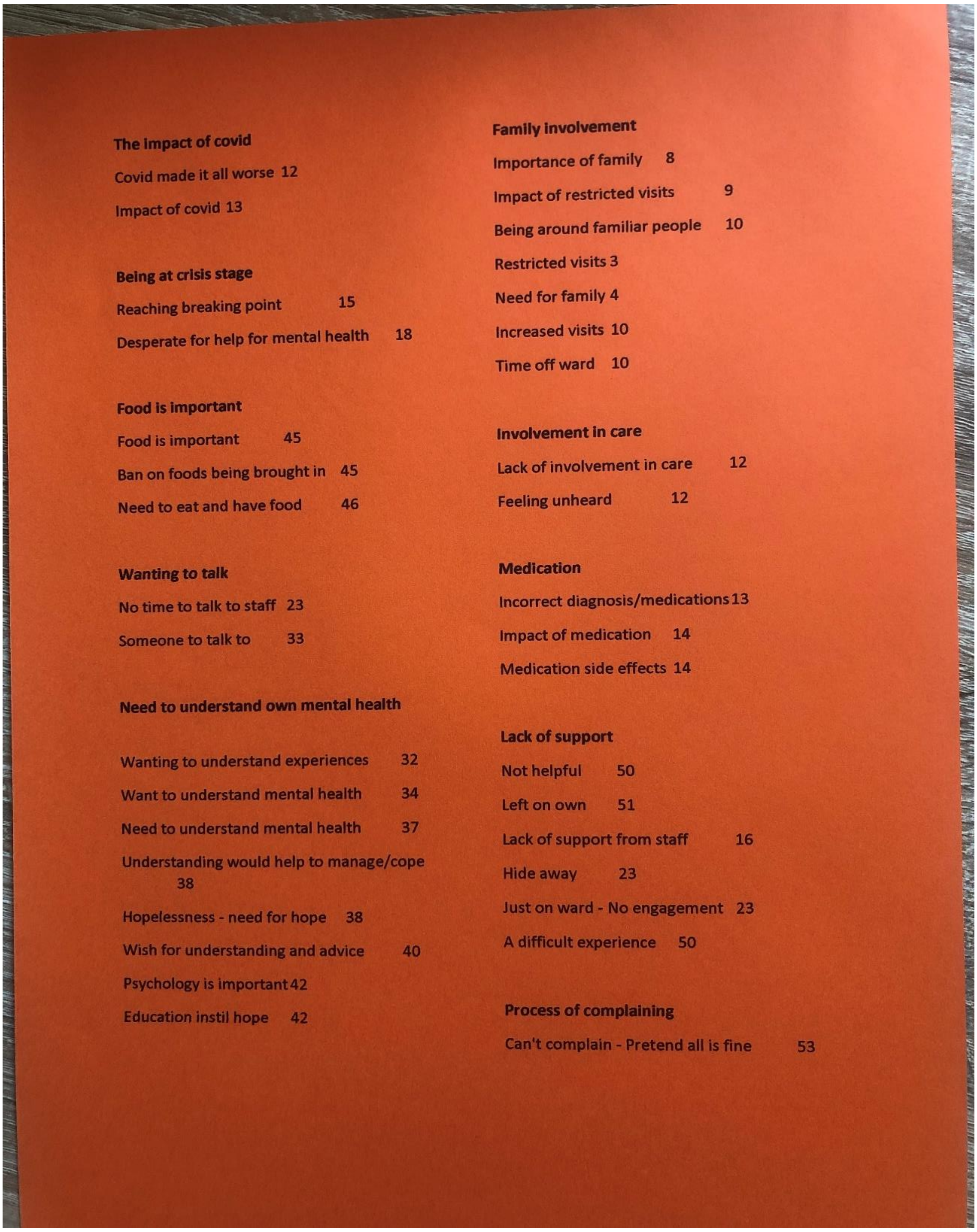
Grouped themes into emergent themes for one participant



The impact of covid

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Being at crisis stage

Reaching breaking point 15

Desperate for help for mental health 18

Food is important

Food is important 45

Ban on foods being brought in 45

Need to eat and have food 46

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No time to talk to staff 23

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Wanting to understand experiences 32

Want to understand mental health 34

Need to understand mental health 37

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Hopelessness - need for hope 38

Wish for understanding and advice 40

Psychology is important 42

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Family involvement

Importance of family 8

Impact of restricted visits 9

Being around familiar people 10

Restricted visits 3

Need for family 4

Increased visits 10

Time off ward 10

Involvement in care

Lack of involvement in care 12

Feeling unheard 12

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Medication side effects 14

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Not helpful 50

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Just on ward - No engagement 23

A difficult experience 50

Process of complaining

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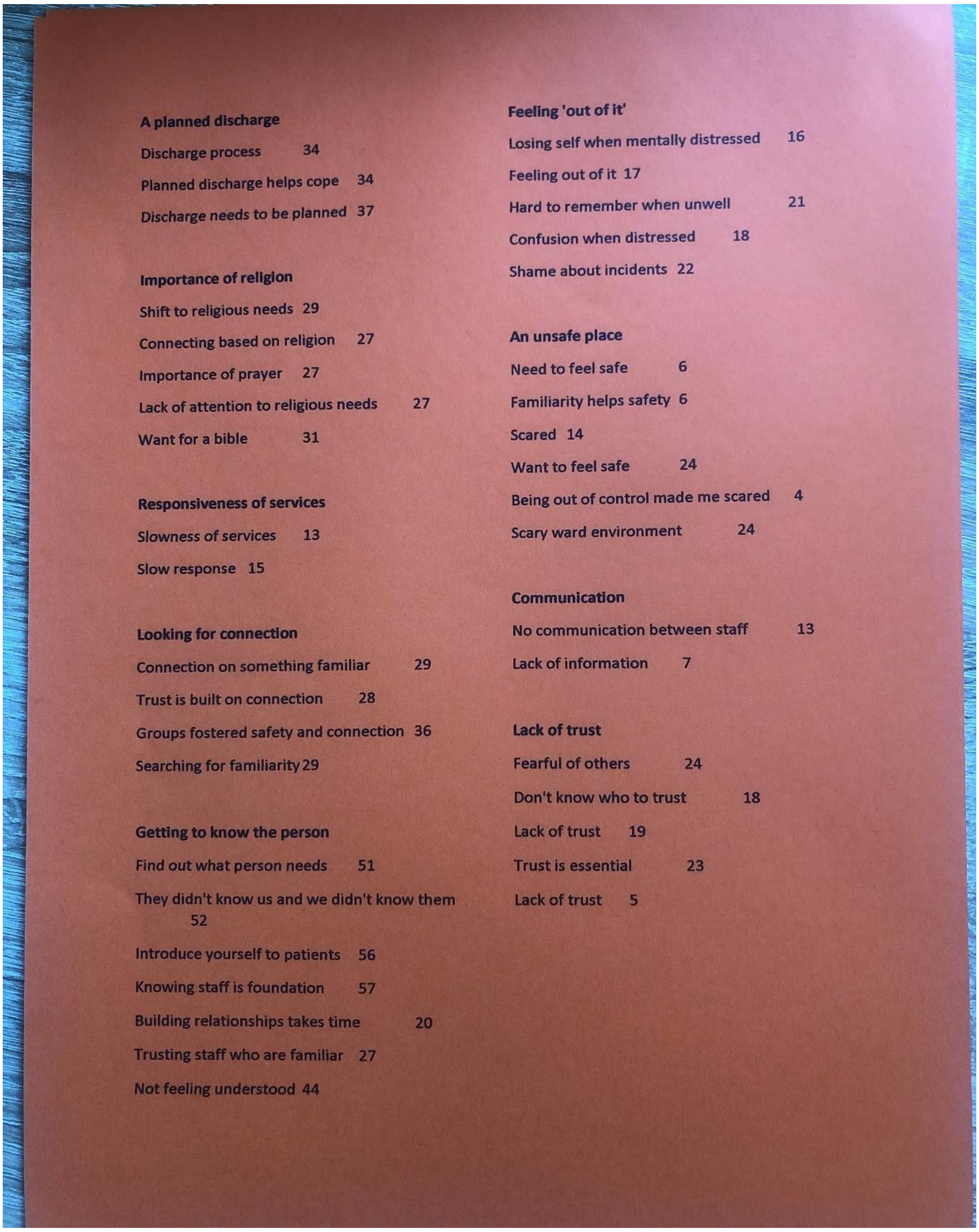

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Shift to religious needs	29
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Feeling out of it	17
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Lack of trust	5

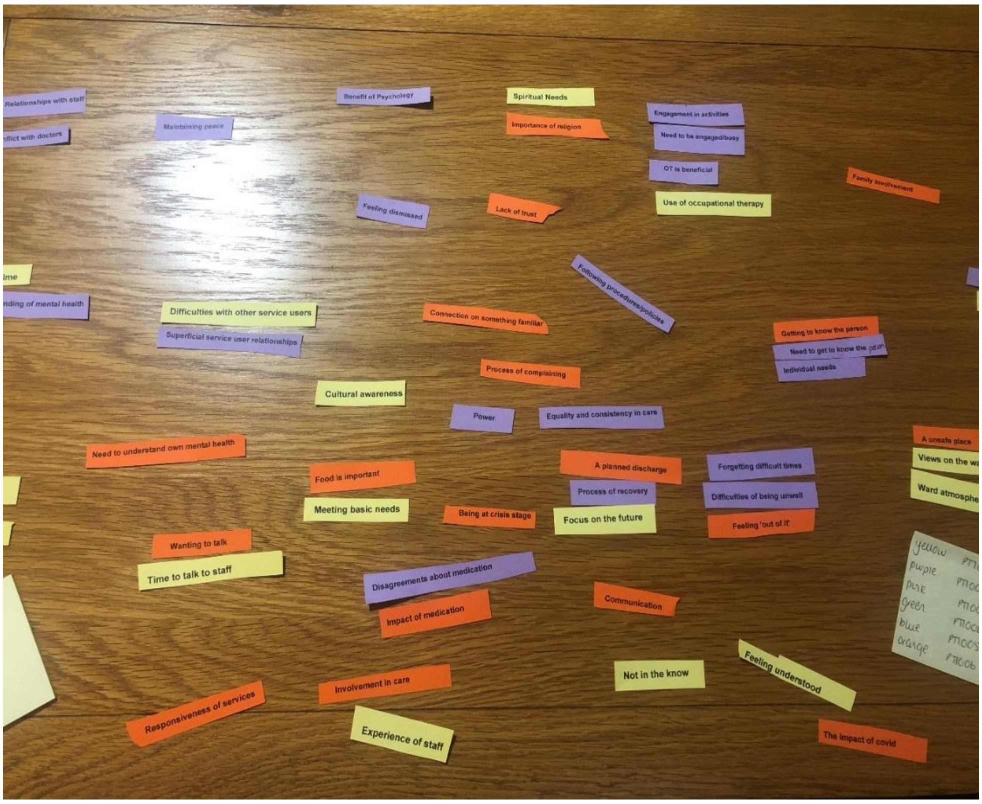
Table of all emergent themes for all participants

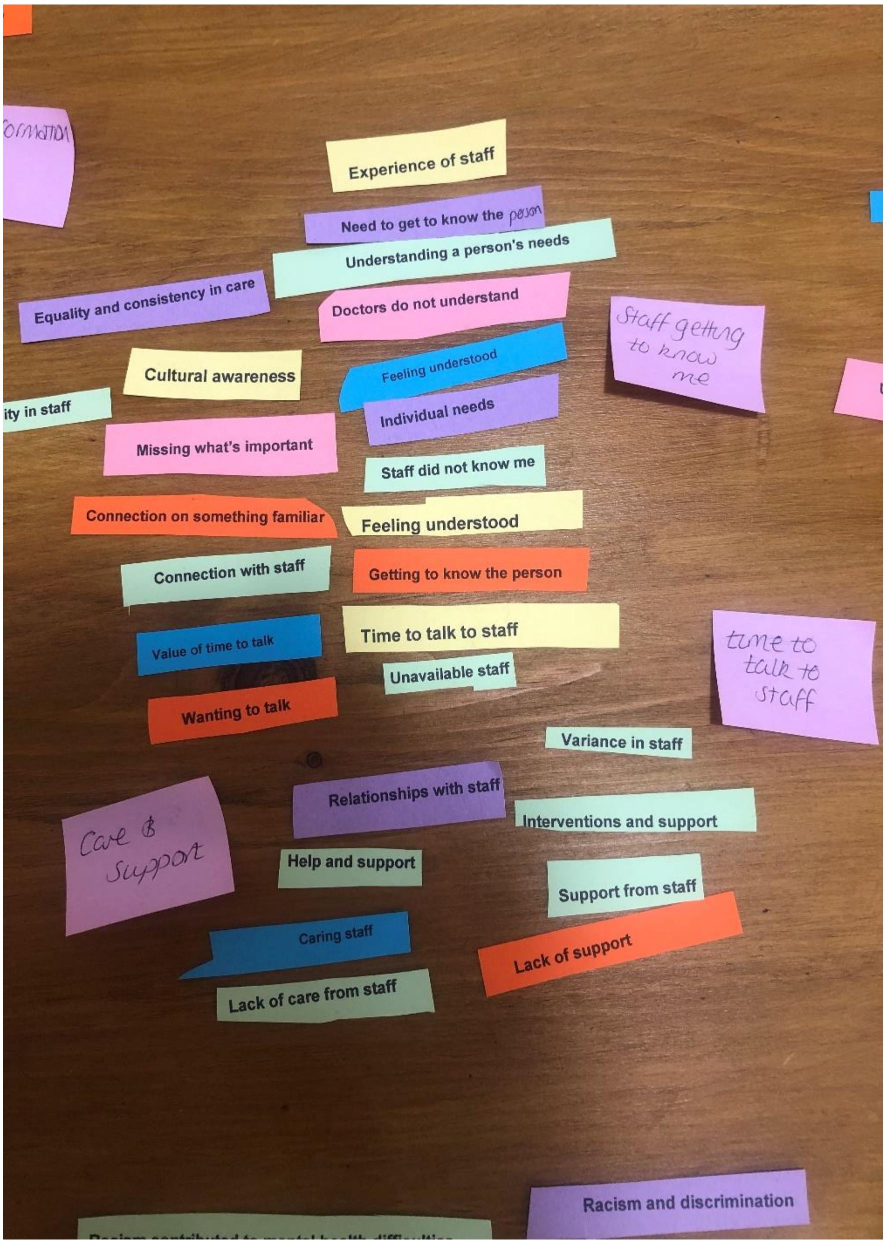
Participant 1	**Participant 2**
Experience of staff	Insight and understanding of mental health
Discrimination due to race	Disagreements about medication Conflict with doctors
Time to talk to staff	Medication side effects
Spiritual Needs	Power held by doctors
Ward atmosphere is important	Feeling dismissed
Time away from stressors	Obliged against wishes
Use of occupational therapy	Feeling unheard
Difficulties with other service users	Challenging power
Not in the know	Biding time until new care team
Feeling understood	Engagement in activities
Financial and social factors	Forgetting difficult times
Experience of racism	Individual needs
Focus on the future	Racism and discrimination
Views on the ward	Following procedures/policies
Meeting basic needs	Need to get to know the person
Cultural awareness	Family as advocates
Personal time	Maintaining peace
	Power
	Superficial service user relationships
	Relationships with staff
	Difficulties of being unwell
	Feeling dismissed
	Process of recovery
	OT is beneficial
	Equality and consistency in care
	Benefit of Psychology
	Need to be engaged/busy

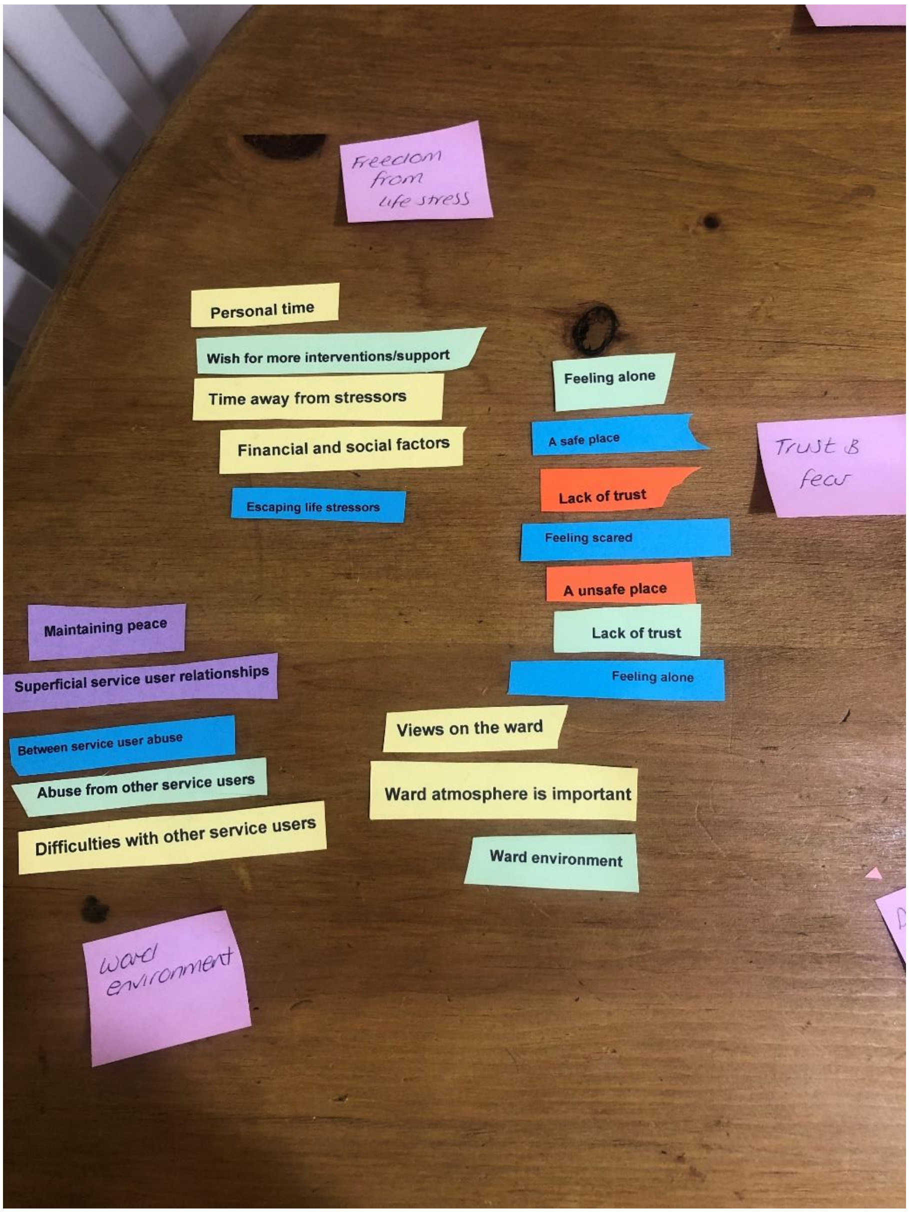
Participant 3	**Participant 4**
Doctors do not understand	Criticising self for admission
Importance of following procedures	Ward environment
Religious identity is important	Music
Need more Psychology	Understanding a person's needs
No point fighting it	Connection with staff
Unaware of mental health services	Feeling alone
Services push people too far	Racism more broadly
Need for change across the system	Racism contributed to mental health difficulties
Need to give service users information Not in the know	Experience of racism on ward
Dislike of medication	Gender differences in care
Communication needs improved	Passivity
Inconsistencies in treatment	Information and explanations
Services hold power	Lack of trust
	Feeling confused by mental health

Feeling dismissed	Family involvement
Given no explanation	Trying to understand why in hospital
Lack of agency	Losing self/not feeling like me
Poor complaints process	Support from staff
No experience of racism	Medication
Need to use external services for support	Need a stronger response against racism
	Wish for more interventions/support
Challenging the 'unwell' view	Help and support
Food needs	Staff did not know me
Nice staff	"A hassle"
Helpfulness of O.T.	Lack of care from staff
Connection with home	Engagement and activities
Missing what’s important	Struggle without freedom
	Reactions and emotions
	Variance in staff
	Feeling dismissed
	Interventions and support
	Reactions and emotions
	Importance of food
	Unavailable staff
	Diversity in staff
	Lack of choice/control
	Feeling helpless
	Lack of collaboration
	Abuse from other service users
Participant 5	**Participant 6**
Learning to cope	The impact of covid
Discrimination & Racism	Being at crisis stage
Value of time to talk	Food is important
Feeling scared	Wanting to talk
Escaping life stressors	Need to understand own mental health
Feeling alone	Family involvement
Need to feel heard	Involvement in care
Feeling understood	Impact of medication
Complaints	Lack of support
Between service user abuse	Process of complaining
Meeting basic needs	A planned discharge
Low self-worth	Importance of religion
Intersectionality	Responsiveness of services
Stigma & Judgment	Connection on something familiar
Responsiveness of services	Getting to know the person
Caring staff	Feeling 'out of it'
A safe place	An unsafe place
Interventions to help mental health	Communication
Hope for help from services	Lack of trust
Spiritual views on mental health	

Theme development process. *Note.* Colours indicate different participant themes




ormation
Experience of staff
Need to get to know the person
Understanding a person's needs
Equality and consistency in care
Doctors do not understand
Staff getting to know me
Cultural awareness
Feeling understood
ity in staff
Individual needs
Missing what's important
Staff did not know me
Connection on something familiar
Feeling understood
Connection with staff
Getting to know the person
Value of time to talk
Time to talk to staff
time to talk to staff
Unavailable staff
Wanting to talk
Variance in staff
Relationships with staff
Care & Support
Interventions and support
Help and support
Support from staff
Caring staff
Lack of support
Lack of care from staff
Racism and discrimination
Racism contributed to mental health difficulties


Freedom from life stress
Personal time
Wish for more interventions/support
Time away from stressors
Financial and social factors
Escaping life stressors
Feeling alone
A safe place
Lack of trust
Feeling scared
A unsafe place
Lack of trust
Feeling alone
Trust & fear
Maintaining peace
Superficial service user relationships
Between service user abuse
Abuse from other service users
Difficulties with other service users
Views on the ward
Ward atmosphere is important
Ward environment
ward environment

Appendix S: Examples of additional themes to illustrate themes

Superordinate Theme	Subtheme	Additional examples of quotes to illustrate them
Importance of Identity	Wanting to Feel understood	They really good, I feel sorry for them in a different way. They, they, in their heart they good people. Well most of them are, most, most of them are. That's in their heart…so like they got like half what they need, the, the team of staff are good people to work with, its just, its just being a bit more informative (P3). I would rather be, in the ward, erm… with the people that really cares for me. Cos, Ive always been like cared for. Whenever I've been on the ward, I've always been cared for. The people help, they really do a lot. They do everything possible to make sure, that, like, I get better. (P5) "it's nice to talk to nurses, and talk to them, and see they are doing. And then they ask you what's going on for you. You get chance to find out stuff from each other, feels nice. And there are nurses from all different backgrounds, and so it is nice" (P1) I just needed a hug. I needed somebody kind. I needed… *pause*… them to be saying nobody hates you, nobody is after you. I needed, you know somebody to talk to.(P4).
	Becoming aware of Mental Health Problems	out of here, because this is, anyone who's got a mental health problem, you're in the worse pla... you're in the worst mental state you could possibly be in, which isn't even either, you know, try'na kill yourself physically or it means you're really ill when you're in here, and everyone kinda knows that as well (P2). And I had to get sectioned again. But this time, I couldn't, I couldn't get outta that outta body experience, for like three weeks. And those three weeks were kinda like, blurry, I had black outs, I have black outs a lot. I didn't remember… I didn't remember like most things. I had to, I had to like jog my memory with like pictures and videos and things like that (P6)

		psychosis basically, because, its when your brain is locked into this, erm… bubble of… not seeing anything far, you know, you cant see far away, you like, you are, you are in this cloud, of smoke. You know, you could only about see yourself but nothing else around you, so and this is, this is quite difficult. You know, it is quite difficult. (P5). So I started reading this, they had these like booklets, from maybe published from a NHS trust, and I read this booklet and it, it, it, identified and you might hear voices, and erm.. paranoia, and err it just stated all the symptoms of psychosis. And I read it and I thought that's me, that's me, that's me, and I thought ahhhh Im ill, its an illness. (P4).
	Overt and covert racism	But the staff there, they were just, they kinda looked at me like I was a piece of nothing. And I was, I was the only girl that actually wasn't white, in, on the ward. Erm… for a while. And then, someone else came, but, yeah, it was… really difficult then. (P2). I thought, obviously cos like I was the only black person on the ward. Erm… that's maybe why I was treated different, cos I'm different. (P6) You know, erm… I can't react to, to, say, the things they saying back to me, or even report it, cos I have got a sense of understanding that they might be probably hearing stuff, they might be seeing stuff. This woman is probably seeing me, as some kind of, some kind of something, I don't know. So, you know, I wouldn't I wouldn't take it out on them, unless it was too obvious and direct, which, I would then obviously then report it (P.5).
Working together	Safety and containment	Its like a second home, its been a place of safety for me, its been a place, that has saved me basically, you know what I mean. (P5). It was a scary place, it were like being in prison. You had no freedom… You just had this square, rectangle probably, 10 meters by 9meters, something like that. To walk around. Not 10 meters, probably 5 meters, yeah. (P4).

		"It was a place of safety for me, it keeps me away from harms way. You know, hurting myself or hurting somebody else. Because, you know I'm jammed up. I'm seeing things, I'm hearing stuff, you know." (P.5).
	Where's the collaboration?	I could never get hold of that doctor, that consultant doctor, she was never really on the ward. She gave me a diagnosis of acute psychosis but that were it. And I was like well what does that mean?... There was no follow up, what, what, what caused it. (P.4). "When you've been tooken away from your home, and you not been told why and you've been forced to take drugs, now imagine that as a person. Now whether you black, white, Chinese, it don't matter, first and foremost you must inform them why they here" (P3). "So, but he is a very, he is obviously a very important part of my, you know, discharge and my, erm, my medication and everything… In a MDT meetings, but I… its… that was a really, really, really, hard for me. Erm… I didn't think I was being taken seriously enough." (P2). "It is just aggrievance. The only thing you can do, is wait til you get out, and sue them." (P3) "I'm a polite person, so I just had to fake smile and like, put up with it [not feeling listened to] really, but it was terrible." (P6).
	Meaningful activity	"Good yeah [occupational therapists] make it interesting and we do fun things. It's its, yeah, it's really good. Yeah the equipment is really good, yeah… Signs are put up for everybody. There is a timetable that goes up, and puts what is on. Erm.. Its offered to everyone, yeah like everyone can do stuff. Yeah so its open to everyone from different backgrounds, from all ethnicities. (P2). "There was what occupational therapist that came onto the ward, they seemed to be, erm… ok. Erm… I found them alright. They would knock on my door, not too hard, gently and say "would you like to do exercise" or arts and crafts, or whatever. And more often than not, I try to do it" (P4)

	Significant of food	Yeah, but I come from a working class background and with everything going on in life, it was nice to just be given dinner, so, the the food is nice, nice meal, and… its erm… *sigh* (P1) “They was just saying supper is on, but I don’t eat what you eat for supper. But I ate it, but I’d like some Caribbean food for supper. But I didn’t know about it, someone said you you can actually get Caribbean meals but not, not, I didn’t…someone gotta tell me when I comes in, we do Caribbean meals, if you feel like that’d be summat they’d like to eat. We do a mixture of meals, but one of them is Caribbean if you’d like summat like that to eat” (P3). “like if I’ve eaten I feel ten times better than if I’m hungry. Do you know what I mean. Like I’m harder to deal with than when I’m full. You know. And your mood changes, doesn’t it? You get hangry *laughs*” (P6).
Connection with community	Religious and spiritual perspective	They didn’t. I just prayed in my room. I just prayed, I just prayed, I prayed a lot when I was in seclusion. Erm… and when I got released, I just pray in my room. I just pray in my room. So nothing was discussed about religious needs or anything like that. There was nothing in place for that. (P6) Id have done, id have done with a bible. You know what I mean. Id have done with a Bible, but you know… I was able to get my mum to bring me one in end. But… at the time… at the time… it would have really helped. (P6) “they don’t understand Rastafarians and in Rastafarian culture, you don’t deal with the objective or psychology, or what’s material, you deal with the spiritual, what’s unseen, what’s magic, what’s spiritual, what’s holy.” (P1)
	Maintaining a Connection with Home	“They they could’ve like, could’ve at least been able to… schedule, schedule more visits… and at the same time… like… do, so when like you get let out for an hour, or like a day, or like for … 24 hours. They could’ve done that. But I wasn’t allowed that. I didn’t do that.” (P6)

		“Don’t make it too difficult for families to come and visit. Don’t make it so restricted. Things like, there’s not a room available, like there should be a room, or expand the time of visiting then if there’s only two rooms. Or let the people come into their [service-users] bedroom” (P4).